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REDACTED REPORT

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AN INVESTIGATION INTO USE OF PSYCHOTROPIC MEDICATIONS AND PSYCHIATRIC HOSPITALIZATIONS OF THREE AND FOUR YEAR OLD CHILDREN UNDER ILLINOIS STATE GUARDIANSHIP

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INTRODUCTION

The Inspector General investigated the death of four-year-old Maya Schauer who died from abuse inflicted by her foster mother, who is now serving a life sentence for Maya's murder. Maya was three-and-a-half when she came into care with her two-and-a-half-year-old sister and one-year-old brother. After a short stay with a maternal grandmother who was overwhelmed by the care of three young children, the siblings were placed in a traditional foster home. Within six months, the Department placed their newborn sibling in the same home. There is no regular respite offered to traditional foster parents who care for young sibling groups of foster children under the age of three. The foster mother in this case had biological children of four and seven years old in addition to the four foster children. When Maya turned four, her foster mother began having difficulty with her. Maya was eventually psychiatrically hospitalized two months before her homicide based on the foster mother's descriptions of her behavior. No attempt was made to verify if the reported behaviors existed across settings at the State pre-kindergarten program that Maya attended.

The Inspector General's investigation found severe systemic failures that compromised Maya's safety and call into question the validity of the information that led to the child's hospitalization. Additionally, the investigation found that a mental health therapist had handed the distressed foster mother a controversial, junk-science treatment book. The author, a former dog groomer, promoted radical, pathological methodologies to be used on foster or special needs children. The young foster parent, overwhelmed with the care of six small children, including the stress of caring for a newborn, appeared to scapegoat the four-year-old. Maya's early death served as an impetus for the Inspector General to conduct a systematic investigation into the practice of DCFS and the DCFS Screening Assessment and Support Services (SASS) funded program in the psychiatric hospitalization of DCFS children ages four and younger. The investigators reviewed all available records to determine whether reported behaviors leading to the children's hospitalizations were both valid and reliable. The investigation also examined whether hospitalizations were based on fundamental attribution errors, which occur when behaviors are explained by internal personality traits or dispositions but the environment in which the behaviors occur is ignored.

Executive Summary

The OIG investigators obtained data from the Office of the DCFS Guardian of all three- and four-year-old wards who had been psychiatrically hospitalized from March 2010, when the Guardian began tracking the hospitalization of young children, through 2012. The data includes 32 children, including Maya.[1] Of them, 31 children had reports of aggressive behaviors that contributed to their hospitalizations.

Of the children in this investigation, those who received necessary community-based services, that enhanced pro-social development, fared better.

The Inspector General's investigation focused on whether the child welfare and mental health systems looked at these often traumatized children through developmental and ecological lenses.

[1] See OIG investigation on death of Maya Schauer (#2011-2976).

A developmental lens views behaviors in the context of age-appropriate and normal developmental struggles, considering the emotional and social competencies of the individual child and the parent or caretaker. A developmental lens places into context common problems, such as an exhausted parent's struggle with a child's sleep and bedtime routines, and recognizes that a preschool child with expressive or receptive language delays may have behavior problems. A child with communication deficits can easily become frustrated and exhibit temper tantrums or aggressive behaviors. One child, four years and 11 months old, had the expressive language of a child aged two years and 11 months. He only received 15 minutes of speech therapy a week at school, which was hardly effective considering the obstacles his speech deficit presented to pro-social skills development.

An ecological approach stresses the importance of placing psychological phenomena in context. Children are social learners and acquire behaviors from face-to-face interactions with parents and family, and might in turn use what they learned when interacting with peers (Kerig and Lindahl, 2001).

As many as a third of children who come into care have seen or been victims of domestic violence in their homes. One three-year-old boy in this investigation came from a family with an extensive history of domestic violence. He entered foster care after his mother committed suicide by shooting herself in the head; he was on the front porch at the time. Previous Inspector General investigations found that children exposed to violence may freeze, withdraw or, sadly, imitate the aggressor. Some children become protective of family members and feel a sense of failure or guilt for not being able to stop the violence. When children are caught in an untrustworthy environment, they may not have the ability to trust a new environment when they are first placed in foster care. Violence inflicted on children directly and children's observations of violent acts are both traumatic situations. The young boy who witnessed the aftermath of his mother's suicide never received grief and loss therapy even though two children's hospitals in adjacent communities provided such services.[2]

Approximately 600,000 of the children born in the United States each year may have been prenatally exposed to alcohol. These children may suffer from a broad range of difficulties including long-term health, behavior, development, and academic achievement. Five mothers in this investigation reported using substances while pregnant; two gave birth to a substance-exposed infant. The DCFS substance abuse screen does not specifically target prenatal alcohol use and prenatal health records were not obtained, even for those infants who came into state custody at birth or shortly thereafter. Neurodevelopmental disorders associated with prenatal alcohol exposure are a serious public health problem. In all but three cases, the records were silent on this risk factor. Recent literature suggests the use of vitamin supplements (choline, folate and vitamin A) to prevent or ameliorate the effects from fetal alcohol exposure.[3]

The intense anxiety and fear that often follow a traumatic event can be especially troubling for children. Some children may demonstrate regressive behaviors such as thumb sucking or bed wetting, may be more prone to nightmares and fear of sleeping alone, and may see their

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[2] See OIG publication: Grief and Loss, Spiritual Support and Child Welfare: A Handbook for Hospital Chaplains & Child Welfare Professionals.

[3] See Appendix: New Research on Vitamin Supplements

performance in school suffer. Other changes in behavior patterns may include throwing tantrums more frequently, displaying aggressive behaviors, or withdrawing and becoming more solitary.

Preschool children typically display negative emotional behaviors when frustrated or irritable. The severity of such behaviors varies depending on the temperament of the child. The degree of difficulty of these behaviors depends, in part, on the individual skill and understanding of the child's caregivers. Some studies (Rubin, 2004) suggest a temporal relationship in which placement change precedes and may contribute to attachment distress, leading to increased aggressive behavior, which often results in visits to emergency departments and even hospitalization.

Although admission to a psychiatric inpatient unit may be necessary for management of risks when communities do not have viable alternatives, Marsenich (2002) noted that no evidence supports the view that hospitalization leads to long-term, positive outcomes relative to other care options. Instead, we must focus on increasing intensity or quality of services and placements in the community for the youngest of our children, including greater collaboration between hospitals, foster parents, child welfare staff, and community mental health providers to assure that the best community care is provided in a timely fashion. It is clinically unsound and ethically problematic for a young child who enters foster care with inappropriate learned social behavior to be given a mental health diagnosis before the child is given enriched opportunities to learn pro-social skills in a reinforcing environment; remedial skills training should be the prudent course of action by a foster care agency.

Methodology

The investigators divided the 32 children into three cohorts based on their age upon entry into foster care. Using an ethnographic qualitative records review, the investigators documented the context of the child's life prior to and after their hospitalization. This context includes the reasons the child came into foster care, the level of isolation or support to the foster family, and whether the child was placed as part of a sibling group, as well as the timely use of evidence-based or evidence supported treatment interventions and strategies. The investigation also determined the children's involvement in early education and recreational or community activities. The investigators paid special attention to transitions, including the number and length of children's placements, reason for transitions, and changes of caseworkers and agencies.

Emerging concerns regarding the effects of psychotropic medication on very young children demanded a deeper analysis on the eight children in this investigation who had either been prescribed Lithium (mood stabilizer), Risperdal (second generation antipsychotic), or Depakote (used to treat adult seizure disorder and adult Bipolar Disorder; used off-label for pediatric seizures), or whose records indicated a discrepancy between the prescribing and consulting psychiatrist. Further analysis also examined issues related to problems with the administration of the psychotropic medication. In some cases, the foster parent disagreed with medicating the child and altered or discontinued the child's medication. In other cases, the child faced a chaotic home, which was likely, rather than a psychiatric disorder requiring medication, to be the root cause of disruptive behaviors.

Findings

The investigation found that 94% of the children in this report were not provided non-chemical, evidence-based interventions before their initial hospitalization. Only six children in this investigation did not receive psychotropic medications, although one of these six was initially prescribed them. Contextual assessment of a child using a Functional Behavioral Assessment may obviate, or at least minimize, the need for both psychiatric hospitalization and psychopharmacologic therapy. In the field of psychopharmacology, different providers maintain differing opinions on treatment strategies for various conditions and behaviors. This study was not intended to critique therapeutic choices; its goal is to emphasize the need to rule out less invasive, and potentially more beneficial, non-chemical strategies before turning to psychopharmacological therapy.

The Need for Ecological and Developmental Assessments

Doctors, especially when prescribing psychotropic medication for children, must have an accurate clinical picture. Psychiatrists rely on patients or informed sources for information on behavior and symptoms outside of the hospital or office setting. For DCFS wards, this source is overwhelmingly foster parents. There was little evidence of the doctors obtaining additional or corroborating information from caseworkers, daycare providers, teachers and therapists. Using only one of these sources may lead to an improper diagnosis and possible inappropriate medication, especially when an overwhelmed foster parent provides the information, or when the symptoms and behaviors described are not placed in a timeline or within a context. This problem is compounded by the tendency to generalize from extreme but rare incidents. Too often, psychiatrists do not know what a child's usual day looks like. The psychiatric assessments did not include either an ecological or developmental analysis that would ensure that a child's response to chaos and or abuse is not carelessly pathologized. Too many assessments relied on a foster parent's description of problematic behaviors without determining whether the problem behaviors exist across settings, and failed to consider a Functional Behavioral Analysis that might obviate the need for psychotropic medication. SASS is using an assessment tool for these young children, under age six, which has not been normed for the age group and was never intended to be used for such young children.

Models stressing *person* pathology have long dominated the study of behavioral, emotional, and learning problems. Discussions of cause, diagnosis, and intervention strategies make this apparent. Foster children who deal with multiple transitions and are exposed to often severe treatment or neglect are especially likely to be harmed by a strictly *person-based* pathological approach.

Lack of context or simple listing of symptoms or incidents can lead to exaggeration of symptoms and recorded misinformation. Amplification, in turn, can lead to classification in a high risk category that places children on certain trajectories. For example, Eli's foster mother, who was caring for three small children under five, said he was trying to set the house on fire and attempting to kill the cat. Eli did not actually try to start a fire; he and his sister were playing in the bathroom where the foster mother had left a lit candle. During play, they tossed toilet paper near the candle that caught fire. Eli also had a nightmare about the cat. The foster mother also reported that he had been expelled from daycare because of his aggression but OIG investigators

found this to be false; the foster parent lost funding for employment related daycare when she could not provide evidence of her self-reported home-based business. When the foster parent took Eli to the Emergency Department, they arrived around 8 p.m. Medical records note that Eli was jumping on the bed at the Emergency Department and was not moved to the unit until 1:00 a.m. On April 20, 2010, the attending physician sent a request through the Psychotropic Medication Consent Line seeking approval for Tenex (centrally-acting alpha agonist/centrally-acting antihypertensive; used to treat adult hypertension and used off-label for heroin withdrawal, migraine headaches, and pediatric ADHD). The consulting psychiatrist, asked why they were choosing Tenex over an antipsychotic when the request came in. The next communication in the database shows that the request for Tenex was rescinded and a request for Risperidal was approved five days later. According to hospital records, Eli did not require medication after all and was discharged that same day. Eli told psychiatric hospital staff that he was bored at home while the foster mother watched television all day.

The Need for Collaboration and True Integration of Information

This investigation demonstrated a need for a more substantial collaboration between the medical providers involved in a child's care. There is a pervasive lack of integrated information on these children. While collaboration between the Department's Clinical Division, consulting psychiatrists, and case managers is critical for the duration of all cases involving serious mental health concerns and very young children, collaboration is of utmost importance at initial intake and at the 30 day post-hospitalization staffing. While some case files included evidence of professionals raising important contextual questions or recommending less invasive interventions, there was no integration of or documented follow-up on those recommendations. With representatives of each part of the child's care team speaking directly to each other, discrepancies in their care can be explored and hopefully rectified. More importantly, a true participatory staffing would ensure uniform review and compliance with parameters and guidelines.

In addition, the investigation also found that once psychotropic medication has been prescribed, there is no required reassessment at specific intervals to ensure that only the minimum required chemical interventions are used.

Children six and under who are referred to Crisis and Referral Entry Service (CARES) need to have Specialized Assessments that would ensure implementation of recommendations contained in this Report and evidence-based practice. The Specialized Assessment must include information regarding the child's typical daily schedule (weekday and weekend), identified problematic behaviors, and data from multiple sources to determine whether those behaviors exist across settings, as well as child-centered collaterals to determine to whom the child feels special. Supervisors must ensure that that each case manager solicits information from all caregivers, school staff, and daycare providers and other relevant professionals through a Child Behavior Checklist. A Functional Behavioral Assessment should be pursued prior to hospitalizing a young child. Several psychiatric hospitals noted the risk these young children face on units with older children and the lack of appropriate programing for such very young children. This suggests that alternatives to hospitalizations should be supported.

The Need for Critical Ancillary Services and Supports to Child and Caretakers

All of DCFS' preschool age children should be in Head Start or State pre-kindergarten programs. Children in this investigation, who received necessary community-based services that enhanced pro-social development, fared better. Critical ancillary services include system of care services, to provide continuity and linkage to the community, occupational, speech or other remedial therapy, and involvement in extra-curricular activities. Children provided with these resources were able to significantly decrease both the number of hospitalizations and number of psychotropic medications. Any treatment modality must involve the caregiver as well as a realistic appraisal of supports that the caregiver may need. Several of the children in this investigation suffered from ever shifting visitation schedules that appeared to ignore the confusing effects these changes had on the children. The number of transitions many of these children experienced was inexcusable.

Recommendations

The Department has a heightened responsibility to children who come into their care from high risk situations.

1. Young children from families with high risk histories of violence, and/or substance abuse and mental illness should receive timely ameliorative and preventive services when they first come into foster care. Young children from high risk households who exhibit aggressive behaviors should receive first line evidence and in rural areas, preferably home-based interventions such as Parent Management Training – The Oregon Model (PMTO), Parent Child Interaction Therapy (PCIT), Incredible Years, and Collaborative Problem Solving
2. An ecological and developmental focused Specialized Assessment must be used for children under age six who have been referred to the CARES hotline or for whom the Guardian receives a request for psychotropic medication. The Assessment should include the following:
    a. Description of identified problematic behaviors;
    b. Ecological and Developmental perspective including prior trauma and neglect suffered by the child and number of transitions;
    c. Corroboration of whether identified problem behaviors occur across settings; with Child Behavior Checklist from key Informants including foster parents, relatives, teachers, early education providers, and other relevant professionals;
    d. The ecological and developmental perspective include prior trauma and neglect suffered by the child and number of transitions the child has encountered;
    e. A description of typical day (weekday and weekend);
    f. Description of sleep routine; visitation schedules, foster home composition;
    g. A Functional Behavior Analysis of the child's behavior; and
    h. Description of non-chemical evidence-based interventions that will be attempted prior to use of psychotropic medication.
3. The above assessment should be developed with collaboration and shared with all professionals involved in the child's care.
4. SASS must stop using the CSPI on children six years of age and under.

5. Children age six and under who are at risk of psychiatric hospitalization must be offered critical ancillary services, including System of Care (SOC) link-up services, occupational therapy and extra-curricular activities. The Department with the help of its Medical Director needs to assure that young wards with aggression problems and speech delays receive enhanced speech therapy.
6. The Department must ensure that all therapy provided to our wards is evidence-based.
7. The Department must ensure that all preschool aged wards attend State pre-kindergarten or Head Start programs.
8. The Assessor should sensitively inquire if the mother may have used alcohol prior to her knowing if she was pregnant. Because recent studies have demonstrated promising potential in the administration of Choline, folate and Vitamin A both prenatally and for use with children who have a risk of prenatal exposure to alcohol, the Department should ensure that foster parents receive a stipend to offset the costs of such supplements for infants and younger children who come into care with any indication of maternal alcohol use.
9. The Department needs to train foster parents and caseworkers on first-line interventions recommended in the Department's consulting psychiatrist's Schematic Summary.
10. This recommendation addresses personnel issues.
11. When a consulting psychiatrist attaches a qualified approval for psychotropic medication, the Department must ensure that the qualifications are met.
12. The Guardian's Office should retain Psychotropic Medication Request Forms completed for wards and ensure that first line treatments, as outlined by the Department's consulting psychiatrist, have been provided prior to approval for psychotropic medication.

INVESTIGATIVE REPORT

Medication Management

Although the use of psychotropic medication in a young and vulnerable population is of concern, psychotropic medications in the pediatric population are not prohibited. Psychotropic medications maintain a level of danger and severity among adult populations and have been studied extensively for safety, efficacy, and long term effects. The same cannot be said about analysis of their use among the pediatric population. Given the logistics, cost, and ethical concerns raised in pediatric studies, there is a lack of data available on the subject. As numerous questions about the effects of psychotropic medication in children remain unanswered, the use of these medications with this population requires strict monitoring.

Chaotic Environments

It is inevitable that a child entering foster care will experience some level of stress following removal from their home. Despite any efforts to keep the transition as seamless as possible, a certain level of strain on the child's emotions and psyche is understandable. Additionally, several of the children reviewed have experienced an exceptional level of stress and chaos in their home environments. It can be expected that the exposure to these additional factors would cause even further behavioral difficulties and psychological effects.

A substantial amount of research, including animal models, provide evidence that "Children who spend early portions of their lives in institutions or those maltreated in their families of origin are at risk for developing emotional and behavioral problems reflecting disorders of emotion and attention regulation" (Loman et al, 2010). Four cases of exemplary chaotic household upbringings serve as examples of this fact; Jason, Liam, Brooke, and Greta all faced initial upbringings in which the stressful home situations likely influenced their emotional state and subsequent behaviors. These children experienced a variety of stressors such as domestic violence, drug use in the home, and direct physical or sexual abuse.

Several components of a child's upbringing can influence the development of behavioral tendencies and emotional capacities (McLaughlin, 2010). Several of the children reviewed were diagnosed with Post-Traumatic Stress Disorder (PTSD); there is sufficient evidence that these children's experiences affected their behaviors and ability to adjust. Jaffee et al (2012) demonstrated that a disruptive home environment not only leads to a sense of environmental confusion, but that a lack of routine in the household can also "undermine children's ability to regulate emotions and behavior." In many of the aforementioned cases, and especially the four presented here, routine and a secure home environment were scarce. It is not surprising that the majority of these children developed behaviors and emotional responses that were inappropriate and seemingly unregulated. Greta exemplifies this. When her biological mother was granted unsupervised visitation rights, she had a difficult time remaining within the confines of the allotted schedule and this had immediate effects on the child's behaviors; the foster parents reported continued difficulties getting her to fall asleep. Even during her subsequent hospitalizations, it is noted that the child was in severe need of improved structure in her life.

Psychotropic Medications including Antipsychotics as First Line Therapy

In January 2015, The Office of the DCFS Guardian released *Prescribing Psychotropic Medication to Children Under 6 Years in State Guardianship Schematic Summary for Prescribers*. This document outlines decision-making strategies for treatment of various psychiatric and behavioral disorders among children within the State of Illinois foster care system. The guidelines emphasize an evaluation process that includes several options for therapeutic services prior to consideration of psychotropic medications. Furthermore, these same guidelines point to numerous other medication options for consideration prior to the use of antipsychotics such as Risperdal.

Considering the numerous comorbidities experienced by several of these children, as well as the multiple overlapping diagnoses, there is rarely a definitive treatment. Strict psychiatric treatment guidelines are scarce. Instead, various parameters exist that suggest best practices for therapeutic considerations when dealing with the involved disorders.

Of the 32 children reviewed, 17 children received an antipsychotic medication at some point throughout their care. The reported reasons for treatment with antipsychotic medications, (e.g. Risperidal, Zyprexa, Seroquel, and Abilify), include a range of symptoms and diagnoses. Associated symptoms include varying levels of aggression, harm to self and others, agitation, impulsivity, explosive and bizarre behaviors, and reported fire setting. The diagnoses for treatment with antipsychotic medication in these 17 cases include Bipolar Disorder, Oppositional Defiant Disorder (ODD), Disruptive Behavior Disorder, Attention Deficit Hyperactivity

Disorder (ADHD), Adjustment Disorder, PTSD, Intermittent Explosive Disorder, Reactive Attachment Disorder (RAD), Impulse Control Disorder, and Mood Disorder.

The DCFS Guardian's guidelines provide useful parameters for a number of the aforementioned disorders and symptoms. Psychotropic medications are not named as first line therapy for any of the conditions in question. Each of the disorders listed in the *Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years in State Guardianship* file include indications for both a preliminary screening tool for diagnostic confirmation, as well as first line therapy consisting of some practice of behavioral therapy. General psychiatric standards of care echo the need to exhaust evidence-based, non-chemical interventions before prescribing psychotropic medication. However, in this investigation there was no evidence-based therapy as first line treatment for the majority of the three- and four-year-olds, 30 of the 32 children.

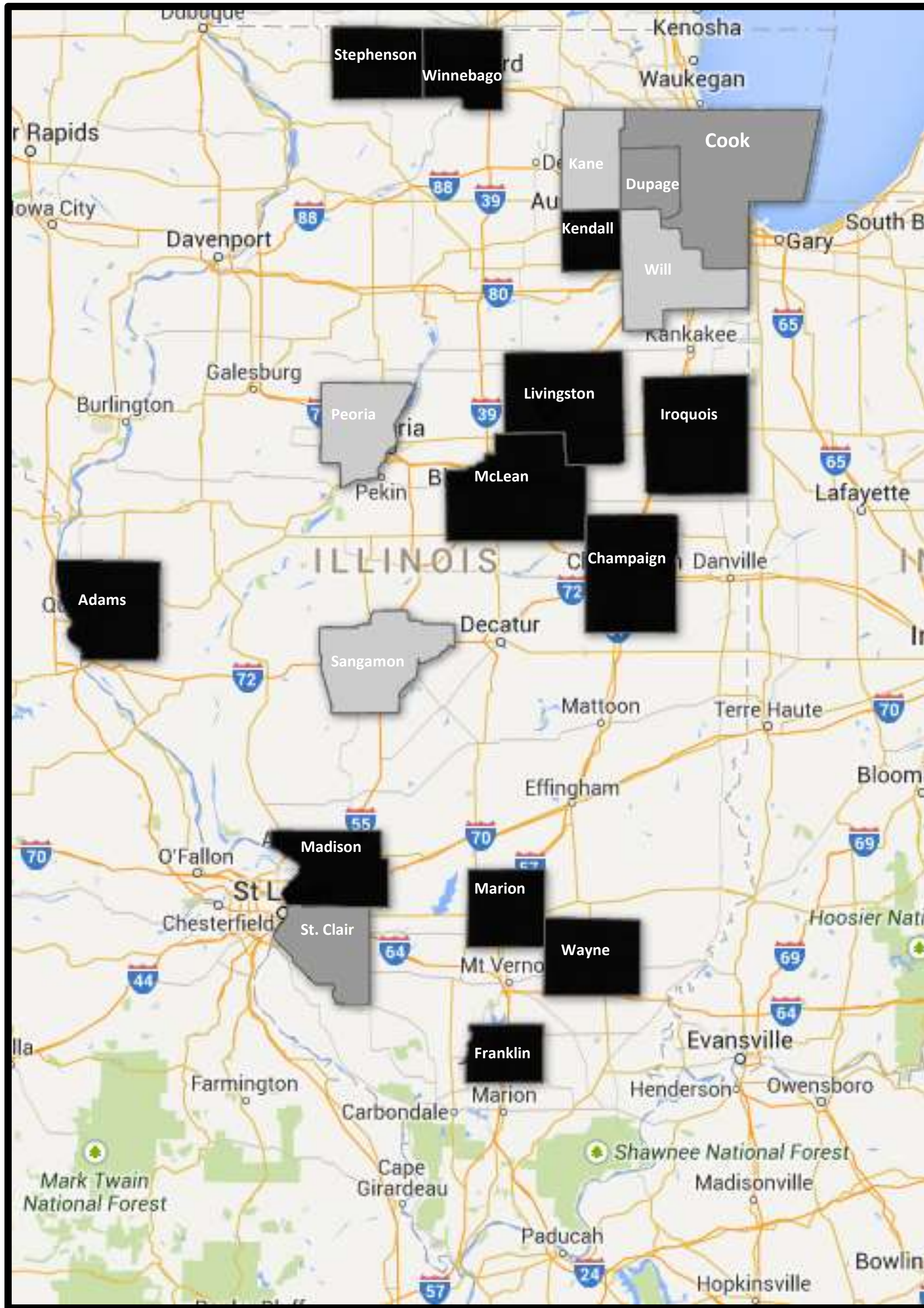
Evidence-Based Resources

All but one (96%) of the three- and four-year-old children hospitalized in this investigation were characterized by "reported" aggression toward others. Fifty-three percent also displayed aggression to themselves (head-banging, scratching, biting) and 18% had reported temper tantrums with some type of property destruction. However, the behavioral descriptions of the antecedent events that led to the aggression and a baseline with measures of frequency, durations and intensity of the aggressive behaviors were not required as part of the initial assessments of the children. SASS's use of the Childhood Severity of Psychiatric Illness (CSPI), a tool that was not normed for very young children, also compromised the initial assessments of the severity of the children's behaviors.

The Department contracts with Northwestern University to maintain the Statewide Provider Database that includes some evidence-based resources in Illinois. However, review of the database revealed a scarcity of evidence-based services. (See map on next page.) The Department also contracts with a state university for consulting psychiatrists (UCP) to review requests for psychotropic medications for DCFS wards. In reviewing the UCP data, there are many examples of the DCFS Guardian or consulting physician suggesting that some form of behavioral therapy be considered or implemented as an alternative treatment option. Similarly, there are numerous occasions in which the consulting physician questions the use of a specific medication, and requests additional information before providing approval for its use. It is unacceptable that these concerns and questions were not effectively communicated to the field and to DCFS Clinical who, even more than prescribing physicians, could be facilitating behavioral treatment and parent training for the caregiver. The legitimate concerns of the consulting psychiatrists have failed to result in meaningful practice change that would require evidence-based, non-chemical interventions to be tried before resorting to psychotropic medications for very young children.

All 32 children in this investigation received mental health services at some point during their placement in foster care. Of the 32 children, 25 (78%) received mental health services from a therapist employed through their foster care agency. However, records overwhelmingly did not show that the therapists provided evidence-based interventions.

Access to Evidence Based Resources by County



■ **0 Evidence Based Practices**

■ **1 Evidence Based Practice**

■ **2 or More Evidence Based Practices**

There are valid evidenced-based interventions for aggression and temper tantrums in young children. These resources include Parent Management Training – The Oregon Model (PMTO), Parent Child Interaction Therapy (PCIT), Incredible Years, and Collaborative Problem Solving. Only ten (31%) of the 32 children had documented participation in an evidence-based intervention in their case record.

Five children received evidence-based mental health interventions. One of the five, Hunter, received Child Parent Psychotherapy from a foster care agency intern for six months after his initial hospitalization.[4] When the intern left the agency, the child was placed on a waitlist at three different community providers. The case manager documented difficulty locating a male therapist that would see DCFS wards and accept the medical card. The remaining four children received evidence-based mental health services from a community agency. Of those four, three children received trauma-focused therapy from Alpha Children's Hospital. One child was on a waitlist for five months before the trauma therapy began. A fourth child received psychotherapy through a program affiliated with Banner Children's Hospital. All five of these children lived in the same county in a major urban area. An additional five children received behavior therapy and assessment from a certified behavioral therapist.

Functional Behavioral Assessments

Understanding the development of problem behaviors is known as Functional Behavioral Assessment (FBA). A key component of this type of assessment is preventing problem behaviors before they occur. Many caregivers deal with problem behaviors by doing nothing until they occur; after a child displays the behavior, there is a punishment. However, punishment does not teach new skills; its goal is to stop problem behaviors from occurring. If the child does not have other behaviors to draw from, they will continue to act out. Any time a child's behavior, positive or negative, is successful in meeting a need, the behavior is likely to be repeated.

Through a Functional Behavioral Assessment it is believed that if those in caregiving roles learn about the behaviors and know when and what may trigger them, positive strategies can be implemented to teach new behaviors. Teachers and caregivers can use the information from a Functional Behavioral Assessment to help a child learn new skills, with the ultimate goal of teaching children how to manage their own behaviors. Following a structured interview format[5] with each child, one can more fully understand problem behaviors, such as where they occur and what purpose they serve for a child. A thorough assessment would include the following: description of the behaviors; definition of potential ecological events that may affect the behavior(s); identification of daily activities; definition of events and situations that predict occurrences of the behavior(s); description of the child's play abilities and difficulties; identification of the "function" of the undesirable behavior(s); definition of the efficiency of the undesirable behavior(s); definition of the primary method(s) used by the child to communicate; definition of what events, actions, and objects are supportive or present challenges to the child; and development of summary statements for each major predictor and/or consequence.

[4] Hunter also received behavioral interventions, See *Functional Behavioral Assessments*, page 15
[5] See Attachment A: Functional Assessment Interview Form – Young Child

Six of the 32 (19%) had a recommendation for a referral for a Functional Behavioral Assessment with a certified behavioral therapist.[6] Jason attended a pre-kindergarten program prior to hospitalization where school staff used stickers as a rewards program to work with his behavior problems. His SOC therapist also worked with the Beta Foster Care Agency therapist to design a behavior modification plan for the grandparents to use in the foster home. His SOC therapist also consulted with an Applied Behavior Analysis (ABA) therapist who recommended a music player with headphones and visual charts. Jason also received services from a behavior analyst after his hospitalization.

Shannon began receiving services from a behavior therapist after her initial hospitalization in February 2010. The services focused on assisting with her behavior issues that included tantrums, aggression, removing her clothing and inappropriate sexual behaviors. Staff at her therapeutic day school utilized a behavior management plan to address elopement, physical aggression, throwing objects and dropping to the ground. During her fourth hospitalization at Kappa Psychiatric Hospital, staff completed a behavioral intervention plan. The clinician determined that Shannon utilized physical aggression to gain attention and escape from demands. The Behavior Analyst provided the foster family with instructions to carry out Shannon's behavior plan in the foster home. During her fifth hospitalization at a children's hospital, staff assisted the foster family with behavioral management strategies and helped safety-proof their home. She received follow-up from a Board Certified Behavior Analyst, outpatient psychiatry services, and individual and family therapies. During her placement in a 90-day diagnostic program at Omicron Diagnostic Program and Residential Program, staff utilized a behavior management plan to help decrease elopement, throwing objects, and physical aggression, and to increase functional communication, walking unassisted, and remaining seated.

Prior to his hospitalization, in the spring of 2009, school staff conducted a Functional Behavioral Assessment to assist Hunter in managing his behaviors. In April 2010, Hunter participated in a Multidisciplinary Developmental and Behavioral Evaluation. His psychiatrist referred him for evaluation to rule out autism. He received diagnoses of Developmental Language Disorder and Disruptive Behavior Disorder NOS. Recommendations included continued psychiatric care, behavior therapy with parent training, speech therapy, weekly occupational therapy and placement in a preschool with a highly structured learning environment. He continued to receive behavior services at school after his hospitalization. The foster parent enrolled Hunter in therapeutic services at a hospital that began, in January 2012, to provide behavioral services. The service had not begun prior to Hunter's adoption.

Isaac had a Pediatric Psychology evaluation that recommended ABA training for his godmother in the spring of 2011 prior to his first hospitalization; however, there was no evidence in the record that his godmother ever received the recommended training. After his hospitalization, a community agency therapist provided the foster mother with a "caught you being good" chart in the foster home. In the fall of 2012 after his fifth hospitalization, school staff developed a behavior system that would be given to the godmother daily. After being removed from the home of his godmother, his new foster mother designed a rewards program for Isaac that allowed him to put an item he wanted on layaway that he could buy after he earned enough green days.

[6] The Behavior Analyst Certification Board (http: //www.bacb.com) provides a search function on their website allows consumers to locate a Certified Behavior Analyst by zip code.

During his third hospitalization, in March 2012, Flynn participated in a neuropsychological evaluation. The clinician recommended that a Behavior Specialist Team conduct a functional analysis in his home and design a behavior program that focused on reducing his aggression and increasing his social skills. After his discharge, he received individual therapy from an agency therapist who noted using both play and art therapy techniques to process his past trauma and help him engage in positive relationships.

In the spring of 2011, while receiving intact family services, Fiona participated in an evaluation with Lambda Community Mental Health Provider. One of the recommendations included a Functional Behavioral Assessment. There was no documentation in the record that Fiona ever participated in the recommended assessment.

Sleep and Non-Chemical Interventions

Twelve (38%) of the 32 children were described as having sleep-related problems: difficulty with initiation and/or maintenance of sleep, nightmares, or night terrors. As a result of these reported difficulties, the first line of documented treatment for 11 of these children was medication.[7] Four of the 12 children were prescribed Clonidine (centrally-acting alpha agonist/centrally-acting antihypertensive; approved to treat hypertension and used off-label for pediatric ADHD) on a long-term basis for difficulties related to sleep and two of the 12 were prescribed both Clonidine and Melatonin simultaneously. Four other children were prescribed medications for sleep only while in the hospital (Clonidine, Benadryl, or Trazodone), however, one of these four children was prescribed Benadryl (first generation antihistamine, motion sickness, and insomnia medication) for sleep following hospitalization. One was prescribed Melatonin only.

Review of the case records revealed no information regarding sleep hygiene, bedtime routines, and how the home environment may contribute to sleep difficulties. Often the records noted "sleep disturbance" without further explanation. Consulting psychiatrists addressed concerns regarding sleep in 12 of the cases. The concerns included etiology of insomnia, treatment of related issues such as sleep apnea, and sleep routine. For example, Xander's prescribing psychiatrist requested 50 mg of Benadryl for issues related to insomnia. The consulting psychiatrist approved the medication for seven days with the following notes:

> The 50 mg dose is a maximum dose for a severe allergy reaction. There is no good guidance for a dosage for a youth under 12 for insomnia. More information needed. What is the etiology of the sleep disturbance? The patient is massively obese for his age (well over the 100% for BMI). Does the patient snore? If so, he may have increased respiratory load or even sleep apnea which could account for all of his symptoms including the lack of concentration and impulsivity. Does he have enlarged tonsils? This information is necessary since the patient is being treated symptomatically and diphenhydramine might actually worsen his ADHD symptoms by exacerbating his sleep problems. I need the answer for this. Also, if not done already, let's refer this one to DCFS Clinical as this is an extremely high risk case.

[7] Perry was reported to have trouble sleeping prior to his first hospitalization but was not prescribed any medication for sleep-related difficulties.

During the 30-day DCFS Clinical meeting, after Isaac's initial hospitalization where he received a prescription for Clonidine to address sleep, the Clinical Convener noted concerns about the four-year-old's sleep routine. The Convener noted:

> Sleep deprivation may also be affecting his behavior during the school day. The worker and pediatrician should address this issue with the worker developing a sleep hygiene program for Isaac. The foster parent should assure that the Isaac abides by the sleep hygiene plan.

The record did not indicate that Isaac's sleep routine was addressed with his foster mother, nor did it indicate that the case worker asked Isaac's pediatrician to discuss sleep with the foster parent.

SASS INITIAL SCREENING AND REFERRAL PROCESS

The Department contracts with Screening, Assessment and Support Services (SASS) to assess the immediate mental health needs of wards to determine whether the needs of the ward can be met with community-based services or if psychiatric hospitalization is necessary. If psychiatric hospitalization is deemed necessary, SASS assists case managers in monitoring care while the ward is hospitalized and assists in developing and implementing appropriate level of care post hospitalization.[8]

The Crisis and Referral Entry Service (CARES) is the initial point of contact for a ward in need of mental health assessment or services. CARES make an initial determination as to whether a ward's immediate mental health needs can be addressed through a referral for community services or whether a ward is in psychiatric crisis that requires immediate referral to a designated SASS provider for screening.[9] Specific case information, including treatment interventions and unusual incidents or events, is recorded in SASS' web-based reporting system.

The level of response to a ward in need of mental health assessment initially depends on whether or not CARES determines that a ward is at risk of psychiatric hospitalization. For wards potentially in need of psychiatric hospitalization, CARES provides SASS with preliminary information about the nature of the crisis within 30 minutes. Unless the child and family's physical location presents immediate danger requiring relocation, a SASS Qualified Mental Health Professionals (QMHP), or a mental health professional under the supervision of a QMHP, is required to meet with the child and perform a face-to-face screening and assessment within 90 minutes. This includes Childhood Severity of Psychiatric Illness (CSPI), mental status evaluation, evaluation of ability to function in environment and daily life, assessment of degree of risk of harm to self, others or property, and the viability of less restrictive resources in community that can meet the child's mental health needs.

SASS workers utilize the CSPI, a decision support instrument, along with other screening and assessment information when deciding whether the use of community services or hospitalization

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[8] Department of Healthcare and Family Services, DCFS and Department of Human Services fund SASS. Any child eligible for public funding under these three programs is eligible for SASS services. A referral to SOC services will also be made by CARES for DCFS wards in crisis.

[9] There are 44 SASS agencies in Illinois; calls are referred to an agency based on where the ward lives and the Local Area Network (LAN) map which identifies geographic boundaries for Illinois.

will meet the immediate mental health needs of the child. The disposition of screening has to be documented on a CSPI summary form and completed within four hours of CARES referral. Response time and case disposition are required to be reported within five calendar days by entering info into the web-based reporting system.

Intervention and Stabilization in Community

In cases where a child's mental health needs can be met without psychiatric hospitalization, SASS crisis intervention and/or placement stabilization are immediately provided to stabilize the child's behavioral and emotional condition. SASS collaborates with the assigned caseworker to develop, coordinate and implement outpatient services that are focused on resolving crisis presentation and helping prevent further occurrences. SASS workers are required to make follow-up appointments within 48-hours after initial screening and assessment. SASS also determines if a child is already receiving mental health services and notify other providers and case workers of the screening. If less restrictive resources are determined to fit the immediate needs of the child, the family is to be provided with an emergency number to access SASS at all times.

Psychiatric Hospitalization

If the SASS screening determines that a child's behaviors or symptoms are severe enough to warrant psychiatric hospitalization, SASS notifies the ward's case manager and coordinates hospitalization and transportation options. The SASS worker participates in admission evaluation and ensures that no ward arrives unaccompanied at the hospital. Upon admission, SASS provides hospital staff with a completed CSPI summary to notify the DCFS consent unit of the ward's hospitalization.

During the hospitalization, SASS workers collaborate with the case management agency for intensive treatment and support options which may be needed to maintain pre-admission placement. SASS is expected to offer mental health and/or other intervention services to support child's level of functioning after discharge. While the child is hospitalized the main goal for SASS is to evaluate the child's living arrangement and assess the caregiver's capacity and willingness to support and maintain the child's functioning level. SASS is responsible for encouraging and supporting caregiver's participation in hospital treatment and discharge planning. SASS offers supportive services to caregivers in order to support participation in developing individual treatment plans.

Collaboration with all participating providers is expected in appropriate discharge planning, and SASS workers participate and provide documentation in every 72-hour staffing throughout hospitalization and discharge. In collaboration with the assigned caseworker, SASS visits the child during hospitalization and prepares for post-hospitalization placement. In collaboration with the caseworker, SASS coordinates and/or provides mental health interventions up to 90-days post-discharge.

Discharge from SASS Services

Children are discharged from the SASS program through an eligibility discharge or service discharge. Eligibility discharge occurs when the child's 90-days expire and no extension has

been authorized either automatically or through demonstration of clinical need as requested by the child's SASS provider. Service discharge is determined by the provider and does not affect the child's statewide eligibility, unless expired. Service discharge occurs when the SASS provider determines there is no further clinical necessity for SASS services. Service discharge can also occur if the child is no longer available to receive services or refuses services.

Within 72-hours of SASS discharge, SASS completes a closing CSPI with the expectation that there has been a demonstrated improvement in the child's overall functioning (See section below). The SASS provider coordinates with participating providers (including the caseworker) involved in continuation of mental health services, before being discharged from the program. At discharge, SASS completes a written Discharge Summary describing the type, quantity and outcome of SASS services as well as the child's current status and treatment recommendations. Within 10 days of discharge, the Discharge Summary should be forwarded to providers participating in the child's treatment.

Childhood Severity of Psychiatric Illness (CSPI)

The CSPI was originally developed in 1995 as a decision support tool for case managers and clinical decision-makers, to provide for the structured assessment of children with possible mental health service needs along a set of dimensions found to be relevant to clinical decision making. A revised version (CSPI-3.0a) was implemented in 2002 and was developed in collaboration with the DCFS, Department of Healthcare and Family Services (HFS), and the Department of Human Services (DHS). This revised version allowed for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. A primary goal of this tool is to assess appropriate use of psychiatric hospital and residential treatment services and to consider those dimensions crucial to good clinical decision-making for expensive mental health service interventions. The form serves as both a decision support tool and as documentation of the identified needs of the child served along with the decisions made with regard to treatment and placement at the time of the crisis.[10]

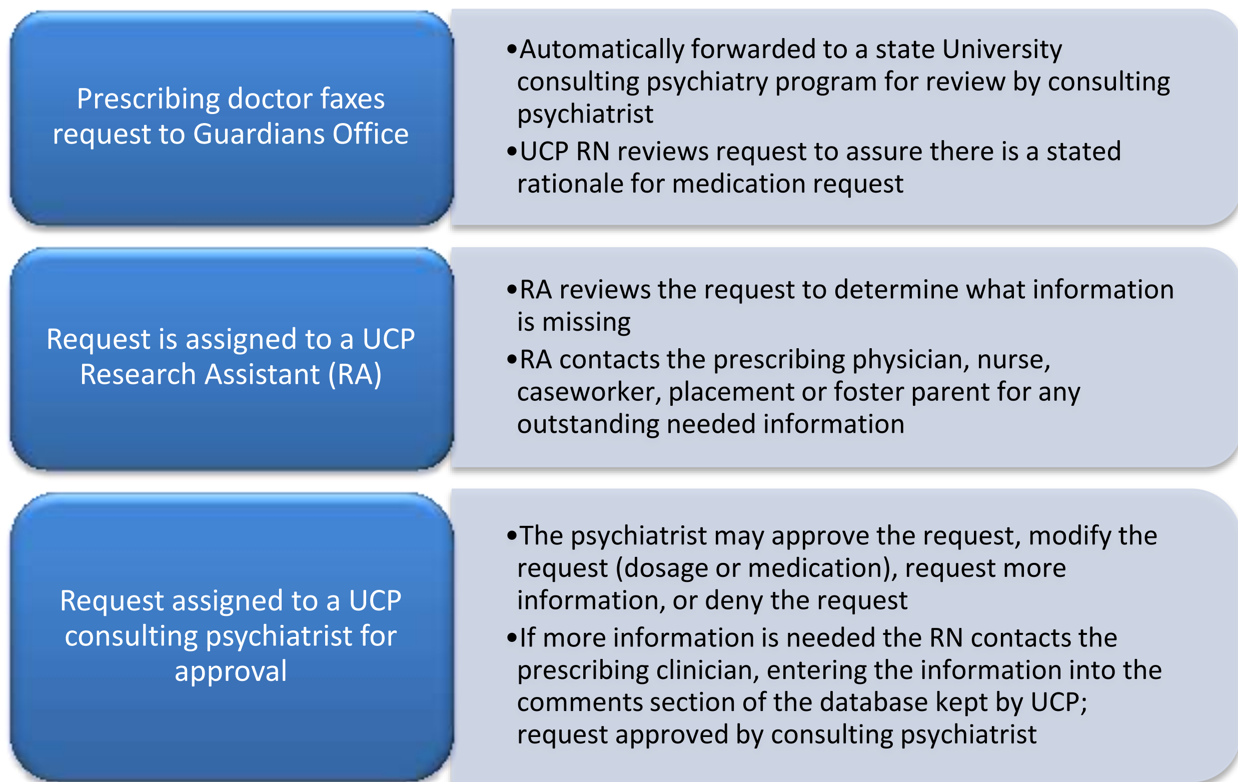
In an interview with the principle developer of the CSPI, he reported that this tool was designed and validated on school-age children and was "never even considered" for children younger than five years. As such, using the CSPI as a crisis decision-making instrument for the three- and four-year-old population is not appropriate. The principle developer recommended utilizing tools that are evidence-based and embed an early development (social, emotional, and behavioral) frame of reference (e.g. Ages and Stages Questionnaire: Social-Emotional). It may be necessary to construct a different protocol for children five and younger that allows for multiple observations of these children, including during peak times of misbehavior and across settings with key informants, rather than a limited SASS assessment.

[10] In order to enhance the reliability of the CSPI, anchor points have been designed to facilitate the translation of levels of each indicator into four action levels. It should be noted that these anchor points represent guidelines. Since it is not feasible to exhaustively define all circumstances that might fit a particular level, the assessor may use some clinical judgment to determine the rating when no clear choice is obvious. This judgment should be guided by a decision on the appropriate level of action required for the specific indicator. It is intended to be completed by the individuals who are directly involved with the youth.

One key objective of the CSPI is to further communication between the child, the family, and the youth's SOC. Consistency and reliability are critical. Therefore, formal training is required prior to any staff completing any tool based on an actual crisis assessment. The Inspector General found that the practice and test vignettes in the training materials did not reference children younger than 11 years old. Additionally, none of the children in the training materials were in foster care or had been involved in the foster care system.

Psychotropic Medication Approval Process

Psychotropic medications prescribed to DCFS wards require consent from the DCFS Guardian before they can be dispensed. The Guardian has established, with a state University Department of Psychiatry, a Psychotropic Medication Consent Line overseen by the University's Consulting Psychiatry Program (UCP) and its Director. The UCP program receives 1100-1200 medication requests per month in addition to reviewing approximately 300 emergency medication incidents. OIG investigators met with the Assistant Director who reviewed the process of obtaining consent.



Upon approval by the consulting psychiatrist, the Assistant Director completes a final review of the request and sends a pdf file to the prescribing physician. The Assistant Director shared that the turnaround time for the consents averages four hours and 15 minutes for inpatient requests and eleven hours (working time) for outpatient requests. However, the consultation process can exceed the average time when the consulting psychiatrist requests further information from the prescriber.

During the approval process, the doctors will review diagnosis, symptoms, and other medication provided. The consulting psychiatrist reviews whether the medication requested is appropriate to treat the symptoms, whether the dose is correct for the size of the child, whether the request is for a first line medication, and whether alternative treatment has been provided. The Assistant Director pointed out that many of the requests are for medication to help with sleep so the consulting psychiatrists may ask about sleep hygiene or routines associated with bedtime.

The Assistant Director reported that the UCP maintains its own database to track the process. The program produces quarterly reports for the DCFS Guardian. The database has expanded over time as they have determined that more fields of information are necessary. Fields include diagnosis, symptoms, height, weight, contact response, discontinued medication, and RN Comment. For example, they added a field for recommendations for treatment in 2011. The database includes notes entered by the consulting psychiatrist. Any questions or concerns going into consent are faxed to the prescriber and then emailed to the case manager. A message board was added to the database to capture information about the kinds of questions answered. They have a box that can be checked by the consulting psychiatrist indicating comments that should be reviewed. They have recently been working with the Department of Healthcare and Family Services as a way of determining other medications the child may be prescribed. There is no formula for renewals or second requests. She did note that having six different doctors means there may be times at which continuity is lost, as a child with multiple requests has various doctors reviewing their requests. As such, they have created a watch list for children who have several requests so that only the Director reviews those cases.

The Assistant Director ran queries of their database on the 32 children being reviewed. OIG investigators found that UCP staff documented contacts with caseworkers, placement, nurses or prescribing physicians, and occasionally foster parents. The database includes a comment field for notes from the RNs or physicians for their internal use in tracking patients. At times, these comments included questions regarding the choice of medication or treatments.

The Assistant Director reported that the program is addressing concerns with the prescription of psychotropic medication to children under the age of six by producing specific guidelines. Resources were specifically allocated for the development of formal guidelines in June 2013. The Assistant Director informed OIG investigators that the guidelines include two forms: a flowchart titled "Prescribing Psychotropic Medication to Children Under 6 Years in State Guardianship" and an eight-page table titled "Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years" with a schematic summary. She stated that, for children under six years, they frequently ask questions about alternative treatments and attempt to capture the answers in the comments field of the database. The guidelines were distributed to providers on January 26, 2015.

The guidelines note that psychotherapeutic trials, parent education, specific psychotherapies and diagnostic assessments should be utilized as first line treatment, and medications added as second, third and fourth line treatments. OIG investigators reviewed the database entries for the children identified in this investigation. Although there were some indications that physicians asked about possible first line treatments, there was often no indication in as to who was asked or if the information was received. Though the guidelines were not in place until 2015, it was reported that these were formally in development since 2013 and informally for years before.

The Guardian's Office reported that they do, on occasion, receive a note from UCP about a concern or question. The Guardian's Office would pass that on to the worker and to DCFS Clinical, but it is expected that UCP would obtain answers by contacting the prescribing physician prior to approving medication. The Assistant Deputy Guardian explained that UCP has research assistants contact providers and workers so questions can be answered prior to medication approval. Children under the age of six are also to be referred by a DCFS Clinical Psychologist to one of three continuity of care clinics[11] where available, or to an identified provider (psychiatrist) to assure consistent oversight. The program supplements the Medicaid payment to psychiatrists with the expectation that they will work closely with other providers and case management services to explore treatment options beyond medication.

DCFS Clinical

For all psychiatrically hospitalized DCFS wards age 12 and under, DCFS Clinical automatically becomes involved in the child's hospitalization stay and conducts post-hospitalization staffings (i.e. 30-day post discharge; 90-day post discharge, and quarterly thereafter). The goal of these staffings is to determine if the discharge and follow-up recommendations are being followed and remain consistent with the presenting problems. The clinical staffings also work to ensure the child receives appropriate services to prevent readmission to the psychiatric hospital.

These staffings are designed to be multi-disciplinary meetings to communicate and plan interventions, but they are poorly attended by key collaterals in the child's life and are often uninformed. Agency staff members, including supervisors, usually attend the meetings but are often unable to provide necessary information such as therapy reports, Individualized Education Plans (IEPs), behavior logs, and medication logs. Foster parents attend less consistently. At times, agency staff has not offered pertinent information. For example, Aiden's foster parent had a recent indicated child protection investigation for abuse of Aiden's six-year-old foster sibling. The caseworker presented the incident as benign although the child was pulled off a bed and dragged 20 feet. The report was not brought to the staffing or sent to the convener beforehand.

It is imperative to sufficiently assess if discharge recommendations are being followed and if the referred services are helping. This would allow the staffing participants to have a full picture of the child's functioning at both home and school or daycare. Information about a typical day in the household should be gathered, including the activities the child participates in, whether there appears to be structure and consistency, and whether there are barriers to the foster parent facilitating interventions. The convener should know if the child is in school, daycare, or recreational activities, and how the child behaves in those settings. It is also important to know if the behaviors that necessitated the hospitalization have decreased. Because many of the children who are hospitalized are reported to have sleep problems, sleep routines should also be addressed. Lack of information may result in less specific planning and may increase the risk of hospitalization. Clinical conveners also lack the authority to enforce recommendations, which makes the possibility of not following the plan more likely.

[11] The program focus on children under six began in January 2015.

CHARACTERISTICS OF CHILDREN IN INVESTIGATION

Entering foster care can be confusing and scary. Of the children in our sample, 22 (69%) were removed from their homes between the ages of two and four years. Given their young ages, it is likely the children did not understand why they were taken out of their homes and away from their mothers and/or fathers. They were then placed into a new home with new rules and new caregivers. It is quite common for a child to experience a wide range of emotions and behaviors as they make the transition into foster care. Some examples include aggression, withdrawal or depression, regression (i.e. baby talk, bedwetting), inappropriate affection towards strangers (i.e. too affectionate or too distant and fearful), and difficulties in school. It is imperative that those assessing and working with children in a time of crisis understand what behaviors are developmentally appropriate and what behavioral issues are a result of trauma.[12]

According to the Handbook for SASS Services, Chapter CMH – 200 Policy and Procedures for Screening, Assessment and Support Services, the SASS provider is to determine if the child "is exhibiting symptoms and behaviors that present a danger to him/herself, others or property and the child cannot be managed safely and appropriately with intensive crisis intervention and stabilization services in a less restrictive setting." If so, the handbook instructs the provider to facilitate an inpatient admission. To provide data that would offer a better understanding of these children's mental health needs, OIG investigators looked more in-depth at the decision to hospitalize. As the decision to hospitalize is predominantly a matter of risk appraisal, OIG investigators divided 31[13] of the 32 children into three separate categories based on the documented reason for hospitalization and the reported risk behaviors related to the hospitalization: Crisis, Non-Crisis, and Doctor Recommended.

Crisis[14]

Seven of the 31 children (23%) were hospitalized based on an immediate, current crisis. All seven children exhibited physically aggressive behaviors at the time of assessment: kicking, punching, spitting, throwing furniture, head-banging, or jumping out of moving vehicles. One of the seven children also expressed suicidal ideation during the assessment.

Non-Crisis[15]

Nineteen of the 31 children (61%) did not appear to be in crisis at the time of the CARES/SASS call thus psychiatric hospitalization was not appropriate. Records indicate that they were hospitalized based on escalating behaviors and not behaviors that signified an immediate danger to themselves or others. In five of the 19 cases (26%), the CARES line was called the day after the behaviors were observed. One child was taken to the emergency room for reported suicidal and homicidal ideation the night before he was admitted for hospitalization. Records indicate that

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[12] See Attachment B: Characteristic Behaviors of Pre-School Aged Children

[13] The OIG examined 31 children; the remaining child was hospitalized prior to becoming a ward of the state

[14] Defined by OIG as the child being in immediate danger of hurting themselves or others and witnessed during the SASS assessment.

[15] Defined by OIG as the child not being in immediate danger of hurting themselves or others and behaviors were not witnessed by the SASS worker. Behaviors were typically noted to have occurred hours or days prior to the SASS assessment.

in a therapy session approximately one week earlier, he picked up a toy gun and pretended to shoot himself in the head and fall to the floor. This child's mother shot herself in the head and he was witness to her suicide, yet this was never explored in his therapies nor did he ever receive grief counseling. His reported suicidal statements regarded a desire to be with his deceased mother.

One child was brought to a community mental health center by her grandmother in order to obtain weekly therapy services. Records indicate that the four-year-old child, her grandmother, and another infant in the grandmother's care spent approximately two-and-a-half hours in the waiting area before being seen by an intake staff member. The child became increasingly restless during the wait, and began running around the waiting room, playing with the water fountain, and hitting and biting her grandmother. Agency staff reported that this child "appeared in crisis and uncontrollable" and requested a SASS assessment. This young child was then forced to wait another hour, for a total of three-and-a-half hours, before SASS evaluated her.

SASS assessed another child after the maternal grandmother reported that the four-year-old slapped her one-month-old cousin, touched siblings inappropriately, and put a razor blade in her underpants. The SASS worker documented that the child "was not in immediate danger to herself or others" but noted that the grandmother "persisted" with hospitalization. Her other granddaughter had been admitted to inpatient psychiatric care several days earlier. The maternal grandmother wanted both girls to be hospitalized together but the hospital's policy did not allow placement of siblings on the same psychiatric unit. As a result, her granddaughter was not hospitalized on the day of the assessment but approximately 72 hours after the evaluation, once a bed at a different hospital became available. Hospital staff documented that while hospitalized, she did not exhibit any problem behaviors, including aggression or sexual behaviors. After approximately three days on the unit, she was transferred to a medical unit for treatment of strep throat and discharged from the hospital two days later.

While two of the 19 children exhibited difficult behaviors during the SASS assessment, documentation noted that they were cooperative and able to be re-directed. Two other children were taken to an emergency room by their foster parents for reportedly increased aggression and dangerous behaviors in the home and directly admitted based on these reports. One child was assessed by SASS at school and determined appropriate for hospitalization after reports of "uncontrollable aggression – throwing items, kicking and threatening to stab people." However, the SASS worker described him as "calm" at the time of the evaluation but "unable to function normally without undivided attention toward himself." Contrary to SASS procedures, one of the 19 children was hospitalized after a SASS phone evaluation.

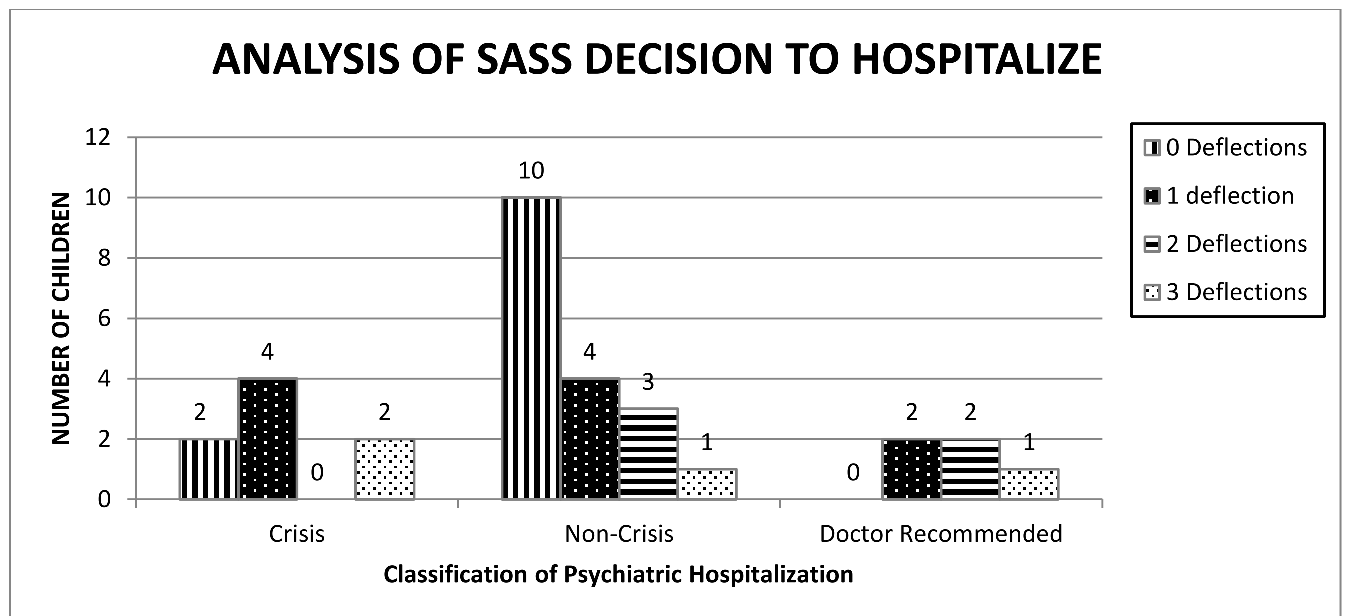
Doctor Recommended

Five of 31 children (16%)[16] were hospitalized at the recommendation of their psychiatrist, primary care physician, or developmental pediatrician. One three-and-a-half-year-old child was hospitalized for self-harming behaviors observed while at a psychiatric appointment; she was banging her head and picking her fingers until they bled. Another child, four-and-a-half years

[16] These four sections do not total 32 as one child in our sample was hospitalized prior to becoming a ward of the state.

old, was recommended for hospitalization by his developmental pediatrician based on the foster parent's report of increased violence and destruction in the home. Neither the pediatrician nor the SASS worker observed these behaviors. A third child was hospitalized following a SASS assessment in which the treating psychiatrist, who was consulted as part of the evaluation, endorsed hospitalization for increased behavior problems.

Two children's psychiatrists recommended them for hospitalization because of medication issues. One child was prescribed Risperdal and Ritalin (stimulant; used to treat ADHD) prior to hospitalization, but his psychiatrist wanted to discontinue these medications and prescribe Focalin (stimulant; used to treat ADHD) and Trileptal (approved to treat partial seizures, used off-label to treat adult Bipolar Disorder) instead. The psychiatrist submitted a request to the Psychotropic Medication Consent Line but was denied; the consulting psychiatrist recommended Lithium and Depakote instead. The child's psychiatrist did not feel comfortable prescribing Lithium or Depakote to a four-year-old on an outpatient basis, so the psychiatrist recommended hospitalization. The second child was also prescribed Risperdal, although his psychiatrist was weaning him from this medication. The child became increasingly aggressive during the process and was recommended for hospitalization to stabilize his symptoms and medications.



Deflections

Twelve of the 31 children (29%) were hospitalized after an initial SASS screening, with only two (17%) being considered in immediate crisis. Five of the 12 children (42%) received no behavioral or mental health services prior to their hospitalization. In other words, the first line of treatment for five children was psychiatric hospitalization. Of the remaining 19 children, 10 were hospitalized after one deflection, five were hospitalized after two deflections and four were deflected three times before initial hospitalization.

Family Risk Factors

There are a wide range of factors that contribute to the likelihood of a child developing externalizing behaviors and psychiatric disorders. Biological parents' mental illness and substance abuse are risk factors to a child's development. Exposure to domestic violence with poor maternal mental health has also been associated with high rates of externalizing and aggressive behaviors in children. Among these 32 children, parental risk factors included mental illness, substance use, and domestic violence. The OIG also assessed overlapping risk factors, identifying two children, Sean and Zoey, who came from families with all three risk factors.[17]

Parental Mental Illness (22)

Among our sample, 22 children (69%) came from a home where at least one parent had diagnosed mental illnesses. Three of the 22 children came from a home where both parents had diagnosed mental illnesses. The parents' diagnoses included Bi-Polar Disorder (13), Depression (8), Axis II Personality Disorder (4), Schizophrenia (4), Anxiety (3) and Psychosis (1). Eleven of the parents were non-compliant with their psychotropic medication and mental health services and 14 of the parents had themselves experienced psychiatric hospitalization. Nine parents had documented suicide attempts; one parent with mental illness committed suicide while her child was on the family's front porch.

Parental Substance Use (19)

Nineteen children (52%) came from a family where at least one parent was a substance abuser. Six children each had one parent who was a poly-substance user and six came from homes where both parents were poly-substance users. Eight parents had drug convictions. Five mothers reported using substances while pregnant; two gave birth to a substance-exposed infant.

The DCFS substance abuse screen does not specifically target prenatal alcohol use and prenatal health records were not obtained, even for those infants who came into state custody at birth or shortly thereafter. Neurodevelopmental disorders associated with prenatal alcohol exposure are a serious public health problem. In all but three cases, the records were silent on this risk factor. Recent literature suggests the use of vitamin supplements (choline, folate and vitamin A) to prevent or ameliorate the effects from fetal alcohol exposure.[18]

Domestic Violence (15)

Fifteen children (47%) came from a home with reported domestic violence.[19] Eleven came from a home where law enforcement responded to domestic violence related calls. Four parents obtained an Order of Protection against a husband or paramour. Three children, two of whom were sisters, had a father with a conviction for domestic battery or domestic abuse. Three children from Cohort Three reported witnessing violence in the home.

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[17] For a discussion of the children, see Zoey on page 54 and Sean on page 60.

[18] See Appendix: New Research on Vitamin Supplements

[19] The presence of DV was determined by children's reports of witnessing violence, law enforcement responses to the home for domestic violence, orders of protection or criminal convictions for violence to family members and recommendations for services to address domestic violence.

Reasons for Psychiatric Hospitalization

Review of the psychiatric records for all 32 children in this investigation revealed more than one reason for a child's psychiatric hospitalization. All but one child was hospitalized for exhibiting some form of physical aggression towards others. Of the remaining 31 children, seven did not exhibit aggression on the hospital unit.[20] Five children did not have any reports of aggression or negative behaviors in the educational program.[21] One four-year-old did not exhibit any aggressive or negative behaviors either in his preschool program or while in the hospital. He lived with his grandparents, but he was removed from their home after six child abuse and neglect investigations against them, one of which was indicated.

Reasons for Psychiatric Hospitalization	N=32
Aggression towards others (parents, caregivers, siblings, peers, animals, including homicidal ideation)	31
Aggression towards self (head banging, hitting, scratching, etc.)	17
Suicidal Ideation	2
Property Destruction (foster home or school setting)	6
Sleep Disturbance	2
Fire Setting	2
Sexual Behaviors	2
Hallucinations	3

Pathologizing Behaviors

Young children exhibiting emotional upset, misbehavior, and learning problems are commonly assigned psychiatric labels that were created to categorize internal disorders. However, the problems these children exhibit are not necessarily rooted in internal pathology. Environments of abuse and neglect, chaotic households, and lack of appropriate responses to a child's behavior can all contribute to these undesirable behaviors. Caregivers also appeared to overstate a variety of behaviors such as fire-setting and sexual behaviors.

Fire Setting

Two children were psychiatrically hospitalized in part because of "fire setting" behaviors. However, a review of the events revealed that the children lacked intent or determined action. The first child, four-year-old Rohan, was playing in the kitchen while his foster mother cooked a meal. The child's toy broom caught fire when he got too close to the cooking flame. The foster mother extinguished the broom and reported the incident to the case manager, who in turn reported the information to the therapist. The record did not contain any indication that the foster mother believed that the child intentionally set the broom on fire. However, the child's therapist called SASS the day after the incident to request an evaluation. The SASS clinician noted that the child engaged in fire setting and exhibited an increase in risk taking and impulsive behaviors. While in the hospital, staff noted that the child did not exhibit any aggression or inappropriate behavior and that he followed directions.

[20] Jason, Nick, Aubrey, Julia, Fiona, Rohan, Maya
[21] Jason, Otto, Perry, Bryce, Brooke

The second child, four-year-old Eli, was brought to the emergency room by his foster mother after increasingly aggressive behaviors and because he “attempted to set the bathroom on fire.” Further investigation into the incident revealed that Eli had been playing with a lit candle in the bathroom when toilet paper caught on fire. He then threw the toilet paper in the bathroom garbage can. He said he was playing in the bathroom because he was bored and his foster mother was watching her “soaps.” His foster mother never enrolled him in a local Head Start or pre-kindergarten. His behavior, when viewed in context, does not support a pathological view of his actions.

Sexual Behaviors

Two sisters, who lived in the same relative foster home, both were psychiatrically hospitalized for the first time after their grandmother reported sexualized behaviors in addition to other aggressive behaviors. According to the grandmother, four-year-old Julia touched her younger brother’s penis and sat on the lap of an older boy at school, attempting to touch his genitals. While hospitalized, staff reported that Julia did not exhibit any aggressive or sexualized behaviors. Mental health professionals determined that Julia was not sexually aggressive or at risk of victimization. Seven months later, Julia’s sister Aubrey, then four years old, was hospitalized after her grandmother reported that she “kisses her little brother on the mouth and touches little brother inappropriately.” The grandmother also reported issues with aggression. Hospital staff noted that during her stay, Aubrey did not exhibit any problem behaviors, including aggression or sexualized behaviors. During a clinical staffing, DCFS staff opined that SASS and the grandmother “overreacted” by hospitalizing Aubrey and believed that any of the incidents about touching her siblings appeared to be exploratory in nature. Eli’s foster parent complained that his five-year-old sister kissed him on the mouth. When asked about the incident, she responded that she saw Justin Beiber do it.

COHORTS

COHORT ONE

The first cohort consists of 10 children who were placed in foster care before reaching 18 months of age. Four children in *Cohort One* were placed in foster care within one month of their birth. *Cohort One* includes two sisters who entered care simultaneously, at one month and 11 months old. The sisters were joined by a newborn infant sibling a year after they came into care. Both sisters were hospitalized when they were four years old. Three other children and their families in *Cohort One* received intact family services prior to the child’s entry into foster care. One child with developmental disabilities drowned in a bathtub at the age of five with a possible seizure disorder contributing to his death. He had been in the foster home for 11 months at the time of his death.[22]

The oldest child within *Cohort One* (Aiden) was 15-months-old when he came into care. His state pre-kindergarten teacher believed he was autistic and the school initiated services. He was hospitalized twice when he was three years old, with less than 60 days between hospitalizations. The record reflected that he didn't comprehend why he was in the hospital. He needed one-on-

[22] See Discussion of Flynn on page 35

one staff supervision to keep him safe from the older children on the unit and to keep him occupied. The foster care agency did not provide supportive services to him or his relative placement at the time of his hospitalizations.

Aiden was one of two children in *Cohort One* who were hospitalized twice. Six children were hospitalized once each; one child was hospitalized three times; and one child was hospitalized four times. Nine of the ten children in *Cohort One* were four years old at the time of their initial hospitalization. The length of stay on psychiatric units for the children in *Cohort One* ranged from four days to 26 days**.** All children in *Cohort One* returned to their prior placement following hospitalization.

In addition to multiple transitions between households and constantly shifting visitation schedules, the children in *Cohort One* had frequent changes in caseworkers and agencies. The number of caseworker changes in *Cohort One* ranged from four (Eli) to 15 (Dennis). Agency changes occurred often, including when a child received approval for specialized foster care or the child moved from one agency's foster home to another agency's foster home. By the time Aiden was four years old, he had seven different caseworkers and experienced eight placement transitions. Dennis entered foster care after being the second substance-exposed infant born to his severely mentally-ill mother. Dennis remained in one foster home and was eventually adopted, but during his seven years in foster care, he had 15 different case managers from four different agencies. He was one of three children in *Cohort One* who never received SOC services.

Five of the 10 children (50%) in *Cohort One* were the subjects of child protection investigations while in foster care. Aiden was 22-months-old when he was the victim of physical abuse in a traditional foster home. He suffered extensive bruising and was removed from the home. Two years later, in his last foster placement, his foster father injured his six-year-old foster sister when he dragged her across a floor, from the bedroom to the bathroom, for refusing to brush her teeth and jumping on a bed. Aiden was returned to this home following the indicated report. The family later adopted Aiden. Three-year-old Otto had been removed from a stable placement where he had lived for over two-and-a-half years to join his three older half siblings (ages eight, seven, and six years old) in a relative placement. Two years later, Otto's school called the hotline to report bruising to his wrists and legs. He told the school that his foster mother would hit him with a belt if he was bad at school. The foster mother, who was pregnant at the time of the alleged incident, was on complete bed rest and later miscarried. She indicated that the foster agency was not providing her with enough assistance. The investigation was unfounded. Jason's relative foster parents, his maternal grandparents, had five unfounded investigations and one founded investigation for Risk of Harm that ultimately resulted in his removal. While in his pre-adoptive foster home, Flynn's foster mother found him floating face down and unresponsive in the bathtub. Flynn later died. At the time of his death, the Department initiated an investigation into his death which was unfounded and his cause of death was determined as accidental drowning. Two-year-old Aubrey and both of her siblings were removed from the home of the paternal grandparents after allegations of burns to Aubrey. The allegations were subsequently unfounded, but the children did not return to the home.

Early Intervention and State Pre-Kindergarten/Head Start

Each of the 10 children in *Cohort One* received early intervention assessments. Eight of the ten children were eligible and participated in 0-3 services. Nine of the ten children were enrolled in and attended a state pre-kindergarten or a Head Start program. Seven of the ten children had IEPs: three qualified for special educational services with an IEP after their third birthday because of their developmental disabilities; three were eligible for IEPs because of behavior problems; and one was eligible for emotional disabilities. One of the children with behavior problems, Jason, received a variety of SOC services and ultimately was removed from a chaotic foster home. Once in a supportive environment, he flourished. By the time he was in was in first grade, Jason no longer needed an IEP.

One child, Eli, was never enrolled in a pre-kindergarten or Head Start. Additionally, his traditional foster mother provided misleading information to get the four-year-old child hospitalized, reporting to professionals that the child had been kicked out of daycare because of his behaviors. Four-year-old Eli and his two siblings left the daycare center because the foster parent was no longer eligible for employment-related daycare services. She had reported herself as self-employed but did not provide required documentation. In the fall, Eli's five-year-old sibling was enrolled in kindergarten but he and his three-year-old sibling stayed home with their foster mother. Eli complained of boredom while his mother watched "soaps." Although there was a full time Head Start program in his community, the foster mother never enrolled Eli, nor did she enroll his younger sister in a state pre-kindergarten.[23]

Although the children in *Cohort One* entered DCFS care as infants, the majority of the records, including the integrated assessments, were silent on each mother's prenatal history, including whether she used alcohol before she was aware she was pregnant or the amount of alcohol she may have consumed during her pregnancy.[24]

Placement Stability

All 10 children in *Cohort One* were in traditional or home-of-relative foster care prior to their hospitalization, with five of the children (50%) in each type of placement at the time of the initial hospitalization. Six of the children received approval for specialized foster care after their first hospitalization. Seven of the children (70%) had numerous placement disruptions before being hospitalized. Six of the ten children's records contained a SOC reference but there was scant documentation of the services in three cases. Two children received SOC services before their hospitalizations. One child, Jason, received a variety of well-documented SOC services.[25]

None or One Placement Transition Prior to Single Hospitalization (3 Children)

Three of the ten children in *Cohort One* had stable placements. Two children were placed in traditional foster homes, did not have any placement disruptions prior to their initial hospitalization, and remained in the same home following discharge. They were both later adopted by their foster families.

[23] See Discussion of Eli on page 92.
[24] See discussion of Parental Substance Use on page 27.
[25] See discussion of System of Care Services on page 107.

Dennis entered foster care at birth and remained in the same traditional foster home for seven years and five months before he was adopted. He was born to a severely mentally-ill 26-year-old mother, and was the second of her children to be born substance-exposed. The mother had three children at the time. She had left the oldest child home alone while she got high. Dennis' parents met at a Mentally Ill Substance Abuse program. Before Dennis' birth, his mother underwent eight psychiatric hospitalizations and his father underwent four. Dennis was placed alongside an older sibling. His early developmental assessment revealed a 30% delay in social-emotional development. He received occupational therapy twice a week. At the age of two-and-a-half years, a developmental screening recommended Dennis for play therapy with his sister to address his social-emotional delays. For the seven years he was in foster care, he never received system of care services.

Dennis's biological parents received recovery coaching services for their substance abuse and Dennis began unsupervised visits with his father when he was three. His mother was allowed unsupervised visits shortly thereafter. Six months later, Dennis spent three unsupervised nights a week with his parents, returning to his foster home for the other four nights. By the fall of 2011, Dennis's biological parents stopped living together. His mother stopped visiting and the father's visits were limited to one per week, an unsupervised eight hours; these visits eventually became inconsistent. Dennis's foster parents reported that he became anxious and distressed. He looked forward to being with his father and could not understand the changing visitation schedule. In early spring 2012, Dennis's preschool reported that he had become uncontrollable, exhibiting temper tantrums and aggressive behavior, and they recommended a referral to SASS to assist in securing a psychological evaluation. The SASS clinician diagnosed him with Intermittent Explosive Disorder. Just before his hospital admission, Dennis said he hated his life. He was hospitalized for 21 days, discharged with a Bipolar diagnosis, and prescribed Abilify (atypical antipsychotic, second generation). His foster mother believed he was reacting to the confusion over the loss of his father and that he did not need psychotropic medication. The community psychiatrist agreed and weaned him off of the medication and removed the Bipolar diagnosis. He enrolled in a new school, received mentoring and individual counseling services, and attended group therapy for young boys that targeted pro-social skills. His foster mother adopted him in 2013.

Eli entered foster care at six months of age after being brutally beaten. He remained in a traditional foster home for six years and three months before he was adopted. His foster mother amplified his behavior and sought specialized foster care; he never received SOC Services.[26]

One child in *Cohort One* had a single placement transition prior to his hospitalization. Hunter entered foster care at the age of one month. His mother suffered from severe mental illness and could not care for him. In 2006, at the age of six months, he moved from a traditional placement to his aunt and uncle's home. In January 2008, the court changed his goal to adoption after terminating parental rights. His mother had signed a specific consent for the aunt and uncle to adopt Hunter, however his case had been handled by three different agencies and five case managers, which delayed movement towards adoption. When Hunter's case transferred in September 2010, the judge expressed concern about how this would delay Hunter's adoption. In December 2011, the court issued an order of no reasonable efforts to the Department because the

[26] See discussion of System of Care Services on page 107.

adoption had not been completed. Six years and two months after he came into care in March 2012, his relative foster parents adopted him. Hunter never received system of care services.

Multiple Transitions and Multiple Hospitalizations (4 Children)

Four of the ten children in *Cohort One* were hospitalized more than once: Aiden and Julia were hospitalized twice, Flynn was hospitalized three times, and Otto was hospitalized four times.

Aiden

Aiden, who had developmental disabilities, experienced six placement transitions prior to his hospitalization at the age of three. Aiden came into foster care in 2009, at 15 months old, after law enforcement arrested his mother for driving while intoxicated with her infant son in the car. Five years earlier, his mother had an accident while intoxicated and almost severed her arm. There were indications that she abused both alcohol and drugs while pregnant with Aiden. Aiden was initially placed with an aunt who lived next door to the mother. He stayed with this aunt for eight months and attended daycare while in her home. Because Aiden's aunt expressed concerns about his development, noting his lack of speech, poor coordination, and tantrums, he received a comprehensive evaluation at the age of 18 months that recommended speech, occupational, physical and developmental therapies through early intervention services. He had significant delays, including a 45% delay in expressive language. Early intervention services began when Aiden was 23 months old. His aunt requested his removal because of his mother's interference with the placement**.** Aiden moved three times after he left his aunt's home. Aiden did not receive the needed speech or occupational therapies due to these transitions. While in his third foster home, at two-and-a-half years old, his mother called the hotline after she observed extensive bruising over his back, buttocks and thighs during a visit. DCP substantiated the abuse allegations against Aiden's current traditional foster parent for Cuts, Welts, Bruises.[27] For his fourth placement, Aiden moved to the home of his maternal aunt for one month. The court returned him to his mother in February 2011.

Aiden remained with his mother under DCFS guardianship, his fifth transition, for seven months. In September 2011, at three years old, Aiden's sixth transition occurred when he returned to foster care after the Department substantiated allegations against the mother for Inadequate Supervision; the mother had left the developmentally delayed child unattended in the bathtub on multiple occasions despite the case manager's warnings and education on drowning. The mother continued to have drug problems and was found outside while Aiden was left alone in the tub.

When he returned to foster care, Aiden returned to his relative foster home with his maternal aunt. He was enrolled in special education with an IEP for his developmental delays. The aunt had three children and expressed problems caring for Aiden. Two weeks after returning to this relative placement, SASS approved Aiden for psychiatric hospitalization but he was once again returned to his aunt's home following discharge. Aiden was readmitted to the hospital approximately two months later, after his aunt called the CARES line and reported that Aiden had been hitting, biting, and throwing objects. He remained hospitalized for 27 days during his second hospitalization. Aiden was assigned a one-to-one staff to help keep him occupied and

[27] Prior to his placement in this traditional foster home, Aiden had been placed with a relative for one week after removal from his second foster placement. The relative placement lasted one week and was temporary.

safe from the older kids on the unit. Hospital staff noted that his speech was profoundly delayed. While he was with his aunt, Aiden's school referred him for an evaluation at The Autism Program of Illinois (TAP) where evaluation determined that he met the criteria for mild to moderate autism. He remained with his aunt for six months before she said she could no longer care for him. Aiden was wait-listed for TAP evaluation during this time and received occupational and speech therapy at a rehabilitation center associated with a hospital. The rehabilitation center recommended using Picture Exchange Communications system (PEC) with Aiden. The PEC system uses pictures to help the child communicate. Aiden was transferred to another school in his district with a strong ABA and sensory approach. The aunt, who had three of her own children, did not receive SOC services. She was not able to transport him to his speech and occupational therapies during the summer break and there was no indication in the record that she received regular respite or assistance with transportation.

Aiden's seventh transition occurred in 2012, at age four, when he was moved to a traditional foster home. His new foster mother was a 23-year-old stay-at-home mother, who had herself been a former ward. Her husband was 29 years old. The home was quickly approved for specialized care and the agency placed a six-year-old girl with developmental disabilities and a speech impediment in the home shortly after Aiden's placement. Three months after Aiden's placement, in October 2012, the Department indicated the foster father for abuse to Aiden's six-year-old foster sister. His foster mother reported that the couple had problems with their foster daughter and were stressed. They had tried to talk to the caseworker but only "played phone tag and gave up." She described the foster daughter as having stressful behaviors such as being "highly sexual," intentionally peeing on the floor, and trying to get Aiden to kiss her on the mouth. On the night of the incident, they had not expected the six-year-old girl to be at home since she was on a visit. The foster mother did not feel well and asked her husband to get the foster daughter ready for bed. He told the child protection and licensing workers that he had asked the girl to brush her teeth, but she would not listen and was jumping on the bed, so he grabbed her and dragged her to the bathroom. She suffered a one-and-a-half-inch J-shaped cut on her arm. The child protection worker noted that the home appeared so cluttered that it would be unsafe for toddlers. The foster father had originally called the child welfare agency to report that the girl fell off the bed and injured herself. During the child protection investigation, the investigator noticed the father appeared extremely anxious and admitted to overreacting and being angry when he dragged the child. The report was indicated for Cuts, Welts, Bruises. During the pending DCP investigation, Aiden was placed in respite care but was later returned to the foster home. Following his return home, case notes documented that the foster mother said she often slept in until noon. The agency provided individual and couples therapy for the foster parents immediately after the abuse incident.

In December 2013, as a result of the TAP evaluation, Aiden received a diagnosis of mild-to-moderate Autism. Aiden was found eligible to receive SSI benefits which secured him additional services. Eight months after his foster father was indicated for abuse, the child welfare agency provided the foster parents with "skills training" through a "Love and Logic" training program – a popular commercial parenting program that is neither evidence-based nor designed for use with special needs children.[28] The agency's clinician noted the parents had been through the "Love and Logic" training sequence at least twice but did not apply the "Love and Logic" modules to

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[28] See OIG report #2011-2976 Maya Schauer which recommends discontinuing use of "Love and Logic."

their home setting. The agency supplemented this training with several "Theraplay-like" sessions with the foster father and Aiden. The school incorporated the TAP recommendations but the foster parents did not.[29] Aiden's school initiated discrete trail training, a program that teaches skills by breaking them down into simplified and structured steps and continued to use the PEC system to help the child communicate. The specialized foster parents failed to incorporate the PEC system in their home while the foster care agency did not reinforce the use of the PEC until weeks before closing the case. The agency never consulted with a board certified ABA therapist. TAP also recommended a sleep program for Aiden which the agency did not implement in the last quarter, at close of case.

The DCFS clinical convener never reviewed the child protection investigation and relied instead on the agency's description of the indicated report.[30] Thus, she believed the six-year-old foster child injured herself when she fell off the bed. She was unaware of the father's level of anger or the fact that he dragged the child from the bedroom to the bathroom to brush her teeth. There was also no sign that TAP or rehabilitation center therapists were informed of the indicated report. At age seven, Aiden was adopted. He had nine caseworkers prior to his adoption.

Flynn

The Department first took protective custody of Flynn at birth in 2007, though he was returned to his mother before being removed again when he was 13 months old. His 23-year-old mother had surrendered her parental rights to her two older children in 2006. She had a long history with domestic violence and failed to protect her older children from her paramour, who bruised her then four-month-old and one-year-old children because they were crying. She had participated in domestic violence services, had obtained an order of protection, and at one time entered a domestic violence shelter, but maintained a pattern of returning to the abuser. She was developmentally delayed (Full Scale IQ 59), had a diagnosis of Intermittent Explosive Disorder, and a personality disorder. Shortly after the court took temporary custody of Flynn, he was returned to his mother and the Department provided intact family services. One year later, after Flynn's mother gave birth to a second infant, her fourth child, the Department substantiated allegations against her for Medical Neglect to the newborn when she failed to seek medical care after the infant stopped breathing on two different occasions. The Department removed 13-month-old Flynn and his newborn sibling from their mother's care and placed them in a traditional foster home.

Within Flynn's first three years in foster care, he had four placements. He and his sister lived in their first foster home for one year and nine months, at which time the foster parent requested their removal, citing the difficulty of the goal of return home. The foster parent had also just discovered that she was pregnant. The children were moved to a relative home for two months, but the relative reported that she was too overwhelmed, and both children were then moved to a traditional foster home. They stayed in the traditional foster home for 14 months until they were placed in a pre-adoptive home.

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[29] His autism had gone undiagnosed in both of his psychiatric hospitalizations.
[30] At the time the convener did not have access to SACWIS records that contained the completed Child Abuse and Neglect investigation.

Flynn had a 40% delay in expressive language skills. He was hospitalized and re-hospitalized at four years old, within the first two months of his placement in the pre-adoptive home. He had returned to his pre-adoptive foster home after his first hospitalization, but SASS approved Flynn to return to the hospital three days later, when the foster mother reported that he tried to choke both her and his sister. He remained hospitalized for 31 days. During that time, his foster parents decided he could not return to their home. He received approval for specialized foster care and his case transferred to a new agency that placed him in a specialized foster home. This new foster home was his sixth home. Flynn remained in the home for only two weeks before he returned to the psychiatric hospital for 74 days. According to his new foster parents, Flynn screamed and ran through the house after waking from vivid nightmares. At 2:00 a.m., he awoke his foster parents by "kicking in their bedroom door." He also hit, bit, and kicked his new foster parents. They reported that he "purposefully urinated and defecated on himself when upset" and only slept a few hours per night. Flynn met with his seventh foster family during hospitalization, with whom he was placed after discharge. While hospitalized, his parents' rights were terminated. His diagnoses included Intermittent Explosive Disorder, Psychosis, and PSTD. He was discharged with prescriptions for Tenex and Zyprexa (second-generation antipsychotic).

Flynn's seventh foster home remained committed to his care. The foster family had experience working with behavior disordered children in the past. The hospital psychologist recommended that a Behavior Specialist Team conduct a functional analysis in his home and design a behavior program that focused on reducing his aggression and increasing his social skills. The psychologist determined that he met the criteria for RAD-Inhibited type, citing that Flynn failed to initiate and respond to social interactions in a developmentally appropriate way. Flynn also received art and play therapy and special education services. He did well and his sister joined him in his adoptive foster home. Flynn's sister was diagnosed with epilepsy and his foster mother of 13 months requested that Flynn be tested for a seizure disorder. Five-year-old Flynn died shortly afterwards from accidental drowning in the bathtub. A suspected seizure disorder was listed as a contributing factor to his death.

Otto

Otto, his parents, and his five older siblings (ages eight, seven, five, three, and two at the time) received intact family services before the children entered foster care. Otto was six months old when he entered foster care. His father had hit his brothers with a belt and Otto's nine-year-old brother shot and killed a cousin with a loaded shotgun the children found in the backyard. The nine-year-old was psychiatrically hospitalized. The father had a history of using drugs including methamphetamine and PCP. Otto was placed with a godparent for four months but returned to his mother when his godparent moved out of state. He remained with his mother for two months. Otto's brother was hospitalized for a second time while Otto was living with his mother.

Otto returned to foster care at 14 months old after his mother, who described herself as overwhelmed and sick, had taken an older brother out of school for two days to watch Otto. Otto was placed in a traditional foster home for six weeks then moved to another traditional foster home, his fourth transition, where he remained for two years and nine months. While in this home, Otto did not meet the criteria for early intervention services. He attended a pre-kindergarten program where he did well, with no reported behavior problems.

There were seven police reports involving domestic troubles at the mother's home between Otto's mother, her paramour, and Otto's father during this time. The children all reported violence in the home, which the parents always denied. The couple split up and reunited before finally separating in August 2011. The mother stopped visiting after the separation and moved to another state a few months later. She had been non-compliant with her bi-polar medication, did not complete random drug tests, and did not participate with drug treatment services. After they broke up, the father wanted the caregivers to adopt but he continued visiting until January 25, 2012. He did not sign consents for DCFS or the private agency to monitor his mental health or substance abuse services and did not cooperate with urine drops. The case had passed legal screening for termination in the fall of 2011.

Otto's three older sisters were in a relative foster home at the time, and he often went to the relative foster home for respite. After being in a stable foster home for close to three years, Otto made his fifth transition when he was moved into this relative foster home. Otto was hospitalized three times while in the relative foster home. His parents had surrendered their rights, with specific consents for the relative foster parent to adopt Otto and his sisters. The school called SASS several times because of his aggressive behaviors. After the school reported that he had a 40 minute tantrum, he was hospitalized. Otto was re-hospitalized 13 months after his initial discharge, in January 2014, when school staff called SASS because Otto became physically aggressive: he threw chairs at staff, hit himself in the head, and hit his head against the wall. He was restrained for 30 minutes and SASS approved him for hospitalization and diagnosed him with Bipolar Disorder. He remained hospitalized for 14 days then returned to his relative foster home.

The following March, Otto's school called the hotline after his teacher observed bruising on his wrist and legs. Otto told them his foster parents hit him with a belt. The foster mother was pregnant and bed-ridden at the time. She indicated that the foster agency was not providing her with enough assistance. SASS then approved Otto for his third hospitalization where he remained for 30 days. At discharge, Gamma Foster Care Agency placed him in a temporary foster home without his sister. The Department unfounded the allegations against the foster parent and Otto returned to his adoptive placement for two days, then he was re-hospitalized for the fourth time. Otto had become uncontrollable at school. A residential placement was considered while he was hospitalized, but he was discharged at the end of May 2014 to a specialized foster home where he remains. His discharge diagnosis was Adjustment Disorder, PTSD, and history of ADD. He was prescribed Tenex and Risperdal. A DCFS Clinical Convener noted in her clinical record that SOC services had been initiated but the agency's record was silent on any SOC services.

Julia

Julia entered foster care at 11 months old with her one-month-old infant sister, Aubrey. The sisters were placed in a specialized foster home for two weeks until a traditional home could be located. They remained in the second home for 17 months and were joined by their mother's third child when the infant was born. The traditional foster home had three children under the age of 2. The foster family kept the children for 17 months until the foster mother issued a 14-day notice, citing increased responsibilities at work. Although the record referenced SOC

services for prevention of disruption, there is no information in the record documenting such services.[31]

The children were moved to paternal grandparents where they remained for five months. The paternal grandparents were investigated for a burn to one of the children and the children moved to the maternal grandmother. Julia and her younger sister Aubrey were in their fourth placement with the maternal grandmother when both were hospitalized. Julia had two hospitalizations: one at age four and one at age five. Julia's second hospitalization happened seven months after she was discharged home to her maternal grandmother. The Department approved Julia for specialized care with her grandmother. Aubrey (see below) was hospitalized at the age of four.

Julia's second hospitalization occurred after her maternal grandmother described the then five-year-old as defiant and aggressive, saying she tried to hurt others and had attention problems and sleep disturbances. The day before hospitalization, Julia reportedly kicked her biological mother and urinated on the floor. Hospital staff spoke with school staff, who did not believe she appeared more "hyper" than the other students and did not observe problems with aggression. Julia returned to her grandmother after 11 days. Six months after the second hospitalization, the grandmother obtained subsidized guardianship of Julia and her two siblings. The children had been in care for four years and seven months when their maternal grandmother was granted guardianship.

Multiple Transitions Prior to Single Hospitalization (3 Children)

Aubrey (Julia's sister)

Aubrey is Julia's sister (see above). Aubrey entered foster care at birth after her mother experienced a psychotic episode that required psychiatric hospitalization. At four years old, Aubrey's maternal grandmother wanted her hospitalized at the same time as her then five-year-old sister, but the hospital notified SASS that they would not hospitalize siblings on the same unit. Aubrey was subsequently admitted to another hospital.[32] Hospital staff noted that Aubrey did not exhibit any problem behaviors on the unit and transferred her to a medical unit after they discovered she had strep. A subsequent DCFS Clinical staffing determined that her maternal grandmother, who had three children ages five and under at the time, had overreacted when she hospitalized Aubrey.

Mikey

Mikey came into care at birth. Three years before his birth, his 27-year-old mother, who was Bipolar and refused medications, attempted to suffocate his sisters, who were then one and four years old. His mother also gave her four-year-old daughter a large dose of Benadryl. She was convicted of aggravated battery to children and found unfit by the court. Mikey's father had an extensive criminal history and had been indicated previously for Sexual Molestation of a five-year-old. The initial integrated assessment noted that termination of parental rights should be sought early on because the parents' past behaviors warned of further danger. A Licensed Clinical Psychologist noted that both parents presented with "severe impairments consistent with a personality disorder." Termination of parental rights was

[31] See Section entitled Critical Ancillary Interventions, page 106.
[32] See section entitled SASS: Initial Screening Assessment and Referral Process, page 18.

recommended because of the father's depravity, the mother's inability to discharge parent's rights, and for both parents' failure to make reasonable efforts to correct conditions and make reasonable progress. The case drifted through services until early 2010, when the parents signed surrenders on then three-year-old Mikey. Before he turned four, Mikey had three placement disruptions. His first two placements were with relatives. When he first came into care, he was placed with paternal grandparents where he remained for seven months. He was moved to his maternal grandparents after his paternal grandfather became too ill to care for him. He stayed with his maternal grandparents for two years. Purportedly, the maternal grandparents did not wish to adopt Mikey, desiring to remain his grandparents rather than full time caregivers. They remained involved, offering respite when he was moved. Following the maternal grandparents' decision not to provide a permanent home, Mikey was moved to an aunt who lived in another state. He was in the home for less than four months before he was returned to a traditional foster home in Illinois, because his aunt said she could not handle him. Mikey, then four years old, had mild-to-moderate delays in receptive speech and moderate-to-severe delays in expressive language; he was difficult to understand. He expressed anger about living in the new foster home, saying he did not want to be there. His fourth placement was with the father of his older half-siblings. Mikey was hospitalized four months into this placement for his self-harming behaviors and aggressive outbursts. He received a diagnosis of RAD and was prescribed Tenex and Risperdal. Mikey began to receive occupational therapy and SOC services. He had sensory problems, perseverating about the feeling of his clothing and socks. SOC services helped offset the cost of occupational equipment for his sensory problems. Mikey had been in foster care for five years when he was adopted by his half-sisters' father and his wife in 2012. Mikey's parents signed surrenders two year earlier.

Jason

Jason was placed in foster care at five months of age after a failed intact family services case in which his parents failed to comply with services to address mental illness and domestic violence. Jason had two older siblings, ages eight and four. The children remained in the home until May 2009 when the grandparents requested removal of all three children because of the grandparents' health issues. Jason and his then six-year-old sister were placed in a traditional foster home for six weeks. The record did not contain a reason for their removal. Jason moved to his third placement in July 2009 where he remained for three months and attended a daycare program where he received weekly speech and developmental therapies. A Social Emotional Evaluation in September 2010 through DHS recommended continued services to address a 30% delay in social emotional development. In the assessment, it was noted that he regressed after visits with his grandparents. In October 2010 Jason returned to the care of the maternal grandparents because the court changed the goal to adoption. The grandparents committed to adopting Jason and his siblings. When Jason returned to his grandparents' home, they elected to stop taking him to the daycare where he was receiving early intervention services. The grandparents did not think he needed to attend because they believed they did not work and early intervention services never transferred to the grandparents' home. In January 2011 Jason began a pre-kindergarten program where speech services were re-instated. School staff reported that Jason struggled with defiance and aggression. Staff used stickers as a rewards program to assist with Jason's behaviors. The agency provided Jason with SOC services.[33] Jason was psychiatrically hospitalized in August 2012 after being placed with the grandparents for nearly two years. He returned to their home and continued to receive extensive supportive services through therapy

[33] See section on System of Care Services, page 107.

and SOC. While in foster care, Jason was prescribed multiple medications, sometimes as many as four at one time to address his behaviors, without approval of the Guardian. Jason was removed from his grandparents in April 2013 and placed in a traditional foster home where he has flourished.[34]

COHORT TWO

Cohort Two consisted of 12 children who were between 23 and 45 months old at the time of their entry into foster care. Six children were hospitalized on one occasion. The length of stay on psychiatric units for the children in *Cohort Two* ranged from five to 37 days. Five of these children and their families received intact family services prior to the child's entry into foster care. Two of the five children and their families received intact services for six to 13 months before being placed in foster care. Nearly three-year-old Maya and her family received intact services for six months to address a substantiated allegation of Medical Neglect against Maya's 20-year-old mother. Zoey and her family received intact services for 13 months to address issues of domestic violence prior to the 18-month-old being placed into foster care. The three remaining children were part of intact family cases prior to their first birthdays and received intact family services lasting nearly two years before being placed in foster care.

Placement and Case Management Transitions

Seven of the 12 children in *Cohort Two* had no placement transitions prior to being hospitalized; five of the seven children lived with a relative, but only one of these children, Layla, achieved permanency without any further placement transitions or subsequent hospitalizations. Two of the seven children in *Cohort Two* received SOC services prior to their hospitalization to assist with placement stabilization.[35] Shannon received SOC services while living with relatives where she remained for three years with six total psychiatric hospitalizations. Shannon was ultimately placed in a residential facility to meet the needs associated with her severe developmental disability.[36] Three-year-old Greta had been placed with a maternal aunt for nine months who reported not having enough outside support to care for her. SOC services had been in place for one month when the agency moved Greta to a traditional placement.

Eleven of the 12 children in *Cohort Two* returned to their prior foster care placements after hospitalization. Casey was the single child in *Cohort Two* who did not return to his prior placement after hospitalization. He was approved for specialized foster care and his prior traditional foster parents asked that he not return to their home because they feared for the safety of their other children. Casey remained in the same specialized foster home until the court returned him to his mother two years later.

Four children in *Cohort Two* received case management from a single agency throughout their time in foster care and all four achieved permanency. One child had eight assigned case managers over two years, nine months while receiving services through Beta Foster Care Agency.

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[34] For an in-depth discussion of Jason's case see section entitled Medication Issues, page 89.
[35] See System of Care Services, page 107.
[36] See section on Shannon under Multiple Hospitalizations, page 49.

Eight children in *Cohort Two* underwent multiple changes in foster care agency and assigned case managers. Four of the eight children in Cohort Two were transferred to a new agency after the Department approved them for specialized foster care services. After his first hospitalization at age four, the Department approved Isaac for specialized foster care and he transferred agencies. Once assigned to Gamma Foster Care Agency, Isaac had eight case managers over 26 months.

Early Intervention and Educational Services

Seven of the 12 children in *Cohort Two* entered foster care prior to age three, making them eligible for early intervention services. Five of the seven children received early intervention services. One of the five, Shannon, began early intervention services prior to her entry into foster care to address severe developmental delays that included a 50% or greater delay across all domains.

Six children in *Cohort Two* were never enrolled in state pre-kindergarten or a Head Start program as required by the Department. One of the six children, Rohan, never attended any educational programming despite becoming Department involved at two years old and being placed with his father who received intact services. His father did not comply with agency requests to enroll his son in pre-kindergarten. Despite Rohan being placed in a traditional foster home for five months prior to his hospitalization, there was no record that the case manager ensured the foster parent enrolled the four-year-old in pre-kindergarten.

The remaining six children in *Cohort Two* attended a state pre-kindergarten program. Six of the children in *Cohort Two* qualified for school-based services with an IEP or 504 plan. Two qualified for services for developmental delays and four qualified for behavior difficulties.

Child Protection Investigations

Eight of the 12 children (67%) in *Cohort Two* had been part of a child abuse and neglect investigation after being placed in foster care. Four-year-old Maya's foster mother was indicated for death by abuse after she murdered the foster child and subsequently was found guilty of first degree murder. Isaac, who was six at the time, was removed from his foster home of four years after the Department investigated allegations of Substantial Risk of Sexual Abuse/Sex Offender Has Access. His foster mother allowed her paramour, who was a registered sex offender, access to the home but continually denied that she allowed him to use her address to register or that she knew he was a registered sex offender. The Department indicated the paramour for Substantial Risk of Sexual Abuse/Sex Offender Has Access, but unfounded the same allegation against the foster mother. Nearly three-year-old Zoey and five siblings were removed from their initial placement with their grandmother after she was indicated for Cuts, Welts, Bruises by abuse. All of the children reported that the grandmother hit them with hangers and belts. Developmentally delayed Shannon required residential placement after six psychiatric hospitalizations when her relative placement could no longer meet her needs. While placed at a residential facility, Shannon was the victim in three separate child abuse/neglect investigations of the facility's staff. The first investigation (January 2014) was indicated for Inadequate Supervision after staff failed to check on her and she was found with chipped teeth and a bloody lip. Seven-year-old Shannon, who was the developmental age equivalent of a 17-month-old, required constant supervision.

The second and third investigations occurred two days apart in November 2014. Both investigations were indicated for Environmental Neglect after staff from the morning shift found Shannon in her room without a pull-up on and with dried and fresh feces on her back and legs. Shannon was required to wear a pull-up diaper at night. Staff also found her bed full of urine. Four-year-old Perry and his two-year-old sister reported abuse by their foster parents shortly after being removed from their home. The sister reported that the former foster father "touched" her and took pictures of her bottom. Perry disclosed that the foster father pulled him by the collar, threw him on the bed and the foster mother slapped him. Both foster parents denied the children's allegations. Allegations of Substantial Risk of Sexual Abuse/Sexualized Behavior of a young child were indicated to an unknown perpetrator regarding Perry's sister. Four months later, the Department initiated a second investigation against the same foster parents after Perry reported his former foster father had knocked him down and rubbed his penis. The former foster father denied the allegations. The DCP investigator unfounded the investigation noting that Perry did not disclose reliable information that rose to the level of abuse. Four-year-old Bryce and his siblings were temporarily placed with a relative caregiver while their previous caregiver was out of the country on a personal matter. While living with the relative, the hotline received a call after a two-year-old sibling was found outside alone. The Department indicated the relative for Inadequate Supervision of the two-year-old and placed Bryce and all the siblings in a traditional foster home until their other relative returned to the country. Four-year-old Casey was the victim of alleged child abuse while spending the night in his respite foster home, when a relative of the respite foster parent sexually molested a 13-year-old foster child who lived in the home. The relative was arrested and indicated for Sexual Molestation to the 13-year-old and Substantial Risk of Sexual Abuse to the other children in the home, including Casey. Four-year-old Rohan's foster parent called the hotline within one week of his placement after she found Rohan and his two-and-a-half-year-old sister naked in a bedroom with Rohan trying to put his penis in his sister's mouth. Allegations of Substantial Risk of Sexual Abuse/Sexualized Behavior of young child were indicated against an unknown perpetrator to Rohan.

Review of Psychiatric Hospitalizations and Placement Transitions

The length of hospital stay for the children in *Cohort Two* ranged from five to 37 days. Only one of the 12 children received specialized foster care prior to hospitalization. Seven of the 12 children received approval for specialized foster care after their initial hospitalization. Four children from *Cohort Two* never received specialized foster care. Six children in Cohort Two had a single hospitalization. The remaining six children had multiple hospitalizations with two children hospitalized twice, one child hospitalized three times, two children hospitalized five times, and one child hospitalized six times.

Single Hospitalization with Placement Stability Prior to Hospitalization (4 Children)

Maya (No Transitions)

Maya and her siblings were originally placed with their maternal grandmother for four days after disruption of the family's intact services case. The Intact family services case was initially opened after the Department substantiated allegations of Medical Neglect against the 20-year-old mother to a then four-month-old sibling. After four days of care, however, the grandmother requested their removal because she could not handle all three children. The agency then placed

Maya and her siblings (ages 2, 20 months, and an infant who joined the household after the initial placement) in a traditional foster home with foster parents who already had two children, ages eight and five. Maya remained in the foster home for seven months before her psychiatric hospitalization. During those seven months, Maya attended a pre-kindergarten program five days per week for a half day. In October 2010, the foster mother requested counseling to address Maya's increasingly aggressive behavior towards the foster mother and her siblings and also described aggressive behaviors at school, however, none of these behaviors were corroborated by other collaterals. A therapist was assigned in February with a start date in early March. In February 2011, the case manager inquired about moving Maya's appointment up because she had "serious concerns" about the other children in the home. The foster mother described injuries to the three-year-old sibling that included scratches on her neck, marks consistent with someone choking her, and bald spots after Maya allegedly ripped out her hair. The foster mother reported that Maya "slammed" her little brother's head into the wall. The therapist could not move up the appointment and instructed the case manager to have the foster mother contact SASS with her concerns. Ten days later, the foster mother contacted SASS when Maya exhibited increased aggression. The SASS clinician deflected Maya from hospitalization and planned to provide crisis services, therapy, and case management, and scheduled the first appointment 10 days after the deflection. When the clinician conducted the first visit, the SASS clinician only met with the foster mother. Three days later the foster mother requested SASS services again. The same SASS clinician screened and approved Maya for hospitalization over the phone. According to the foster mother, three-year-old Maya reportedly retrieved a knife from a child-locked drawer and made superficial cuts to her wrist. Maya reportedly told the foster mother that she did it because she was angry. The foster mother was the only person to observe Maya's aggressive and sexualized behaviors. Maya remained hospitalized for seven days and returned to the same traditional foster home. Her diagnoses included PTSD and a Mood Disorder; she was not prescribed any psychotropic medications. The foster family requested respite, but the POS agency denied their request despite the fact that the foster mother cared for five children under age five. Maya's mental health services included one hour per week with a SASS clinician, but the first session did not occur until 11 days post discharge. In April 2011, school staff sent the case manager an email noting that Maya had made progress in pre-readiness skills but needed improvement with her numbers and letters. During the placement case, the assigned case manager did not document any communication with school staff regarding Maya's allegedly aggressive and sexualized behaviors. Maya continued to attend a half-day pre-kindergarten program. Maya died in May 2011 and her foster mother has since been convicted of first-degree murder.[37]

Layla (No Transitions)

Layla entered foster care after substantiated allegations of neglect against her mother to Layla and her infant twin siblings. Layla was placed with her godmother and the godmother's one-year-old child for two years before she was psychiatrically hospitalized. She passed all developmental screenings without any need for early intervention services. She participated in unsupervised overnight visits with her mother and in January 2012, approximately 18 months after entering foster care, Layla was told she would be going home. In April 2012, however, visits with her mother ceased when her mother was sentenced to five years in prison for a weapons conviction. Layla had recently started play therapy and completed two sessions. One

[37] See OIG death investigation Maya Schauer OIG#2011-2976

month after Layla learned that she would not return home, her godmother reported Layla was pinching and hitting herself, pulling out her own hair, and talking to herself, but Layla denied having an imaginary friend. Layla was psychiatrically hospitalized and remained hospitalized for five days, then returned to her godmother's care. She was diagnosed with Intermittent Explosive Disorder with no medication. She received weekly in-home SASS services to address coping and social skills deficits. The foster care agency arranged for SOC services to provide Layla with respite and community activities. In June 2013, Layla's godmother obtained subsidized guardianship, just one year after Layla's hospitalization.

Bryce (No Transitions)

Bryce entered relative foster care because of his parents' substance abuse issues that included heroin and prescription drug abuse. Bryce was placed with a paternal aunt along with his three siblings (ages seven years, 13 years, and 15 months) and his aunt's four-week-old infant. Bryce remained in the home for seven months before his psychiatric hospitalization. Bryce's reason for hospitalization included increased physical aggression towards his seven-year-old brother, infant cousin, and pregnant aunt, over a two-week period. When asked about his aggression towards his aunt, Bryce responded that he did not want her to have a baby. Bryce drew pictures of the house burning down, with him as the lone survivor, and reported that a friend in his head told him to draw the pictures of the house burning and to hurt his brother. During a phone consultation, the SASS screener requested that the foster mother bring Bryce to the emergency room citing concerns for herself and other members of the household. Four-year-old Bryce was admitted and remained hospitalized for five days. Hospital staff noted that Bryce was the youngest and smallest child on the unit. He was discharged back to his relative foster placement with a diagnosis of Adjustment Disorder. Bryce did not receive any prescriptions for psychotropic medication. SOC services began after his discharge and he met with the SOC worker on a weekly basis to address anger control and promotion of social and peer interactions. The SOC case closed three months later. The foster parent reported an improvement in his behavior. Bryce's biological mother visited consistently while his father visited sporadically. In August 2010, Bryce's aunt travelled to Mexico for two months to assist her husband with citizenship and Bryce and his siblings were temporarily placed with another relative. The aunt returned from Mexico in November 2010, resumed caring for Bryce and his siblings, and received a foster care license in January 2011. In March 2011, Bryce's biological father died after an accidental overdose of opiates and methadone. His mother relapsed after the father's death and never re-engaged in services. After the father's death, Bryce's aunt reported an increase in Bryce's aggression and his fighting with peers. The agency referred Bryce to SOC services that included providing the aunt with support and education regarding trauma and its effects on children. Bryce had weekly SOC services from July through November 2011. Bryce began kindergarten in the fall of 2012 and his aunt reported that he did well in school. The SACWIS notes did not contain any contacts by the case manager with his school. Bryce's aunt obtained subsidized guardianship of him and the Department closed his case in August 2013.

Rohan (One Transition)

Rohan's family received intact services for 23 months after the Department indicated his 24-year-old mother for Inadequate Supervision when she left then one-year-old Rohan with a friend and did not return. Intact services began in December 2007, and five months later the

Department again indicated the mother for Inadequate Supervision after she left Rohan and his three older siblings (ages seven, five, and three) with a 17-year-old relative for the weekend. The mother gave birth to her fifth child in August 2008. The mother completed court-ordered parenting classes and the agency recommended mental health assessment. The agency closed the intact case in January 2009. Six months later, the Department indicated the mother for Cuts, Welts, Bruises to four of her children, including two-year-old Rohan. The mother admitted to hitting her children with a belt nicknamed the "demon." The Department took protective custody of Rohan and his four siblings (then ages eight, five, four, and 10 months). The three oldest children were placed in relative foster care and Rohan and his 10-month-old sibling were placed with the non-custodial father. The Department monitored him for three months and the court closed his case in October 2009. Two months later, in December 2009, police responded to a domestic disturbance in the home when the father's paramour engaged in a physical altercation with the uncle's paramour, who also lived in the home. Three-year-old Rohan and three paternal half-siblings witnessed the violence. The Department indicated the paramour for Substantial Risk of Injury to all four children and provided intact family services. The Department referred the paramour for mental health and substance abuse assessments, which she refused. The father refused to complete parenting and a substance abuse assessment and failed to take Rohan for a physical and immunizations, an early intervention assessment, and enrollment in Head Start, as instructed by the intact services worker. The family moved twice during the intact family case without notifying the intact worker. In February 2011, the Department initiated second and third investigations for allegations of Failure to Thrive, Risk of Substantial Injury, and Medical Neglect. Rohan's six-month-old half sibling required hospitalization and received a diagnosis of non-organic failure to thrive. At this time, four-year-old Rohan and four of his paternal half-siblings (three years, two years, one year, and six months) were removed from the home and placed in foster care.

In the first two weeks after removal from their father, Rohan and his two-year-old half-sister moved twice because the foster parents reported being unable to handle their behaviors. Rohan had been found naked with his half-sister, trying to put his penis in her mouth. While both children had lived with their father, there were reports that the children witnessed adults in the home engage in sexual intercourse. The Department indicated an unknown perpetrator for Substantial Risk of Sexual Injury to both children. Rohan was placed in a traditional foster home with two older foster siblings, ages 18 and 19, and began therapy to address sexualized behaviors. Five months later, an incident occurred in the foster home when Rohan was playing in the kitchen while his foster mother cooked. The foster mother had purchased Rohan a small broom; while she was cooking, he lit the broom on the stove. The foster mother extinguished the broom quickly, but reported the incident to the case manager and therapist. In the recent past, Rohan had learned his mother's house had caught on fire and he had become fascinated with fire. Rohan's therapist called SASS after learning of the incident. SASS approved Rohan for hospitalization.[38] Rohan remained hospitalized for nine days, was diagnosed with Intermittent Explosive Disorder and Impulse Control Disorder, and was given a prescription for Tenex. Hospital staff noted that Rohan did not exhibit any aggressive or inappropriate behavior while on the unit. Rohan returned to his traditional foster parent, who expressed an interest in adoption. The foster parent preferred the agency therapist and SASS closed their case with no services. After Rohan's hospitalization, his therapist consulted with a psychologist with expertise in child

[38] See section entitled Pathologizing Behaviors, page 28.

sexuality regarding his sexualized behaviors. The psychologist disputed the conclusion that Rohan compelled his sister to engage in sexualized behavior; rather the behavior appeared cooperative and directly mimicked the adult sexualized behavior the children had witnessed. Beginning in January 2012, the foster mother reported observing Rohan speak to several different imaginary friends. Although Rohan's foster mother did not report being very concerned about his imaginary friends and Rohan's therapist did not believe the behavior appeared psychotic or that he suffered from a dissociative disorder, Rohan's case manager noted being very alarmed. In April 2012, the foster parent eliminated most sugar from Rohan's diet, provided healthy snacks, and noted improved behavior. The school established a 504 plan to address Rohan's behaviors that same month. In November 2012, he began taking Ritalin and continued to take Tenex four times per day. At times Rohan exhibited sexualized behaviors; in December 2012, his foster mother reported that he attempted to order pornography on pay-per-view. As a result, the foster mother installed parental controls on the television. In April 2013, he continued to visit with his father once a month, but had not seen his mother in almost two years. In May 2013, the therapist noted that Rohan had attached to his foster mother and recommended adoption. He was successfully discharged from therapy in December 2013. He continued to take Tenex and Ritalin. The foster parent adopted Rohan in August 2014 and DCFS closed his case.

Single Hospitalization and Placement Transitions Prior to Hospitalization (1 Child)

Casey entered foster care after the Department substantiated allegations of Inadequate Supervision against his parents related to their significant substance abuse. The foster care agency initially placed Casey with paternal relatives. After one month, the relatives issued a 14-day notice citing the caregiver's health. The agency then placed him in a traditional foster home with a one-year-old foster sibling. Casey remained in that home for two months before his psychiatric hospitalization. During that time, he qualified for early intervention services that included speech and occupational therapies, but the services had not begun at the time of his hospitalization. In addition, rather than attending an early education program, the three-year-old attended daycare provided by his foster parent's adult daughter. From April through June 2011, agency staff noted that Casey displayed socially disconnected behaviors, became defiant, and exhibited physical aggression as well as self-injurious behaviors such as head banging, biting, and scratching. The agency referred him for play therapy and he had three sessions prior to his hospitalization. The agency also referred him for SOC Services, which had not started at the time of his hospitalization.

At the age of three, Casey was one of the youngest children in *Cohort Two* to be hospitalized and he had been in foster care the shortest length of time. SASS had deflected him from hospitalization, two months prior to his initial hospitalization, when his foster mother reported that he had extreme verbal outbursts and temper tantrums. On the day of his hospitalization in July 2011, the foster mother reported two incidents earlier in the day where he tried to strangle his one-year-old foster sibling while at daycare and demonstrated head banging, biting himself, and picking at his fingers until they bled. He remained hospitalized for 37 days, the longest initial hospitalization for any of the children in *Cohort Two*. During Casey's hospitalization, his foster parents requested that he not return to their home, citing concern for the younger foster child. The Department approved him for specialized foster care and placed in him in a new home upon discharge. Casey's case was transferred to a new agency because of his specialized status. His discharge diagnosis was Intermittent Explosive Disorder with no prescription for medication.

Casey adjusted to his new foster home and the new agency provided respite services for the foster family. The foster mother reported no problems with aggression; however, he used profane language when upset. He experienced difficulty with bed time and bath time, but could be successfully re-directed.

After his discharge from the hospital and placement in the new foster home in August 2011, Casey began weekly play therapy with an agency therapist, which also included family therapy once a month. His agency therapist diagnosed him with Intermittent Explosive Disorder and RAD in September 2011. Casey had been visiting with his biological father on a weekly basis but his mother had moved out of state and not maintained any contact. In January 2012, Casey's father stopped participating in services and visiting. Six months later, his mother engaged in services, completed an in-patient substance abuse treatment program, attended support meetings, and participated in random urine screens. The mother also engaged in individual therapy services to address diagnoses of depression and anxiety. In September 2012, Casey's therapist removed the diagnosis of IED and added a diagnosis of PTSD. He continued to have a RAD diagnosis.

In November 2012, Casey began consistent visitation with his mother, twice per month. The visits increased to weekly in February 2013. One month later, the court set the goal as return home to his mother in October 2013. Over the summer, the mother had unsupervised visits with Casey and the case manager visited her out of state home, approving the residence for visits. In July 2013, Casey began unsupervised visits at this mother's home. The agency referred the case to Interstate Compact for assessment. The receiving state denied the placement citing that the mother, who only worked part-time, relied on her paramour for financial stability. The paramour had substantiated allegations of Environmental Neglect and Inadequate Supervision in 2006 to his then 12- and 13-year-old children. Casey's therapist noted that a delay in his return home would have a negative impact. His therapist concluded that his symptoms of RAD had resolved because of appropriate attachments with his foster family and biological mother. The mother ensured that she knew of community resources should her son need mental health services in the future. Casey had been attending a kindergarten program and performed at grade level. The court returned Casey to his mother in October 2013.

Single Hospitalization and Transition After Hospitalization (1 Child)

Wyatt (One Transition after Hospitalization)

Wyatt entered foster care at two years old after the Department substantiated an allegation of Substantial Risk of Injury against his severely mentally ill mother. The mother had two older children removed from her care prior to Wyatt's birth because of burns to a one-year-old. Wyatt was placed in a relative placement with godparents, and was the only child in the home. Within three months of placement, Wyatt had a medical evaluation after his caregiver reported that he had difficulty regulating his emotions and had aggressive outbursts. Wyatt demonstrated delays in all developmental areas and received a diagnosis of PTSD and Global Developmental delays. Recommendations included psychotherapy, behavior, family, speech, occupational, and developmental therapies. The agency provided his caregivers with respite services and Wyatt participated in early intervention services to address his delays, which transferred to a school-based program on his third birthday. Eight months later, in January 2010, a neurological

evaluation revealed Dysgenesis of the Corpus Callosum.[39] Shortly after his diagnosis the Department approved Wyatt for specialized foster care. He began weekly psychotherapy to address emotional and physical abuse, developmental delays, self-injurious behaviors, sexual acting out, lack of regulatory function, and frequent and violent outbursts. He attended year round school in a state pre-kindergarten to maintain his acquired skills and minimize aggression.

Over the next 10 months, Wyatt continued to have tantrums and aggressive behaviors. In November 2010, SASS deflected Wyatt from hospitalization after his caregiver reported increased head banging and aggression towards himself and others. The SASS clinician obtained corroboration of aggression from his therapist and teachers. SASS began stabilization services to assist the foster family with behavioral interventions in the home. Three-year-old Wyatt had an evaluation through Banner Children's Hospital in January 2011 and received prescriptions for Ritalin and Risperidal. In March 2011, Wyatt participated in a partial hospitalization program for two weeks from 9 a.m. to 3 p.m. daily. His discharge diagnoses included ADHD Combined Type and RAD and he was prescribed Risperdal and Clonidine. He received medication monitoring through a psychiatrist at Epsilon Community Mental Health Provider. The foster parents were referred for trauma and de-escalation training to help assist in managing Wyatt's behaviors. At this time the court also terminated parental rights.

In the fall of 2011, Wyatt's psychiatrist began tapering his Risperdal, which resulted in increasingly aggressive behaviors towards himself and others. Wyatt was hospitalized for 19 days and received a diagnosis of Bipolar Disorder with a prescription for Tenex. Wyatt returned to his foster home, but his behaviors became increasingly difficult for the foster parents to handle. School staff added a behavioral intervention plan to his IEP.

In January 2012, four months after his discharge from the hospital, an Older Caregiver Evaluation recommended that the foster care agency locate a new adoptive resource for Wyatt. His 60-year-old relative foster mother had diabetes and asthma, and reported intermittent depression. She had recently begun therapy after the death of her mother six months earlier and received homemaker services through the Department of Rehab Services to assist with laundry and cleaning. The 57-year-old foster father also had diabetes and had required back surgery at the end of 2011. The surgery required rehabilitation and the foster mother determined she was unable to care for the foster father in the home. The foster father reported that he suffered from anxiety for which he saw a therapist and took Lexapro (antidepressant). The foster parents also had significant financial difficulties.

In April 2012, Wyatt's teacher reported that Wyatt had high anxiety in new situations that manifested in negative behaviors. An updated psychiatric evaluation diagnosed him with Pervasive Developmental Disorder NOS, RAD of infancy, PTSD, Depressive Disorder NOS and Separation Anxiety Disorder. In August 2012, the agency identified an adoptive placement for Wyatt and his therapist addressed the move in therapy. In that same month, before Wyatt was placed in the new home, his foster mother called SASS and reported increased kicking, hitting, and scratching, which she believed increased after he learned of the move. SASS deflected him from hospitalization. He moved to his new specialized foster home the following month after completing several pre-placement visits. After his move, Wyatt's behavior problems subsided

[39] Dysgensis of the Corpus Callosum is a malformation between the right and left hemispheres in the brain.

and his new school removed the behavior plan from his IEP, but he continued to receive special education services. His medication monitoring transferred to a different Epsilon Community Mental Health Provider location closer to the new foster home and he transitioned from weekly therapy at one local hospital to Alpha Children's Hospital. The agency also provided respite services. On February 25, 2014 the caregiver adopted Wyatt and DCFS closed his case.

Multiple Hospitalizations and Minimal Placement Transitions (4 Children)

Six of the 12 children (50%) in *Cohort Two* had two or more psychiatric hospitalizations. Three of these six children had five or more subsequent hospitalizations.

Shannon (Six Hospitalizations, One Transition to Residential Placement)

Shannon entered foster care at three years old after her mother allowed her father, a convicted sex offender, access to the home. At the time she entered foster care in July 2009, she was already receiving early intervention services to address delays of 51% or greater in all domains and functioned at the equivalent of a 13-16 month old with a limited vocabulary of 10-15 words. She received speech, occupational, physical, and developmental therapies through early intervention until her third birthday, when services transferred to the local school district. She also received supplemental speech and occupational services on a weekly basis. The agency referred her for SOC services to assist with her behaviors in the home. Shannon remained in her relative placement for three years, from July 2009 through July 2012. In September 2009, within two months of her placement in relative foster care, Shannon was psychiatrically hospitalized for 20 days, her first hospitalization. In the months leading up to her hospitalization, SASS deflected her from hospitalization four times after her relative caregivers reported aggression and self-injurious behaviors. At the time of her first hospitalization, the relative foster mother reported that Shannon had increased aggression, put her finger in her rectum, smeared feces on the wall, and experienced night terrors. Shannon's daycare provider reported extreme aggression towards other children and said she ate wood chips, grass, and mulch. Three-year-old Shannon was discharged from the hospital with diagnoses including PTSD, Intermittent Explosive Disorder, and rule out Expressive Language Disorder with a prescription for Depakote. Over the next two years and nine months, Shannon was psychiatrically hospitalized five more times. Approximately one month after her first hospitalization, Shannon began individual therapy with the foster care agency therapist. She was re-hospitalized in February 2010 for 23 days, her second hospitalization, for behaviors that included increased aggression and increased sexualized behaviors. She remained on Depakote and the hospital psychiatrist added Topamax (anti-seizure). Her diagnoses included PTSD and Developmental Language Delay. During hospitalization she required a one-on-one aide to assist her in participating in group.

In May 2010, approximately two months after being discharged from her second hospitalization, she received a diagnosis of Pervasive Developmental Disorder. While the evaluating clinician recommended Child-Parent Psychotherapy, there was no evidence she received the mental health service as recommended and continued with her therapist through the foster care agency. Shannon was re-hospitalized for 13 days in March 2011, her third hospitalization, for behaviors that included urinating on the floor, inserting items in her anus and vagina, physical aggression towards other, and eating non-nutritive items. Shannon's foster parents visited during her hospitalization and participated in a family session. Upon discharge she received diagnoses of

Intermittent Explosive Disorder, PTSD, and Pervasive Developmental Disorder and was prescribed Topamax and Seroquel (second-generation antipsychotic, used to treat Bipolar Disorder). In August 2011, Shannon began kindergarten at a therapeutic day school where she received a one-on-one classroom aide in a class with four other children. Shannon had an IEP for services that included occupational, physical and speech therapies. Staff utilized a behavior management plan.

In December 2011, nine months after her third hospitalization, Shannon returned to the psychiatric hospital for 16 days for auditory and visual hallucinations, lack of sleep and physical aggression. During this fourth hospitalization, staff completed a behavioral intervention plan. The Behavior Analyst provided the foster family with instructions to carry out Shannon's behavior plan in the foster home. Her discharge diagnosis included Mood Disorder NOS and Pervasive Developmental Disorder NOS. Six months later, in June 2012, Shannon returned for a fifth hospitalization of 15 days for increased aggression, avoidance of activities, and impulsivity. During her hospitalization, staff assisted the foster family with behavioral management strategies and safety proofing their home. Her diagnoses included PDD, PTSD, and Unspecified Intellectual Disabilities. At discharge, her medications included Clonidine and Seroquel. Six days after discharge, Shannon was re-hospitalized a sixth time, for 15 days, for increased aggression that included throwing furniture, tearing clothes, smearing feces, and tying a necklace around her neck until her face turned red. During the hospitalization, staff explored the foster parents' abilities to meet Shannon's needs. The foster parents expressed ongoing frustration and requested additional supports in the home given the need to constantly supervise Shannon. Her diagnoses remained PTSD, PDD, and Unspecified Mental Retardation. Her medications included Clonidine, Seroquel, and Benadryl for sleep. She received behavior management therapy from a Board Certified Behavior Analyst, outpatient psychiatry services, and individual and family therapies. After her sixth hospitalization in July 2012, Shannon's foster parents issued a 14-day notice to the agency, citing that they could no longer ensure Shannon's safety in their home. Shannon had learned to unlock doors and repeatedly ate things that were a choking hazard. The foster parents stated that she required 24 hour supervision and they did not believe they could provide that level of care. The foster parents expressed a desire to remain a part of Shannon's life and advocate for her best interests. At this time Shannon participated in a 90-day diagnostic program that recommended placement in a residential setting. In January 2013, Shannon transitioned to a residential placement where both her mother and relative foster parents continued to visit. In February 2013, the court changed her goal to not suitable for home environment. While placed in residential care, Shannon was the victim of three substantiated child abuse and neglect investigations against residential staff.

Isaac (Five Hospitalizations, One Transition after Hospitalization)

At the time of Isaac's birth, his 17-year-old mother had not completed the necessary training for Isaac's discharge and she was subsequently indicated for Substantial Risk of Harm. The maternal aunt (also the biological mother's guardian), reported concerns about the mother's use of marijuana and cocaine. Over the next 21 months, Isaac lived in the home of a maternal aunt and the mother was in and out of the home sporadically. The mother expressed an interest in giving the aunt guardianship, but never followed through. During the intact case, the Department substantiated allegations against the mother of Cuts, Welts, Bruises to then 19-month-old Isaac. The mother appealed and the Department indicated an unknown perpetrator. Weeks before

Isaac's second birthday, the court awarded guardianship to the Department who placed Isaac with his godmother. While Isaac lived with his godmother, he received early intervention services to address a speech and language delay. In December 2009 Isaac had tubes placed in his ears to address speech issues. In August 2010, three-year-old Isaac saw a psychiatrist for aggressive, defiant, and hyperactive behaviors. He was diagnosed with ADHD combined type, Anxiety Disorder and rule out ODD. The psychiatrist prescribed Tenex. In November 2010, Isaac was prescribed Adderall (stimulant; used to treat ADHD) but he did not tolerate it well, and the psychiatrist replaced the Adderall with Ritalin five months later. Psychotropic medication was the first line of treatment for Isaac, and no other therapies or services had been put in place to address his behaviors.

The case manager referred Isaac for a mental health assessment in April 2011, after he had already been on psychotropic medication for eight months, because the godmother reported "very destructive" behavior and anger issues. He received a diagnosis of Mood Disorder NOS because of extreme emotions with highs and lows. The godmother reported that Isaac experienced anxiety about being removed from her care and returned to his mother. The community mental health agency planned to provide weekly services, but the services did not begin until four months after his assessment. The community agency record did not contain detailed documents regarding the occurrence or substance of weekly sessions. In May 2011, Isaac participated in a Speech, Occupational, and Pediatric Psychology Evaluation due to concerns with speech delays, disruptive behavior, hyperactivity, aggressive behavior, and self-injurious behavior. He was diagnosed with ADHD Combined Type and recommendations included a speech evaluation, counseling, and ABA training for his foster parent. The record did not contain any indication that the godmother ever received ABA training. While Isaac continued to receive mental health service from a community provider, there was no indication that the agency evaluated the effectiveness of the service in light of his continued aggressive and self-injurious behaviors.

In August 2011, four-year-old Isaac began a pre-kindergarten program at his local elementary school. Prior to his enrollment, he attended a daycare while his godmother worked. According to the godmother, Isaac hit, pushed, and spit on other children at daycare. At a DCFS Clinical staff meeting after his first hospitalization, the godmother reported that Isaac "could not handle" enrollment in a Head Start program, therefore she had him attend a full day at day care. The case record was silent about Isaac's enrollment in Head Start or any subsequent difficulties he may have experienced in the program. One month later, in September 2011, Isaac's godmother required hospitalization for depression and received a prescription for Zoloft (Selective Serotonin Reuptake Inhibitor – SSRI). She began medical leave for "severe depression and severe anxiety" and remained on medical leave at the time of Isaac's first hospitalization. The record did not contain any indication that the foster care agency reviewed the godmother's ability to care for Isaac at that time. In December 2011, just before his fifth birthday, SASS approved Isaac for hospitalization. The foster parent reported that he attempted to strangle her granddaughter (age unknown) and had not slept in three days. Isaac's psychiatrist recommended that the foster parent take him to the emergency room for an evaluation. Isaac's first hospitalization was for six days and he was discharged with diagnoses of ADHD and ODD for which he was prescribed Clonidine and Tenex. At discharge, he returned to his godmother and the Department approved him for specialized foster care. At that time, his case transferred to Gamma Foster Care Agency, but his services with the community agency continued. The

godmother was referred for a parenting group at the community agency to gain effective parenting skills. Isaac continued to receive medication monitoring with his treating psychiatrist. After Isaac's discharge from his first hospitalization, a DCFS Clinical Convener staffed his case noting that the godmother allowed Isaac to go three days without eating, which she attributed in part to the godmother's own eating habits. Additionally, she noted the godmother "requires little sleep [herself] and so refuses to practice getting him down at a reasonable time." According to the staffing document, Isaac's therapist reported that he napped 2 to 6 p.m. and then at his 8 p.m. bedtime refused to go to bed and did not fall asleep until midnight. School staff reported that Isaac had difficulty remaining alert throughout the school day. This DCFS Convener recommended that the case manager refer Isaac for a psychological evaluation to determine his level of intellectual functioning as well as a psycho-neurological assessment given his diagnoses of ADHD and Fetal Alcohol Syndrome (which had been reported by the foster parent, despite records indicating that FAS had been ruled out in May 2011 during his Speech, Occupational and Pediatric Psychology Evaluation).[40] Regarding Isaac's sleep habits, the Clinical Convener recommended that the case manager and pediatrician address this issue and develop a sleep hygiene program. At the 30 day staffing, the Gamma Foster Care Agency case manager had not ensured that Isaac's pediatrician addressed his eating and sleep difficulties. He continued to see his SASS therapist through the community agency, and had been referred to a therapist through Gamma Foster Care Agency, but no therapist had been assigned. In regards to recommendations about the godmother, a community agency parent educator made one home visit, but the godmother refused services. Additionally, the godmother would not commit to attending group parenting sessions at the agency. The Clinical Convener noted that given the godmother's prior psychiatric admission, the case manager and therapist should ensure that the godmother's mental health needs were being addressed and did not negatively affect Isaac. The case record did not contain any evidence that agency staff assessed the godmother's mental health or discussed the Convener's concerns with the assigned licensing worker until after his removal from her home, over two years later.

In April 2012, the community agency noted that Isaac made progress in weekly individual therapy sessions and his godmother reported his behavior "wasn't as bad." He did well in school and expressed his feelings better. The community agency clinician noted that they had worked on coping skills, expression of feelings, and relaxation techniques and they provided the godmother with a "Caught you Being Good" chart to use in the foster home. Between June and September 2012, Isaac was psychiatrically hospitalized four more times, totaling 29 days of inpatient hospitalizations with only one day between the second and third hospitalizations. At discharge after each hospitalization, Isaac returned to his godmother. Reasons for hospitalization all four times included aggression, agitation and hyperactivity. DCFS Clinical staffed Isaac's case after his consecutive hospitalizations in June and July 2012. The Convener noted that the foster parent reported his behavior improved after visits with his mother ended. His medications changed to Adderall and Seroquel. His therapist with Gamma Foster Care Agency saw him weekly for individual and family therapy. While he received special education for speech services at school, Isaac's IEP did not address behavior problems and he did not attend summer

[40] The evaluation noted that Isaac did not have all the physical characteristics required to meet the criteria for the formal diagnosis. The clinician noted that his behavior problems may be related to in-utero exposure to alcohol. There was no indication that the clinician considered a diagnosis of Neurobehavioral Disorder associated with prenatal alcohol exposure.

school. A new Gamma Foster Care Agency worker took over Isaac's case in June 2012 and discovered that the previous worker had not completed the recommended referrals for psychological and neuro-psychological evaluations. Additionally, the godmother had not completed training for specialized foster parents or attended Trauma for Caregivers. All of the prior recommendations had been made six months earlier, in January 2012. After Isaac's fifth hospitalization, staff continued to recommend he remain with his godmother in order to minimize the trauma associated with moving placements. The DCFS Convener noted that while Isaac received mental health services from two providers, therapeutic interventions and progress remained unknown because therapy reports had not been submitted. Additionally, it remained unknown if the godmother had attended the previously recommended trauma training. The DCFS Clinical Convener recommended that the case manager explore a referral for Isaac to receive Eye Movement Desensitization Reprocessing (EMDR) therapy, noting "EMDR is one of the treatments of choice for traumatized children.[41]" The Convener surmised "Isaac's ability to remain in a family setting without continued hospitalization is extremely guarded." The appropriateness of Isaac's placement with his godmother was not evaluated until after his fifth hospitalization, in September 2012, when the possibility of residential placement was considered. The Department did not approve residential placement, however, and Isaac remained with his godmother. Child welfare staff never considered that the godmother, who had documented mental health issues and refused to participate in services, was contributing to Isaac's behavior difficulties. The record contained no indication that Isaac ever received the recommended ABA services or the foster parent received previously recommended trainings. In Fall 2012, school staff and Isaac's godmother reported improvements in his behaviors including less aggression and decreased hyper-activity. School staff developed a behavior system for him that was given to the godmother daily. His school incorporated speech and occupational services in February 2013.

In June 2013, the Department initiated a child abuse investigation after a report that the godmother allowed a registered sex offender to live in her home. During the investigation, Isaac provided credible statements that the paramour lived in the home. The Department indicated the paramour for Risk of Harm/Sex Offender Has Access and unfounded allegations against the godmother based on her denial that her paramour lived in the home. The agency removed Isaac from the home and placed him in a specialized foster home. The godmother appealed his removal, but the decision was upheld given that the godmother had placed Isaac in an unsafe situation. According to the case manager, Isaac adjusted well to his new placement and the foster parent provided him with increased structure, such as a behavior plan that allowed him to put an item he wanted on lay-a-way; when he earned enough green days, they could buy the item. Isaac continued medication monitoring with his treating psychiatrist, and in June 2013 his medication changed from Adderall to Focalin and he continued on Clonidine. His SASS follow-up with the community agency ended in Summer 2013, but he continued to have weekly therapy with an Gamma Foster Care Agency therapist. Shortly after Isaac's removal from pre-adoptive placement with his godmother, the biological mother expressed an interest in having her parental rights reinstated. At a clinical staffing in September 2013, the case manager reported that Isaac

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[41] The National Institute of Health and Care Excellence (2005) does not recommend EMDR as treatment for PTSD in children, rather, use of trauma-based behavioral therapy adapted to suit children's age is the preferred treatment. Two staff from DCFS clinical (a clinical convener and clinician completing an integrated assessment) inappropriately recommended use of EMDR with two of the children in this investigation. See discussion of Reyane' on page 65.

no longer experienced nightmares, slept better, and did not display aggressive or hyper behavior in his new foster home. One week later, the court re-instated the biological mother's parental rights and Isaac began visits with his mother. However, at the end of October 2013, it was discovered that the godmother's adoption petition had already been filed and the biological mother's rights were once again terminated. In November 2013, Isaac began to receive increased educational services after his school reported that he failed all of his classes, and he was enrolled in a program that provided extra help with a reading specialist for 30 minutes each day. A new IEP provided for a self-contained classroom with social work services, occupational therapy, and reading assistance. In January 2014, Isaac "indirectly made statements about killing himself" and said he felt like no one loved him. The court re-instated visits with his mother and godmother that same month. Visits with his godmother were unsupervised. Isaac's foster parent reported increased aggressive behaviors, sleep disturbances, and telling the foster parent he did not have to listen during this time period. His school performance had improved and in March 2014, Isaac received passing grades, included some A's. In November 2014, the court dismissed the godmother's petition for adoption and all visits with Isaac ceased. He continued to visit with his mother twice a week. In January 2015, his foster mother's health deteriorated and Gamma Foster Care Agency placed him in a new specialized foster home. He remained in the home for two months and the foster mother had difficulty caring for Isaac along with two other specialized children in the home, ages seven and 12. He moved into a new specialized foster home in March 2015, where he remains. His goal is return to his mother with a target of summer 2015.

Zoey (Two Hospitalizations, One Transition Before Hospitalization)

Zoey entered foster care at two-and-a-half years old after a failed intact family case and on-going domestic violence between her parents. Zoey's 22-year-old father forced himself into the home and hit her 32-year-old mother with a bottle and slammed her face into a towel bar, which Zoey's four-year-old sibling witnessed. The Department took custody of Zoey and her five siblings (ages 14 years, 12 years, four years, one year, and three months) and all of the children were placed with the grandmother. At the time of entry into foster care, Zoey passed her developmental screening and did not meet the criteria for early intervention services. All of the children were removed from the grandmother six months later when the Department indicated the grandmother for Cuts, Welts, Bruises after she beat the children with belts and hangers. The agency then placed three-year-old Zoey with three siblings (then ages three years, six years, and 21 months) in a traditional foster home which also included the family's two biological children. Zoey's foster family enrolled her in a licensed daycare and learning center one month after placement in July 2011. Daycare staff reported that Zoey had aggressive behaviors and called the CARES lines four months later because of aggression and defiance. The SASS clinician called the foster parent, who met the clinician at the daycare for the assessment. According to the foster mother, Zoey had been exhibiting outbursts for one month with head banging, scratching and biting herself. The foster mother did not believe that Zoey needed psychiatric hospitalization. SASS deflected her from hospitalization and opened a case for community services. Two weeks later, Zoey and her foster family participated in a mental health assessment. The clinician noted that Zoey presented with mood swings and aggression. During the assessment, the foster mother reported that the family considered issuing a 14-day notice for Zoey's removal because of her behaviors. The case record did not contain any indication that the foster family, who cared for five children, received any respite services. The SASS clinician diagnosed Zoey with Mood Disorder NOS and recommended counseling, psychiatry up to twice per week, and services from

a family resource developer. Zoey participated in her first session with her SASS therapist 39 days after her initial assessment. In December 2011, the foster mother requested a SASS evaluation after Zoey exhibited increased aggression at daycare and in the foster home. Zoey scratched herself, banged her head, and kicked the wall. The foster mother believed Zoey's behaviors placed the other children in the home in danger. SASS approved Zoey for her first hospitalization of six days, during which she was diagnosed with Mood Disorder. Zoey did not receive a prescription for psychotropic medication at discharge and returned to her foster home. Two days after her discharge, Zoey was readmitted for a second hospitalization for aggression towards her foster mother and siblings and head banging. She remained hospitalized for 11 days during which the foster parents attended two family sessions. At discharge, her diagnoses included Mood Disorder NOS, ODD, RAD, and PTSD. She received a prescription for Clonidine and returned to the foster home. In February 2012, Zoey began taking Tenex and Trileptal. After Zoey's discharge from her second hospitalization in January 2012, the foster parents reported sexually problematic behavior between Zoey and her three-year-old sister. Both girls had sex abuse evaluations and were referred to Delta Community Mental Health Provider for services. The sisters disclosed that their older brother sexually molested them. Visits with the brother ended. Delta Community Mental Health Provider also provided the foster parents with psycho-educational training. Zoey attended weekly play therapy through Iota Community Mental Health Provider and received SOC services. The foster parents received trauma training classes through a community agency. One month later, DCFS approved Zoey for specialized foster care and the foster father stayed home full-time to meet the needs of Zoey and the other foster children in the home. Zoey was medically hospitalized from April 18 through May 5, 2012 for Dress Syndrome, a reaction to certain medications.[42] Zoey attended kindergarten and continued to receive weekly therapy from Delta Community Mental Health Provider and weekly play therapy. The foster parents attended one session a month with Zoey to work on attachment. Zoey also received monthly medication monitoring. Her foster parents adopted her in May 2013.

Greta (Two Hospitalizations, One Transition Before Hospitalization)

Greta entered foster care at three years old after the Department substantiated three different incidents of Inadequate Supervision. On all three occasions, Greta was found outside, at times without appropriate clothing, without any adult supervision. The police responded to calls from neighbors and found Greta wandering by the side of the highway. At the time of the third call when police went to the home they could not wake Greta's mother to answer the door. When the mother awoke she told the police all of the doors had been locked and that Greta must have crawled out the window above her bed while she slept. The 34-year-old mother had a significant history of mental health and poly-substance abuse. Greta's first placement with a maternal relative disrupted after nine months because the aunt could not handle Greta's behaviors. The agency placed Greta in traditional foster home for three months when she required psychiatric hospitalization. The foster home consisted of five other children ages six, eight, 10, 11 and 19.

In November 2009, eight months after entering foster care, Greta received a psychological evaluation from Lambda Community Mental Health Provider. Greta was diagnosed with ADHD with a Full Scale IQ of 105 (within the average range). Greta exhibited significant executive functioning deficits related to inhibiting her behavior, maintaining emotional control, planning

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[42] See Medications Issues-Zoey on page 91.

and organizing information, and memory recall. Additionally, her communication skills, home living, self-care, social skills and motor skills measured below average and she exhibited difficulties with sensory processing, attention, and aggression. Her recommendations included strategies to address her inattention, impulsivity, and sensory issues, a referral for an Occupational and Sensory Integration Therapy evaluation, and trauma-focused therapy where Greta's foster parents could learn how her trauma history impacted her behaviors and strategies to manage those behaviors. The evaluation also recommended evaluation for possible medication management of her ADHD symptoms once she had an opportunity to participate in occupational and individual therapies. Two months later, in January 2010, Greta began outpatient psychiatry services and received a prescription for Ritalin. She also received individual therapy and family therapy with her biological mother at Victory Community Mental Health Provider. She had been referred for system of care services but records did not indicate that these services began prior to hospitalization. Greta attended a pre-kindergarten program with an IEP and spent 100% of her time in the special education classroom. She required a highly structured, small setting in order to function at school. In March 2010, Greta's psychiatrist observed her head banging and picking her fingers until they bled. The foster parent reported that Greta was aggressive toward her foster family and peers at her preschool program, screamed for hours at a time, and required restraint during tantrums to prevent her from harming herself or others, threatened to cut her foster parent, and was abusive to the family pet. SASS approved Greta for her first hospitalization (16 days). She received diagnoses of ADHD, Mood Disorder, and ODD with prescriptions for Risperdal and Ritalin. Upon discharge, Greta returned to her foster home and the Department approved her for specialized foster care.

In March 2010, the court also granted Greta's mother unsupervised overnight visits in addition to the existing visiting plan that included visits five days per week, from 3:30 p.m. until 7:30 p.m. The visiting schedule as reflected in the case record was chaotic and often fluctuated because of the mother's work schedule, and Greta sometimes returned to the foster home at 10 p.m.[43] The foster parent reported that Greta had difficulty returning from her mother's home and often had a difficult time falling asleep.

In mid-May 2010, Greta's psychiatrist recommended hospitalization for behaviors her foster parent reported: Greta ran away from the babysitter at her mother's house after nightfall, pushed neighborhood children, broke household items, and required restraints at preschool. During this second hospitalization, which lasted six days, Greta participated in a comprehensive psychiatric evaluation. According to hospital staff, Greta did well in the hospital and occasionally needed redirection. Her therapist stated that Greta required structure and expressed concern to child welfare staff that the mother could not provide the structure she needed. She was discharged with diagnoses of ADHD, Mood Disorder, and RAD and prescriptions for Ritalin and Risperdal. Greta returned to her specialized foster home at the end of May 2010.

At the end of May 2010, after Greta's discharge from her second hospitalization, child welfare staff held a Child and Family Team meeting to discuss case progress. The mother's therapist at a community mental health provider, drug treatment worker, and housing advocate also attended the meeting. Greta had been referred to individual therapy at Victory Community Mental Health Provider, but the therapist reported that she had only seen Greta twice prior to her being put on

[43] See section entitled Chaotic Environment, page 11.

psychotropic medication. Therapy was transferred to her mother's therapist who provided 30 minutes of play therapy and 30 minutes of family therapy weekly. Additionally, SASS therapy had also occurred in the mother's home. Greta was returned home to her mother in July 2010 and DCFS retained guardianship. The foster care agency provided follow-up services for six months. During this time, Greta's SASS case was transferred to a community program and she was assigned a therapist. The new therapist, who planned to meet weekly with the family for joint play and family therapy sessions, reported scheduling difficulties with the mother. In the same month, Greta's psychiatrist stopped her Ritalin prescription after a recommendation from the DCFS Consulting Psychiatrist. At the end of August, the mother's therapist reported that she had not been consistent with therapy, and that the mother expressed frustration with Greta's lack of improvement and lack of motivation to complete tasks. Greta's psychiatrist added Concerta (stimulant; used to treat ADHD) to her prescription for Risperdal because the mother reported she had difficulty focusing in school. In September 2010, the mother's psychiatrist informed the case manager that the mother had not been in for medication monitoring since the beginning of June. The psychiatrist wrote one-month prescriptions for Abilify and Lexapro to address the mother's depression and Klonopin (anti-anxiety) to assist with sleep at that appointment. When the case manager asked the mother about her psychiatry services, the mother reported that she had difficulty keeping up with appointments.

Greta and her mother continued to participate in weekly family therapy and the therapist noted no concerns about the mother's parenting abilities. In October 2010, Greta's mother reported that she returned to her psychiatrist, who confirmed that the mother went back on Lexapro. One month later, the mother informed the case manager that she stopped taking her medication because she no longer needed it. The case manager did not document any conversations with the mother's psychiatrist regarding her ability to parent without medication. In December 2010, the mother reported obtaining a prescription for Vicodin after a reported work related injury. The case manager asked the mother if she informed the prescribing physician about her prior substance abuse issues, to which the mother answered no. The case manager suggested the mother contact her substance abuse counselor to discuss the prescription. The record did not contain any further documentation about the prescription or follow-up regarding substance abuse issues. In the months leading up to the closing of the family case, agency staff noted that Greta's mother needed to obtain stable housing prior to the closing court date. The mother had a housing advocate affiliated with the local community mental health agency but she did not obtain housing prior to case closure. In January 2011, the case manager testified that the mother had complied with all services and completed her service plan. Based on the agency's recommendation, the court closed the case and returned guardianship to the mother.

Placement Instability and Multiple Hospitalizations (2 Children)

Two of the children in *Cohort Two* experienced multiple hospitalizations as well as significant placement instability.

Perry (Three Hospitalizations, Four Transitions)

Perry and his family had two different intact cases totaling over two years of services. Perry's 23-year-old father and 20-year-old mother became involved with the Department just prior to his birth when the Department indicated the father for burns by neglect to Perry's two-year-old

sibling. During the pending DCP investigation, Perry was born prematurely. One week after his birth, the hotline received a call alleging the parents left the infant and sibling with an inappropriate caregiver overnight and DCP subsequently indicated both parents for Inadequate Supervision and Substantial Risk of Physical Injury. Both parents had substance abuse issues that included prescription drug abuse as well as ongoing criminal cases for fraud and forgery. The parents did not successfully complete any services throughout the intact family case. In May 2009, 10-month-old Perry and his older sibling began protective daycare and received early intervention services. One year later, in June 2010, the parents reported that they were both likely to return to prison for failure to adhere to court orders stemming from their criminal convictions and arranged for relatives to care for the children. The Department closed the intact family case and provided the relatives with information about the Extended Family Support Program.

Five months later, in November 2010, the Department indicated the parents for Inadequate Supervision after the police reported on three different occasions they found Perry, age three, outside alone. The Department provided intact family services for a second time, lasting two months, then took custody of Perry and his five- and one-year-old siblings when law enforcement found Perry wandering along the highway at 6:30 a.m. The Department indicated the parents for Inadequate Supervision and placed the children in foster care. Perry entered foster care in February 2011 and remained in the same foster home for 13 months with his younger sister and the foster family's 12-year-old biological child. He received speech therapy through an early intervention program beginning September 2011 and no longer required speech services after six months. He attended a state pre-kindergarten program beginning in December 2011. One month prior to Perry's first hospitalization, the foster parents reported behavior problems that included Perry biting himself, experiencing sleep disturbances, and having behavior problems at preschool. The foster care agency referred the foster parents to a community agency for services, but a contract had not been completed prior to his hospitalization. Four days before his hospitalization, the foster mother called the CARES hotline after Perry attempted to suffocate his sister. SASS could not locate a facility that would admit a three-year-old. Several days later, the foster mother contacted the CARES hotline for a second time because Perry continued to exhibit behavior problems and reported hallucinating animals. Two psychiatric hospitals declined to admit Perry because of his age and he was ultimately admitted to a psychiatric hospital located out of state the following day for his first hospitalization. Perry returned to his foster home after 10 days with diagnoses that included RAD, Psychotic Disorder, and ADHD Combined Type. He received a prescription for Risperdal and began tele-psychiatry in July 2012. After discharge, Perry received follow-up services from SASS, but no additional therapeutic services had started by September 2012 when he was re-hospitalized, four months after his initial discharge. His second hospitalization lasted 17 days. The DCFS Clinical Convener provided the case manager with therapy recommendations; but there was no indication that the case manager completed the referral. There were also problems with Perry's medications.[44] During Perry's second hospitalization, Perry again received diagnoses of ADHD and RAD and his medication changed from Risperdal to Tenex. Although Perry returned to his original foster home, the family did not visit during his hospitalization.[45]

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[44] See section entitled Medication Issues, p. 89.

[45] The foster home was located 110 miles, approximately two hours, from the psychiatric hospital.

Perry began individual therapy in October 2012 with a Licensed Clinical Professional Counselor at a community mental health provider. His school completed a report in the beginning of October 2012, noting that he did not exhibit behavior problems and followed directions. The teacher expressed concern that Perry's hospitalizations interfered with his learning and socializing. The teacher also noted that Perry had not been toilet trained and the foster parent did not cooperate with sending additional underwear to school. In October 2012, DCFS informed the foster parents that the children would be removed from their home citing their inability to control Perry's escalating emotional and behavioral issues. Perry was placed in a new traditional foster home where his sister joined him two weeks later. In December 2012, the foster parents requested removal of both siblings, citing their inability to provide Perry the attention he required; they had one child of their own and were in the process of adopting another child through DCFS. Both siblings were moved to their third traditional foster home in January 2013. At this time Perry was waitlisted for Head Start services. He had not been in an educational program since leaving his previous school in October 2012. At the end of January, Perry transitioned to a new therapist after his initial therapist left the agency. In March 2013, his sister reported to the same therapist that their foster father at their initial placement touched her and took pictures of her bottom. Perry later disclosed that both previous foster parents hit him and the foster father slapped him in the face and threw him on the bed. The Department substantiated findings of sexual abuse against an unknown perpetrator.

In the summer of 2013, the psychiatrist discontinued Perry's medication and his therapist decreased his individual therapy to twice a month noting that he showed progress and his foster parents could redirect him. Shortly after that, the foster parents reported increased problems with Perry in the home that included physical aggression towards his sister and threatening statements. According to the foster mother, Perry expressed a desire to kill his previous foster parents and made similar threats to his current foster parents. He reported having fireworks in his head and hearing bad voices that told him to do bad things. The foster care agency provided respite services and referred the foster parents to trauma training. Eleven months after discharge from his second hospitalization, SASS assessed Perry after his foster mother reported that Perry made statements about killing his previous foster parents, including cutting their faces off. He was hospitalized a third time, for 20 days, for psychosis, aggression, and self-harming. According to hospital records, five-year-old Perry was still not toilet trained. Throughout his hospitalization, Perry continued to report a desire to kill his previous foster parents. He participated in family and individual therapy sessions to address triggers for aggression and self-harming. At discharge, Perry received a diagnosis of RAD and ADHD. Perry did not return to his foster home because they did not feel they could meet his needs. At the time of his discharge, a specialized foster placement could not be located and five-year-old Perry was placed in a shelter where he remained for 75 days. In November 2013, Perry's case was transferred to Sigma Foster Care Agency and he was placed in a specialized foster home, 170 miles from his sister's foster placement. The agency provided therapy and medication management. Perry's parents signed surrenders for his sister to be adopted by the former foster family but Perry's goal remained return home. His mother had re-engaged in services, but his father remained incarcerated. Visits with his parents and his sibling were difficult because of the distance and Perry had difficulty with his behaviors while riding in the car. On several occasions, he attempted to get out of the moving vehicle and struck the case aide transporting him. The visiting schedule was restructured so that visits occurred less frequently, but for a longer duration each time. In the beginning of 2014 Perry's school evaluated him for special education services. His

behaviors prevented him from learning and required a behavior plan. The court terminated parental rights in October 2014 and Perry remains in a specialized foster home.

Sean (Five Hospitalizations, Three Transitions)

Sean, age three, and his six-year-old half-sibling entered foster care after their mother committed suicide by shooting herself in the head while both children and the half-sibling's grandmother were in the home. Emergency responders reported that Sean had to be removed from his mother's body and was covered in her blood. The Department took protective custody and placed both children with the grandmother. The mother and father had a history of domestic violence and police records noted that the children witnessed the father beat the mother. At the time of the mother's suicide the father was incarcerated for his third DUI.

The foster care agency referred Sean to a therapist with Empire Community Mental Health Provider who provided weekly sessions, beginning in July 2010.[46] The court mandated Sean and his sibling's removal from the grandmother's home 45 days after placement, after paternity testing ruled out the grandmother's son as the sibling's father. Rho Foster Care Agency moved the children to live with a maternal aunt; however she requested the removal of both children after three months because she felt overwhelmed. In November 2010, Rho Foster Care Agency placed Sean and his sister in a traditional foster home where Sean remained for three years. During this time, he was psychiatrically hospitalized five times and prescribed 10 different psychotropic medications. In February 2010, his foster parents enrolled him in Zeta Preschool for both preschool and daycare. His foster parents noted concerns about his therapist and told the case manager they did not believe that therapy addressed his physical aggression. In October 2011, Sean's therapist, who had been seeing him for over one year, described an incident where the foster mother became upset after observing Sean playing with guns in the therapy playroom. He agreed to stop playing with the guns if the foster mother returned to the play room. The therapist did not note anything else about the incident. The therapist knew that Sean's mother had killed herself with a gun and that he had been on the scene when it happened. The following day the foster mother called for a SASS assessment after Sean demonstrated increased aggression and threatened to kill himself. During the SASS assessment the foster mother described the incident from the therapist's office where Sean picked up a toy gun, put it to his head and then fell to the ground. The SASS therapist noted that during the assessment Sean made suicidal and homicidal threats. He was approved for his first hospitalization and remained hospitalized for eight days.

At a DCFS Clinical staffing during Sean's hospitalization, the convener recommended the agency to consider a therapeutic preschool setting that provided group play opportunities to promote peer relationships. At a follow-up staffing 30 days later, in December 2011, the same convener noted Sean's continued struggle with behavior problems as reported by Zeta Preschool staff. Given the agency and foster parents' concerns with his prior therapist, the convener recommended that the foster care agency refer Sean to a therapy provider that had experience with traumatized children. The convener noted that Sean, who had been in foster care for over a year, had never participated in grief therapy after the traumatic loss of his mother.

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[46] Sean's therapist through Empire Community Mental Health Provider held a license as a professional counselor.

In December 2011, the agency referred Sean for therapy at Theta Community Mental Health Provider with a therapist licensed in Marriage and Family Therapy. He attended biweekly and, as the foster mother described, sessions consisted of both foster parents discussing issues with the therapist while Sean played in the same room. At times, Sean answered the therapist's questions.

The agency did not secure a different preschool setting for Sean and he continued to attend Zeta Preschool until his enrollment in kindergarten in the fall of 2012. Over the next 10 months, the record contained documentation of Sean's difficulties at Zeta Preschool with both peers and teachers. The Zeta Preschool administrator spoke with the case manager and reported that the teachers struggled to do what was best for him. He also received several suspensions for his behaviors that included physical aggression and swearing.

In January 2012, Sean's psychiatrist started him on Ritalin for ADHD unspecified. A note from the DCFS consulting psychiatrist documented that therapy did not help alleviate Sean's behaviors. Sean continued to receive therapy from Theta Community Mental Health Provider and his therapist changed to a QMHP. The record did not contain any indication that either therapist had experience in trauma or grief therapy. Throughout his treatment, Sean continued to make statements that he wanted to die, wanted to be with his mother, and wanted to kill himself. Sean had four subsequent psychiatric hospitalizations over the next 19 months. He returned to the same traditional foster home upon each discharge. DCFS Clinical provided the agency with recommendations for ensuring that Sean received the appropriate services after each hospitalization and reiterated Sean's need for a therapist experienced in trauma and grief therapy. The DCFS Clinical Convener also recommended a referral to SOC for placement stabilization and enrollment in extracurricular activities. The record did not contain any documentation that the agency ever ensured Sean received the recommended services. After Sean's fifth hospitalization of 48 days in the spring of 2013, he underwent testing to rule out any medical causes for his behavior difficulties, including an MRI, EEG, and a sleep study, all of which were unremarkable. During this time, the agency case manager noted concerns about the foster mother's stress level and planned to explore the possibility of respite, but there was no documentation that the agency ever approved respite for the family. In May 2013, Sean began Prozac (SSRI; used to treat Major Depressive Disorder and Bipolar Disorder). In July 2013, SASS deflected Sean from a sixth hospitalization after the foster mother reported that he poured gasoline on himself. The foster mother intervened and believed that she could handle him in the home. That summer the Department approved Sean for specialized foster care and his case transferred from Rho Foster Care Agency to Hudson Foster Care Agency. After Sean's fifth hospitalization, the Department referred him to a 90 day diagnostic program through Omicron Diagnostic Program and Residential Program. He remained in their program for 90 days then transferred to their residential treatment program. The foster parents reported uncertainty about allowing Sean to return to their home and their continued commitment to his adoption, even though they had adopted Sean's sister. Sean's father had previously signed consents for the family to adopt him. Sean remains in a residential placement.

COHORT THREE

The third cohort consisted of 10 children who were over four years old, or 49 to 58 months, at the time of placement into foster care. This cohort had the shortest length of stay in foster care prior to their initial hospitalization. One child, Victor, was already hospitalized at the time he entered into DCFS custody. Three children were in foster care less than a month before they were hospitalized. Two children, Taylor and Xander, were in shelters when their hospitalizations were approved; one was in the shelter for four days and the second child was in a shelter for 23 days at the time of hospitalization. The third child, Quentin, was placed in a foster home only two days prior to his hospitalization. Overall, nine children in the third cohort were hospitalized within six months of coming into foster care.

Five children in this cohort had a single hospitalization, three had two hospitalizations, and two had four hospitalizations. The length of stay for initial hospitalization ranged from seven to 52 days for children in *Cohort Three*, excluding Victor's hospitalization of 89 days, as it began before his involvement with DCFS. Only three children in *Cohort Three* had stable placements.

Six children (60%) came from families with domestic violence or physical abuse histories. One child suffered from the sudden violent death of his baby sister who perished in a home fire. He did not receive timely grief and loss therapy although a local children's hospital offered such services. Additionally, he and two other children in the third cohort were "wait listed" for needed counseling (trauma focused cognitive behavioral therapy) or educational services. Five months passed before one of the children received the wait listed service from Alpha Children's Hospital. The child who lost his sister to a fire was finally accepted for therapy in February 2015; however, as of the writing of this report he still had not attended services due to foster parents being unwilling to take him. A fourth child who was to receive a Functional Behavior Assessment was never referred for the assessment. Four of the children qualified for special educational services. Two children had prenatal exposure to alcohol.

Victor

A four-year-old child, Victor, became a ward of the state while hospitalized after his guardians, a maternal uncle and his wife, were no longer willing to care for him. He had been living with his relatives under private guardianship after the death of his mother in 2008. He was two years old at the time of her death. Victor's family reported a long history of mental illness and his mother abused alcohol and drugs, including while she was pregnant. The relatives reported the mother's cause of death as pancreatitis. Neonatal hospital records confirm that the biological mother used crack cocaine and tested positive for opioids and barbiturates at the time of his birth. While living with relatives, he received a diagnosis of rickets from a vitamin D deficiency. Victor resided with his relatives for approximately 16 months prior to hospitalization. He was admitted to Kappa Psychiatric Hospital on March 26, 2010 for "aggressive behaviors toward three-year-old cousin" and his relatives' relinquished guardianship on April 16, 2010. Victor believed he was in the hospital because he "hit his head on the table and now has to sleep here." Records indicated that Victor did not display any of the behaviors reported by his relatives while hospitalized and he acted as "a normal little boy." He was not prescribed any medication. He remained in the hospital for another two months while a stable, appropriate placement could be located. DCFS clinical became involved prior to dependency and recommended a specialized

foster home with no children under the age of 12 years in the home. The Department located a specialized home and placed Victor on June 23, 2010. Upon discharge, Victor received weekly in-home individual and family therapy to address issues related to Attachment Disorder. Per records, Victor flourished in this home and did not display any of the difficulties reported prior to his initial hospitalization. He attended a state pre-kindergarten program in January 2011 and began all-day kindergarten that fall. He was placed in an accelerated reading program in January 2012. He was adopted in February 2013 and DCFS closed his case. Victor was one of five children in *Cohort Three* who did not have a subsequent hospitalization.

Intact Family Services

Four of the 10 children in *Cohort Three* received Intact Family Services prior to becoming wards of the state. The average length of services received was 11 months, with a range of seven to 13 months. For all four children, Intact Family Services were opened after the child's third birthday. Two of the four children were never enrolled in an educational program while involved in Intact Services. One of the four was enrolled in a state pre-kindergarten prior to the opening of the Intact case and one was enrolled in a day care program with a "preschool component" within two weeks of case opening.

Placement Stability

In addition to the many transitions these children had already encountered upon entry into DCFS custody, such as being removed from their biological home and placed in foster care, or living with different caretakers prior to DCFS guardianship, the children in *Cohort Three* continued to experience frequent changes in placements, caseworkers, and agencies. The number of caseworker changes in *Cohort Three* ranged from one, for Nick, to 14, for Fiona. The number of agency changes ranged from zero changes, for five children, to four changes, for Xander. The remaining four children each had one change in agency.

Keandra, who experienced three placement disruptions prior to hospitalization, was the only child to experience disruptions before her first hospitalization. After the initial hospitalization, seven of the 10 children experienced placement disruptions, and five of the 10 were discharged to new placements. One child, Liam, experienced one disruption; three children experienced two disruptions; two children experienced three disruptions; and one, Fiona, experienced seven disruptions. Two of these seven children, Xander and Fiona, eventually entered residential care. Only two of the nine children experienced stable placement, meaning they had no placement disruptions prior to the hospitalization and they were returned to the same home upon discharge.

Three of the 10 children comprising *Cohort Three* received SOC services prior to initial hospitalization.[47] Three children were in specialized care prior to hospitalization and five of the 10 children entered specialized care after their discharge from the hospital.

Subsequent Investigations while in Foster Care

Four children in *Cohort Three* were the subjects of child protection investigations while they were in foster care. Taylor was the subject of two investigations; both were unfounded. One

[47] See System of Care Services, page 107.

investigation related to Taylor's foster parent leaving him at the hospital while being assessed by SASS, resulting in his second hospitalization. He was placed in a new foster home after this hospitalization. The second investigation occurred in December 2014 after an anonymous person called the hotline alleging Taylor's foster parents abused cocaine and physically abused his 11-year-old foster brother while under the influence. Taylor and his foster brother denied physical abuse and both foster parents denied any issues with substance abuse. The Department unfounded the allegations.

In December 2014, seven-year-old Liam was the subject of an investigation after his foster father pulled on Liam's shirt to calm him down, allegedly leaving a mark on the child's stomach. The foster father denied knowingly leaving a mark. There was no indication of a bruise caused by pinching or grabbing and Liam denied being grabbed by anyone at any time.

Xander and Quentin were the other children involved in investigations. Both of their investigations were indicated. In May 2011, Xander's foster mother was arrested for domestic battery against her adoptive daughter and Xander was subsequently moved to a new foster home. Quentin's foster mother was indicated for Inadequate Supervision in September 2012 after leaving Quentin and his three foster siblings home alone. Quentin was moved to a new foster home upon completion of the indicated investigation.

Three children (Nick, Fiona, and Xander) also made an outcry against members of their biological home once they were in foster care.

Early Education/State Pre-Kindergarten/Head Start

Only one of the 10 children in *Cohort Three*, Xander, had documentation of Early Intervention services. Six of the 10 children attended either a state pre-kindergarten, private preschool program, or Head Start program. Two children were enrolled in a daycare program that developed their own preschool curriculum and one child, Taylor, was enrolled in Zeta Preschool and a learning center but was reportedly expelled from both programs. One child's record contained conflicting information; hospital records indicated both "not yet in school" and also "pre-k at daycare." The foster parent stated, "he is doing well in school." Information was gathered that he attended a preschool "when public school was not in session" but the preschool did not have any records and the administrator could not recall the child. Four of the 10 children had IEP's; three to address developmental and emotional-behavioral issues and one to address emotional-behavioral issues.

No Placement Transitions and Single Hospitalization (3 Children)

Three children in *Cohort Three* had stable placements. One child, Victor, was placed in the hospital prior to becoming a ward but was placed in a specialized foster home upon discharge from the hospital and was subsequently adopted. Two children did not have any placement disruptions prior to their first hospitalization and returned to the same placement after discharge. Both children were placed in traditional foster homes, and one child qualified for specialized care four months after her hospitalization; her foster family later adopted her. The second child returned home to the care of his mother.

Reyane’

The police took protective custody of four-year-old Reyane’ on December 30, 2011 after the mother reported being homeless with “no place to go.” The biological mother refused to go to a shelter or to a relative or friend’s home. Reyane’ and her mother were outside the maternal grandmother’s home at the time of the incident and the police placed Reyane’ with the maternal grandmother. Police records indicated that the grandmother had a bed, clothing, and toys for Reyane’. The Department indicated the mother for Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare of a Minor. According to records, Reyane’s maternal grandmother reported that the child had lived with her since August 2011 because of the mother being “in a violent relationship, using drugs, and being evicted from her apartment.”

Reyane’s mother reported a long history of depression and anxiety and reported using marijuana as a way to self-medicate for depression. According to records, police responded to the biological mother’s address approximately 18 times since 2009 because of domestic violence. It is unknown if Reyane’ witnessed any of the violence.

Reyane’ attended a Head Start program in fall 2011, prior to entering foster care. She had significant behavioral problems including inability to stay seated or to focus and aggression toward peers. She did not receive any additional services through school prior to her entry into foster care. On January 26, 2012 Reyane’ was seen by her pediatrician. At the appointment, her grandmother expressed concerns regarding Reyane’s behavior at home and school. The pediatrician referred her to a psychiatrist, but the psychiatrist had a one-month wait list.

The grandmother reported concerns to the caseworker on several occasions regarding Reyane’s aggressive, impulsive, and hyperactive behaviors. The caseworker referred the grandmother to a community mental health provider. On January 30, 2012, at 12:15 p.m., Reyane’, her grandmother, her caseworker, and the six-week-old infant in the grandmother’s care, drove to the community mental health provider. They waited nearly two hours to be seen. During this time, Reyane’ had a difficult time behaving; she ran around the lobby and played with the water fountain. Her behavior escalated to hitting and biting the grandmother, spitting at her, and dumping water on her. She also began to show aggression to the infant. Records indicated that the community mental health provider staff member believed Reyane’ was “in crisis and uncontrollable” and checked with a supervisor to get SASS involved. Reyane’ was taken back to the waiting room for an additional hour to wait for SASS. Reyane’s behavior continued to escalate and she could not be redirected. SASS determined that Reyane’s reported self-harming and aggressive behaviors with the infant, the family cat, and her grandmother met the criteria for hospitalization. Her grandmother transported her to the ER at a hospital. At the ER, the grandmother reported that she had to restrain Reyane’ for fear she would hurt herself. Reyane’ also reported that she kicked her cat because she wanted “it out of her room.” From that hospital, she was taken via ambulance to a psychiatric hospital. Reyane’ arrived at the psychiatric hospital, asleep, at approximately 10:15 p.m., unaccompanied by family.

Reyane’ remained hospitalized for seven days. She was discharged back to her grandmother on February 6, 2012 with a diagnosis of Disruptive Behavior Disorder and ADHD. She was not prescribed any psychotropic medication but it was recommended that she take Omega-3 Fatty Acids to benefit ADHD and mood symptoms. She was also approved for specialized foster care.

The clinician completing the Integrated Assessment recommended that Reyane' receive EMDR therapy to address issues related to the trauma she experienced while in her mother's care, including domestic violence and housing instability.[48] This recommendation was endorsed at the DCFS Clinical Initial Staffing. On March 19, 2012 Reyane' attended only one session of EMDR; her grandmother felt that because Reyane' could not sit still and focus during treatment, this was not appropriate treatment for Reyane'. At the 30-Day Clinical Staffing, her grandmother requested behavioral therapy as an alternative treatment but the clinical staffing team urged the grandmother to continue with EMDR for a few more sessions. The grandmother did not schedule another EMDR appointment. Instead, she established a very structured routine to help with day to day activities and sleep.

Reyane' began SASS services on March 6, 2012, approximately one month after discharge from the hospital. Services included individual and family therapy. On March 16, 2012 a psychiatrist diagnosed her with ADHD and ODD and prescribed Ritalin and Melatonin. In August 2012, Reyane' began weekly individual therapy through Phi Foster Care Agency. Upon beginning kindergarten in August 2012, school staff reported that Reyane' "worked at her developmental capacity; however, she struggled with focus and boundary issues." She did not qualify for special education services. In November 2012, after an increase in the dosage of her medication, the grandmother reported that her behavior difficulties decreased "dramatically." She was discharged from Phi Foster Care Agency in May 2013 as it was reported that she had satisfactory progress in her treatment goals and the grandmother believed that Reyane' was no longer in need of counseling. In the fall of 2013, the grandmother and school staff reported a marked improvement in her behavior, describing increased focus and less aggression. On February 27, 2014, Reyane's mother signed a specific consent for her to be adopted by her grandmother. Termination of parental rights occurred on April 10, 2014 and her grandmother adopted her on February 24, 2015.

Nick

Nick's family first came to the attention of the Department in January 2011 when police arrested his biological father for repeatedly hitting his paramour's four-year-old child in the face. The Department placed then four-year-old Nick and his five- and seven-year-old siblings under a safety plan with their paternal grandmother as their biological mother lived out of state. The children lived with their grandmother for approximately 10 days before it was discovered that the grandmother bailed her son out of jail and allowed him access to his children. All three children were placed in a shelter for one week prior to placement in a traditional foster home. While they were initially placed together, the boys were separated because of their aggression toward each other. The Department indicated the father for Cuts, Welts, Bruises to two of his paramour's children and Substantial Risk of Physical Injury to Nick and his siblings. Approximately four months after entering foster care, Nick and his five-year-old brother reported sexual abuse by their father, uncle, and the uncle's boyfriend. The Department indicated the father and uncle for

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[48]The National Institute of Health and Care Excellence (2005) does not recommend EMDR as treatment for PTSD in children, rather, use of trauma-based behavioral therapy adapted to suit children's age is the preferred treatment. Two staff from DCFS clinical (a clinical convener and clinician completing an integrated assessment) inappropriately recommended use of EMDR with two of the children in this investigation. See discussion of Isaac on page 51.

Sexual Penetration and Sexual Molestation of Nick and his five-year-old brother. All three men were also indicated for Risk of Sexual Harm to the seven-year-old brother.

Nick's parents had a long history of domestic violence prior to their divorce in 2009. They had a 50/50 custody arrangement, but their father no longer allowed their mother access to the children in May 2010. The mother obtained an order of protection against the father after he broke into her home. She moved out of state one month later, citing that she needed to get away from the father. Nick's father also had two prior convictions for domestic battery. The court convicted him of aggravated battery to a child in March 2012 and sentenced him to four years stemming from the January 2011 arrest.

Before his foster parent requested SASS services in May 2011, Nick did not receive any therapeutic services to address his history of experiencing sexual abuse and the other forms of violence he witnessed and likely endured. In the Integrated Assessment, the mother said the father's violence towards herself and the children included him hitting the children and striking her if she tried to intervene. The mother reported that during the couple's marriage, she suffered a miscarriage after the father beat her. Approximately three months prior to the foster mother's request for SASS services, the foster family gave a 14-day notice for all three boys to be removed from their home but reconsidered when Rho Foster Care Agency promised to put services in place. SOC services were provided but it is unclear when they began. Records only reflect that Nick received crisis intervention as well as individual and family therapy services through SASS for 30 minutes per week.

Records contained conflicting information about Nick's educational services. Some records indicated that he attended a state pre-kindergarten program and other records documented that he was not enrolled in any educational program. Some of the records indicate that he reportedly attended a preschool, but "only [on] days public school was not in session." The public school system in his area did not have any record of his enrollment at any time.

Nick was deflected from hospitalization three times in the five weeks before his hospitalization. On July 2, 2011, he was hospitalized for 11 days and was discharged to the same foster parents. Hospital records document that he did not display physically aggressive behaviors but did exhibit symptoms of inattention. His discharge diagnosis was PTSD and he was prescribed Prozac. No new referrals were made; recommendations included continuation of SASS services. On August 7, 2011, SASS deflected him from hospitalization after the foster parents reported he bit himself, kicked the foster parent, and urinated on the floor when in time out.

On August 22, 2011 the court approved placement of Nick and his two siblings with their mother in another state. Interstate Compact approved the home for placement and DCFS maintained guardianship and monitored the children over the following four months. The mother and her children participated in family therapy and the mother ensured that Nick received follow-up for his psychotropic medications as well as individual therapy to address his past physical and sexual abuse at the hands of his father and uncle. In December 2011, Nick's out of state psychiatrist requested Depakote but the consulting psychiatrist's attempts to reach Nick's psychiatrist in order to determine the need for medication went unanswered; the consulting psychiatrist denied the request. On February 1, 2012 the court returned Guardianship of all three children to the mother, the father surrendered his parental rights, and the Department closed the case.

Multiple Transitions and Single Hospitalization (2 Children)

Liam

Liam's mother had a long history of involvement with the Department; she had been a ward herself because of inadequate supervision and sexual abuse. She became involved with the Department as a parent in October 2003, after giving birth to her sixth child. The hospital referred her for child welfare services based on her request for parent training and counseling. The Department referred the mother to community agencies and closed the referral. She gave birth to Liam, her ninth child, three-and-a-half years later.

Approximately seven years after becoming Department involved**,** in December 2010, hospital staff called the hotline when the 31-year-old mother gave birth to her twelfth child. She had been discharged from the hospital several days earlier and had not returned to visit or take the infant home when he was ready for discharge. The infant was subsequently placed with a voluntary placement program. During the investigation, the investigator observed squalid conditions in the home and discovered the parents kept an older child out of school to assist with caring for the younger children, including then three-year-old Liam. The Department indicated the parents for Inadequate Supervision of the infant and Risk of Harm to the 11 siblings; the Department recommended intact family services. The family participated in intact services through Rho Foster Care Agency from December 2010 through December 2011. Both parents were referred for alcohol and drug assessments and mental health services. The father was court ordered to receive domestic violence counseling. The intact case manager also assisted with registering three of the children in school. It is unclear if one of these three children was Liam.

During the intact family case in March 2011, the father was indicated for Cuts, Welts, Bruises to an 11-year-old sibling; during a fight in the home, a 13-year-old sibling threw a frying pan at the father. He then threw the pan back, striking the 11-year-old sibling. Law enforcement arrested the father and he remained in jail for 23 days. Between September and December 2011, the Department conducted four additional investigations involving the parents and the 11-year-old sibling. The first and second investigations involved a physical altercation between the 11-year-old and the mother. The third investigation was expunged and there was no information at the time of the OIG review. The fourth investigation, under a different SCR number, was initiated after the 11-year-old sibling disclosed to the maternal grandmother that the 17-year-old sibling molested her. According to family members, a maternal uncle had previously molested the 17-year-old and the mother had knowledge of the abuse. The investigation was unfounded and expunged.

The family was also evicted from their five-bedroom home during the intact case, at the beginning of December 2011. The family moved into a homeless shelter, but the mother reported that she had kicked her oldest child out of the home and did not allow him to come to the shelter because he had attempted to strangle her. While living in the shelter, a five-year-old sibling reported sexual abuse by a 14-year-old sibling during a physical for school. During the investigation, the five-year-old and the eight-year-old sisters confirmed their 14- and 17-year-old brothers had sexually abused them. When the father found out, he got in a physical altercation with the 14-year-old and the shelter asked the family to leave. Ten of the 12 siblings were placed

in foster care. The oldest child did not enter foster care and the infant remained in the voluntary placement program.

While involved in intact family services, Liam was never enrolled in an early education program. The family was referred for therapeutic services at Alpha Children's Hospital in August 2011 but was told there was a three to six month waiting list.

Liam was placed in a specialized foster home with two of his sisters, three and 14 years of age. He participated in and passed a screening for Head Start services in January 2012, although he demonstrated difficulties with communication, motor skills, and social-emotional development. Approximately three months after placement in their home, the foster parents called the CARES line on the evening of March 1, 2012. SASS did not come to the home until the following morning. Liam was described as physically aggressive and often required restraint. The SASS worker deflected him to community services. Later that afternoon, the case manager went to the home and spoke with Liam, who reported that no one liked him and he wanted to throw himself out of the window. It was also documented that he reported auditory hallucinations: "a devil sits on my shoulder and tells me things in my ear." The case manager called the SASS worker, who then approved hospitalization. SASS participated in the hospital staffings, but did not provide any further services.

While hospitalized for 52 days, Liam participated in both group and individual therapies. Family therapy was offered but did not occur; there was no documentation regarding a reason. His biological mother participated in staffings over the phone and his parents participated in one supervised visit. The foster parent provided information during the intake but did not have any further involvement because he would not return to the home. During the 72 hour staffing, it was recommended that Liam be placed in a specialized foster home in which the foster parent was not employed and did not use day care services. They also recommended that any other children in the home be older than Liam. Once the agency identified the new foster family, they participated in several pre-placement visits before discharge. Liam was discharged with a diagnosis of Intermittent Explosive Disorder, ADHD and a prescription for Tenex. Liam was placed in the new specialized foster home with one other child, an eight-year-old foster brother.

Upon discharge, Liam was referred for trauma-focused therapy once again at Alpha Children's Hospital. Services did not begin until September 2012, five months after his discharge. He reportedly did well in this home and did not exhibit any of the previously reported behaviors. He did well with structure and routine. He was not enrolled in an educational program as the DCFS convener recommended he begin a Head Start program once his "emotional needs stabilize."

Liam attended a therapeutic school program at a community mental health provider during the summer of 2012, began half-day kindergarten in the fall, and transitioned to a Saturday program at the community mental health provider. He attended summer camp in 2013 and began first grade in regular education in the fall of 2013. According to the case records, the foster parent reported that he did well in school.

Both parents participated in Parenting Capacity Assessments in the fall of 2013 that noted poor prognosis for parenting their children. Visits observed by the clinicians were described as generally chaotic and the parents struggled to provide minimal levels of appropriate supervision.

Liam continues to do remarkably well in his current placement. No behavior difficulties have been documented. Parental rights have not been terminated at the time of this report. His current foster family noted a desire to adopt Liam if rights are terminated.

Quentin

At age 13, Quentin's biological mother was placed in foster care in another state as a result of domestic violence between her parents. While in foster care, the mother reported instability and was sexually assaulted, which resulted in pregnancy. She gave birth to her first child while in foster care, at the age of 14. A year later, she and her child returned to her mother's care in Illinois. In January 2006, the toddler's daycare called the hotline and reported burns; the Department opened an investigation. Neither the mother nor the maternal grandmother could adequately explain the injuries and the Department took protective custody of the toddler. The then 15-year-old mother and 33-year-old grandmother were indicated for Burns by Neglect and Cuts, Welts, Bruises to the then two-year-old child. The child was placed in foster care.

In December 2006, at the age of 16, the mother gave birth to Quentin and the Department took protective custody because the mother had not complied with previous services. After Quentin's birth, the mother engaged in parent training services. While she initially agreed to engage in counseling to address issues related to depression, blunted affect, and emotional numbing, she never successfully engaged in the service. The agency requested a court-ordered psychological evaluation because of the mother's refusal to engage in therapy, but the court denied the request.

Quentin was returned home in the fall of 2007 and his brother followed one month later. Both children were enrolled in a Head Start program so that their mother could continue to attend school. However, she quit school shortly after the boys returned home, reporting it was too difficult now that the boys were home. She requested assistance enrolling in a different educational program but only had sporadic attendance and stopped going in May 2008. Quentin's Head Start program dropped him for lack of attendance at that time. The mother decided to keep Quentin home with her because she did not work or attend school. The court closed the case in June 2008, one month later.

In 2011, the hotline received two reports of physical abuse by the mother to the then seven-year-old sibling. In May 2011, the Department indicated the mother for Cuts, Welts, Bruises to the older sibling who had bruises and welts from being struck with a belt buckle. The Department put a safety plan in place and the children remained in the home. On October 27, 2011 the Department placed four-year-old Quentin and the seven-year-old sibling in foster care after indicating the mother for both Torture and Cuts, Welts, Bruises to the older sibling and Risk of Harm to Quentin. The maternal great-grandfather was also indicated for Torture to the older sibling.

SASS deflected Quentin from hospitalization in April 2011, while residing with his mother. SASS recommended family therapy, group therapy, and individual therapy. The case remained open for five months. In May 2011 Quentin reportedly began counseling twice a month through a community mental health provider for aggressive and destructive behavior in the home. According to clinical records, Quentin's mother reported he had a diagnosis of ADHD, but she refused any psychotropic medications for him.

Quentin and his seven-year-old brother were initially placed in a traditional foster home. Within two days police were called to the home to "help corral the children during their aggressive incidents." The foster parents gave notice for the children's removal and were on the way to the agency when Quentin tried to jump from the moving car. The foster parents also reported that he displayed verbal and physical aggression toward them including threats to kill members of his foster family. SASS assessed Quentin and approved him for hospitalization.

Quentin remained hospitalized for 31 days. He was placed on precautions for expressing suicidal ideation. Quentin participated in individual counseling and received one on one monitoring but he refused group participation. His new foster parent visited twice during the hospitalization. His mother did not visit or participate in staffings during his hospitalization. Hospital staff reported Quentin was very aggressive and was given daily shots of Benadryl to decrease his agitation. Quentin began Ritalin during hospitalization, but the medication was discontinued after a noted increase in aggression. The psychiatrist switched his medication to Tenex. At the time of discharge, his diagnoses included ADHD and PTSD.

Quentin was discharged to a specialized foster home where he remained for nine months. The foster mother, a single parent, had a nine-year-old daughter who also lived in the home. Quentin received individual and family counseling in his foster home with a Sigma Foster Care Agency therapist as well as medication monitoring. His therapist added a diagnosis of Adjustment Disorder with mixed Anxiety and Depression. Quentin had difficulty adjusting to his foster placement and often reported missing his mother. His behaviors included cursing, threatening to kill others, head banging, kicking, and biting. His foster mother used a rewards system in the foster home and reported that he responded to redirection. In January 2012, he began supervised visitation with his mother and the foster parent reported some behavior difficulties after visits. He attended daycare programming because of a waitlist at Head Start.

In March 2012, Quentin's psychiatrist took him off of Tenex and began Strattera (approved to treat ADHD). He discontinued this medication in the fall of 2012 because he no longer required medication. Quentin began kindergarten in the fall. Approximately a month after school started, his foster parent informed the agency that she planned to move out of state. Quentin's therapist prepared him for his upcoming move and separation from his foster parent to whom he had become attached. In November 2012, he went on an extended visit in his older sibling's foster home until the agency located a new specialized foster home in December 2012. Quentin had pre-placement visits to his new home and continued to receive in-home counseling. His therapist described the foster parent as stable and consistent with the ability to redirect Quentin. While in the new home, Quentin had difficulty adjusting, stating he missed his biological family and his old foster mother. There were also four other children in his foster home and he had been used to more attention from his previous caregiver. The current foster mother had three children ages 14, 12 and 10, and a non-verbal four-year-old foster child.

In January 2013, Sigma Foster Care Agency provided family therapy with the biological mother, Quentin, and his sibling to assist with returning home. In April, the agency recommended the mother begin attending appointments for both of the children. A school report from kindergarten described Quentin as a good learner who enjoyed reading, but he had difficulty sitting still and making friends. In August 2013, Quentin began unsupervised visits with his mother and brother, but he began having difficulties with behaviors after visits. According to his therapist, Quentin

experienced conflict about wanting to return home, as he also felt attached to his current foster parent. In October 2013, the school reported angry outbursts because Quentin had not been returned home as planned. He continued to perform well academically, but his teacher noted that his anger interfered with his behavior. He received a one-day suspension from first grade after threatening two students. That same month, his biological mother was arrested after an altercation with police and was issued a citation for resisting arrest. Quentin continued to have difficulty with behaviors in school and experienced multiple outbursts and tantrums that required his removal from the classroom. During this time, Quentin and his brother had overnight visits with their mother and family therapy in her home. In December 2013, Quentin had to be restrained by school staff when he tried to flee following an altercation with other students. In January 2014, the mother participated in a mental health assessment where she disclosed experiencing anxiety and panic attacks. The court granted the agency the right to place the children with the mother that same month.

In February 2014, Quentin was prescribed psychotropic medication again, Prozac, because of continued behavioral difficulties. An IEP was completed in February as well and the school placed Quentin in an ED classroom. School staff described Quentin as a bright child whose emotions prevented him from success at school.

Quentin returned home on April 11, 2014. The agency continued to monitor the case and provide services. At the time of this report, the case was still open but records indicate the agency will seek closure this spring.

Multiple Transitions and Two Hospitalizations (3 Children)

Taylor

Taylor entered foster care at four years old after a fire occurred in his home that killed his 2-month-old sister. The investigator found that Taylor, along with his twin sister and a five-year-old sibling, lived with their mother, a known prostitute and drug user, and a maternal grandmother and aunt, both of whom had prior Department involvement. None of the children had been enrolled in educational services and the twins' baby teeth had been removed because of "bottle rot." The home appeared chaotic and all three children reported physical abuse at the hands of adults in the home. Given the family's history, a relative placement could not be located. While the Department attempted to locate a placement that would take all three siblings, the children were placed in an emergency shelter. Taylor began an educational program at the shelter, but had difficulty interacting with other children and exhibited aggressive behaviors that required staff to restrain him. Approximately two weeks after entering protective custody, Taylor became overwhelmed and tried to strike the young children with a ping-pong paddle. His tantrum lasted over an hour. Two days later shelter, staff had him assessed for psychiatric hospitalization after continued aggression that included hitting, biting, and spitting. He also banged his head into a pole and overturned furniture. SASS assessed Taylor as being a danger to himself and others and approved him for hospitalization.

Taylor remained hospitalized for 31 days. He was given Benadryl as an emergency medication 11 times for behaviors that included aggression, agitation, non-compliance, and outbursts. He also received Thorazine (first-generation antipsychotic) eight times to address the same

behaviors. Taylor's hospital psychiatrist determined that he needed a home environment as soon as possible and stressed the importance of finding a foster home that would be able to handle aggressive behaviors, lack of frustration tolerance, and his inability to handle his emotions. He received a diagnosis of ADHD and a prescription for Clonidine. The DCFS Clinical Staffing convener recommended an assessment for developmental delays that included a speech impediment. The convener also approved Taylor for specialized foster care to help meet his emotional and educational needs.

Following his discharge in November 2012, Gamma Foster Care Agency placed Taylor in the foster home where his two sisters had been placed. The foster parents enrolled Taylor and his twin in Zeta Preschool from 8 a.m. to 5 p.m. daily. The Department paid for the daycare because the foster parents operated an online business. Gamma Foster Care Agency assigned a therapist[49] to complete a mental health assessment and provide subsequent play therapy.[50] His therapist did not conduct his first individual therapy session until February 2013, over 60 days after his discharge from the hospital and placement in the foster home. Both DCFS Clinical and Gamma Foster Care Agency instructed the case manager to refer Taylor to a child evaluation and research center for an assessment in January 2013. There is also documentation that, during this staffing, Taylor's foster mother reported that she was not giving him his psychotropic medication and she wanted to "assess" him with the medication.

A newly assigned case manager visited the home at the beginning of February 2013. The foster mother reported that Taylor needed a refill of his Clonidine[51] but his psychiatrist could not see him for another two weeks. During this visit, the foster parent requested tutoring for Taylor and his siblings. The record did not contain a discussion with the foster parent regarding securing an educational placement such as Head Start or a state pre-kindergarten program to address his educational delays. The record was also silent on the foster parent's reasons for requesting tutoring for Taylor. Approximately one week later, the foster family issued a 14-day notice for removal of all three children from their home. The foster parents cited an inability to handle the children's behaviors as a reason for removal. The family agreed to keep the children until a new specialized placement could be located that would take all three siblings.

Both during placement at the shelter and his specialized foster home, Taylor exhibited aggressive behaviors in educational and daycare settings. He had difficulty with frustration tolerance, difficulty interacting with other children, and could not handle being told no. In the beginning of March 2013, staff at Zeta Preschool informed the foster mother that Taylor could not return to their program because he jeopardized the safety of the other children in the program.

Two days later, after being removed from daycare, he became aggressive during an individual therapy session. The foster mother brought Taylor to the ER for a SASS assessment. Records indicate that the foster mother left the hospital when SASS arrived. SASS intended to deflect Taylor from hospitalization but the foster mother stated she would no longer care for him when police went to her home. SASS then called Taylor's case manager to pick him up but she

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[49] Taylor's therapist had a license as a Professional Counselor.

[50] The therapist documented completing the Mental Health Assessment in February 2013. Taylor's case record did not contain a copy of the completed assessment.

[51] Taylor's last refill for his Clonidine occurred on January 1, 2013 for a 30 day supply.

reported she was not able to do so. Because Taylor did not have a placement to return to, he was admitted to the hospital then transferred to another hospital.

Taylor remained hospitalized for 34 days.[52] He was secluded once for biting and scratching, and he received emergency Benadryl seven times for aggression. Taylor's hospital psychiatrist recommended that he be placed apart from his siblings. Taylor received a diagnosis of Intermittent Explosive Disorder and Conduct Disorder. A DCFS Clinical Convener reiterated the recommendation for an assessment at a child evaluation and research center. Despite multiple recommendations, OIG investigators learned that this referral never took place.

At time of discharge from his second hospitalization in April 2013, Gamma Foster Care Agency placed Taylor in a new specialized foster home that cared for one older child. The case record did not contain any information about the new foster parents meeting with Taylor or his treating psychiatrist prior to his discharge. In his new foster home Taylor continued to receive individual play therapy from his Gamma Foster Care Agency therapist. The foster family enrolled him in summer camp. In July 2013, Taylor was referred to Epsilon Community Mental Health Provider for medication monitoring. His play therapist completed a report that he was making significant progress in his new foster home. Taylor was taken off all psychotropic medications in August 2013.

Prior to the start of school in the fall of 2013, Taylor's foster family ensured he received an assessment for special education services. When Taylor entered kindergarten, he had been in foster care for 11 months and did not know the alphabet, colors, or how to write his own name. The school completed an IEP in December 2013 and noted significant delays in physical, cognitive, and social-emotional development. In addition to special education classes, Taylor received weekly social work services and occupational therapy.

In April 2014, Taylor's mother informed the agency she was pregnant and would like to engage in services and visit with her children. She had not seen any of her children or made herself available for services since the children came into care in September 2012. In the fall of 2014, the court changed Taylor's goal to substitute care pending court determination on termination of parental rights after the mother had not engaged in services or visited with her children. Taylor's foster family committed to his adoption. The case also transferred from Gamma Foster Care Agency to Omicron Diagnostic Program and Residential Program that fall. When Taylor's case transferred, his individual therapy with his Gamma Foster Care Agency therapist ended. The new agency referred him for trauma-focused cognitive behavioral therapy but the provider had a waitlist. As of the writing of this report, Taylor has not begun therapeutic services and parental rights have not been terminated.

Brooke

In 2005, a then 22-year-old mother had an intact family case in another state with her two-year-old child. Five years later, in February 2010, the family came to the attention of the Illinois DCFS after the police contacted the hotline when the father failed a field sobriety test. The mother and a then three-and-a-half-month-old sibling were in the car at the time of the traffic

[52] At this time Taylor had been psychiatrically hospitalized for approximately 60 of the 180 days he had been placed in foster care.

stop and the infant's car seat had not been secured correctly. The Department indicated the parents for Risk of Harm and opened an intact family services case for one year. At the time of the intact family case, the mother was on probation for breaking a woman's jaw. The mother began individual counseling in April, but was discharged after three weeks for non-attendance. In June 2010, she began individual therapy to address issues of substance abuse and domestic violence, but only attended sporadically through October. She attended no appointments between November 2010 and February 2011. During the open intact case, the case manager contacted the hotline after finding meth in the family's home; the mother also tested positive for the substance. The Department took custody of four-year-old Brooke in February 2011, as well as her six- and one-year-old-siblings. They were placed in the home of a relative. The court mandated the mother reengage in services after her children were placed in foster care.

According to Brooke's mother, Brooke tested positive for opiates at birth because she took Tylenol 3 before she went into labor. Brooke was born with the genetic disorder Leopard Syndrome that causes a heart condition known as cardio-hypermyopothy, which required regular appointments with a cardiologist. Brooke attended a state pre-kindergarten program starting at the age of three, from August 2009 through May 2011. Brooke received individual therapy at a foster care agency as well as SOC Services from a community agency.

In May 2011, the case manager contacted the CARES line during a home visit. Brooke had disclosed sexual abuse by her mother and had been touching her younger sister inappropriately. Brooke's older sibling corroborated that the mother took the children to a hotel where they watched her have sex. During the visit, Brooke also made several statements about wanting to die. Brooke and her older sibling, age six, engaged in inappropriate sexual behavior, including touching each other without any clothes on. The SASS clinician deflected Brooke from hospitalization and provided weekly services in the foster home. SASS also recommended that the agency provide respite for the foster mother. As a result of the outcry, the Department initiated a child abuse investigation that was subsequently unfounded.

In June 2011, Brooke was referred to the foster care agency for a mental health assessment to address numerous incidents of inappropriate language, sexualized behaviors, and recurrent suicidal and homicidal statements. She presented as cheerful and expressed a desire to assist others. The agency assessed that Brooke performed at developmental level and had no issues in her early childhood program. Brooke could become easily jealous and attempted to control situations. The clinician noted that Brooke's hyper-vigilance was related to her chaotic environment while with her mother. The clinician diagnosed Brooke with an Adjustment Disorder with Mixed Disturbance of Emotions of Conduct. Recommendations included weekly counseling: 30 minutes of individual counseling and 30 minutes of family counseling.

In July 2011, Brooke's SASS therapist approved her for hospitalization during a scheduled therapy session. According to the foster mother's report, Brooke had been aggressive all day and had punched her brother and sister. She also kicked the dog and attempted to make the dog bite her younger sister. The foster mother described several instances of Brooke trying to kill her younger sister. During the SASS evaluation, Brooke told the SASS clinician that she wanted her sister dead. The SASS clinician noted that Brooke had hallucinations after Brooke stated that a man named Tiny took over her body.

While hospitalized, Brooke attended group, individual, and recreational therapies. The foster mother visited Brooke in the hospital and participated in staff meetings. The psychiatrist spoke with Brooke's cardiologist and received approval before beginning medication in the hospital. She was discharged to the same relative placement seven days after her admission with a diagnosis of Impulse Control Disorder and ADHD and a prescription for Tenex. At discharge, it was recommended that Brooke continue therapy through the foster care agency and SASS services. It was also recommended that Brooke receive SOC services to assist the foster parent with management of Brooke's behaviors.

Approximately one month after Brooke's discharge, her older brother was psychiatrically hospitalized and did not return to the home. Brooke began kindergarten in the fall of 2011 and her foster mother reported that Brooke had difficulty with behaviors at school; school staff did not corroborate the foster mother's statements. The foster mother also ran out of Brooke's medication and her behavior issues in the home escalated. As a result, Brooke experienced a second hospitalization in the psychiatric unit in October 2011 that lasted nine days. The reasons for admission included suicidal gestures and aggression in her foster home. During her hospitalization, case management staff determined that Brooke would not return to her relative foster home because they could not provide the care she required. Both her biological and foster mothers visited during her hospitalization. She was discharged with a diagnosis of ODD and ADHD with a new prescription for Intuniv (extended release form of the active ingredient in Tenex). She would continue to receive therapy services at the foster care agency as well as SOC services.

Brooke was placed in a traditional foster home that had experience with children with aggressive and disruptive behaviors. One of the foster parents worked nights and slept during the day. There were also three other foster children in the home who were two years, three years, and 10 years of age. A SASS post-hospital assessment conducted in December 2011 noted that Brooke met the criteria for ADHD and RAD as evidenced by her history of experiencing neglect, repeated changes in primary caregivers, temper tantrums, ambivalence with caregivers, love-hate relationships, easy manipulation of others, and attachment concerns.

In February 2012, Brooke was moved to a third foster home as the previous foster parents reported personal problems that precluded them from continuing to care for her. Brooke was temporarily placed in a respite foster home for one month, then she moved into a fourth foster home in March 2012. The foster family reported that Brooke adjusted to their home well. She transitioned to a new school with few problems. The foster parents continued to transport her to therapy and enrolled her in swimming and tumbling classes. She began first grade in the fall of 2012. The goal remained return home and the foster parents encouraged the mother to attend church with the family. The biological mother attended Brooke's cardiology appointments.

In the spring of 2013, the mother stopped visiting, stopped participating in services, and had a positive urinalysis for meth. The court suspended all visits between the mother and her children and changed the goal to termination of parental rights. During this time, the foster parents reported an increase in Brooke's negative behaviors that included anxiety, lying, sexualized behaviors, and stealing. SOC services were re-instated to assist Brooke and the foster family. Her therapist through the foster care agency addressed the change in goal during therapy sessions.

In September 2013, the Assistant State's Attorney filed an order of protection on Brooke's behalf after two incidents where the mother and maternal grandmother attempted to see Brooke alone in the community. School had been notified that the mother was not allowed to visit her child. The foster parents expressed concern about the mother attempting to kidnap Brooke. The foster family committed to adopting Brooke and provided consistent sibling visitation with her siblings placed in a different foster home. She remained on Intuniv for her diagnosis of ODD.

In November 2013, the mother once again tested positive for meth, the court revoked her probation, and she was sentenced to two years in prison. She remained incarcerated and the court terminated parental rights in August 2014. Brooke did well in her adoptive placement, attended school in a regular classroom, and took tap and ballet classes.

Fiona

Fiona entered foster care at the age of four. She had previously lived with her father as her primary caretaker. The father has been previously diagnosed with Bipolar Disorder, Intermittent Explosive Disorder, Anti-Social Personality Disorder, and PTSD. The father had prescriptions for Seroquel and Depakote, but did not comply with his medication regimen. The father also had a history of multiple psychiatric hospitalizations, but did not cooperate with child welfare staff's requests for consent for release of information. The father abused prescription medications, including morphine, and required hospitalization for possible morphine overdose.

Fiona was involved in numerous services prior to her placement in foster care and her first hospitalization. In May 2010, Fiona's 57-year-old father reported to then two-year-old Fiona's pediatrician that the Department initiated an investigation against him for an injury on Fiona's forehead that would not heal. The father said the injury resulted from a fall. The pediatrician noted no signs of abuse during the exam. There was no record of the investigation in CANTS.

In July 2010, Fiona was seen by Ms. Adams, Licensed Professional Counselor, at the Foxtrot Community Mental Health Provider following her father's reports of sexualized behavior ("playing with herself," running around naked) and regression with toilet training. She reportedly had difficulty sleeping and would only sleep for a few hours at a time. She would throw temper tantrums, pull her own hair, and was defiant to adults. Ms. Adams diagnosed Fiona with Disruptive Behavior Disorder. Records did not indicate how often Fiona and/or her father were seen for individual and family therapy. Fiona's father also brought her to her pediatrician's office, Dr. Baldwin, in July 2010. Fiona's father had concerns that she has been "messed with," as she played with herself at times and "tried to insert or press objects on genitalia." He also wanted "something to put her down" at night to help her stay asleep. Fiona's father reported that Foxtrot suggested he try prescription medication. Upon examination, Dr. Baldwin noted "normal female genitalia for her age. No evidence of trauma to genitalia or anus." He also reported that a two-year-old might be too young to diagnose with Bipolar Disorder or to treat with medications.

In November 2010, the Department initiated a second investigation after Fiona's therapist noted a laceration above her eye. Her father reported that she got the injury during a visit with her mother and he stitched the wound closed. During this investigation, Fiona's father admitted to being overwhelmed with Fiona's caretaking. The Department opened a case for voluntary intact family services and unfounded the DCP investigation. Fiona was referred to psychiatrist Dr.

Charles. He provided tele-psychiatry services to then thee-year-old Fiona and diagnosed her with Bipolar Disorder, Most Recent Episode Manic, Mild; Rule-Out Attention-Deficit/Hyperactivity Disorder; and Enuresis, Diurnal and Nocturnal. Dr. Charles initially prescribed Clonidine and Lamictal (used to treat seizure disorder and Bipolar Disorder in adults and pediatric seizures) but added Adderall within a month. He continued to increase the dosages of these medications during the course of her treatment, without any noticeable change in behaviors. In December 2011, the case manager referred the father for parenting classes. He received biweekly parenting help for six months until he was discharged for non-compliance with services, continued use of corporal punishment, and witnessed loss of control with Fiona.

In April 2011, Fiona underwent a psychological evaluation with Dr. Edwards at Lambda Community Mental Health Provider. She was referred at the request of intact family services caseworker, Ms. Dixon, due to concerns regarding prenatal alcohol exposure. Fiona was reported to have language delays and demonstrated hyperactivity, impulsivity, and aggressive behavior. She was accompanied to this evaluation by both of her biological parents. Per Dr. Edwards, Ms. Adams at Foxtrot Community Mental Health Provider had documented extensive behavioral problems, including biting, kicking, screaming, masturbating, and inserting objects into her vagina. Fiona's father and mother also reported that Fiona is "glued" to her father and will refer to him as "my man" and will often become jealous of women he dates. Fiona was subsequently diagnosed with Attention-Deficit/Hyperactivity Disorder, Combined Type; Communication Disorder, Not Otherwise Specified; and Toxic Exposure to Alcohol (FAS with normal growth). Dr. Edwards documented that Fiona's emotional dysregulation was more likely related to her diagnosis of FAS and sensory integration difficulties than Bipolar Disorder. However, she noted that due to her parent's history of mental illness, Fiona is at an increased risk for significant psychiatric issues. Dr. Edwards recommended several services and educational interventions including continued speech and occupational therapies and a Functional Behavioral Assessment. Dr. Edwards did not address nor provide any recommendations for Fiona's sexualized behaviors.

The Department initiated a third investigation in May 2011, during the intact family case. Fiona's father was indicated for Substantial Risk of Harm after he punched Fiona in the nose. Between May 2011 and December 2011, services were sporadic due to Fiona and her father traveling out of state. They spent approximately five weeks in Texas during May and June 2011, before returning to Illinois. Services at Foxtrot Community Mental Health Provider reportedly ended in July 2011 when Fiona's father reported he and Fiona were moving out of state. They relocated to Nevada in September 2011. During their absence from Illinois, the father was detained for hitting and kicking Fiona to get her in the car in a restaurant parking lot. Law enforcement in that state did not take any action. Fiona's case manager documented a request for a well-child check in the city to which the family moved but noted that the local child welfare agency did not perform the service. The intact family case remained open and Fiona and her father returned to Illinois in December 2011.

Upon their return, the Department initiated their fourth and fifth investigations for allegations of Risk of Substantial Harm and Inadequate Supervision based on reports that the father took so many medications he could not supervise his daughter. Additionally, the father buckled and left Fiona alone in their car while he finished his dinner inside a restaurant. She reportedly was put in the car for misbehaving while they were eating. Restaurant staff called law enforcement and the father brought Fiona back inside the restaurant. Police told the father that it was inappropriate to

leave Fiona alone in a car. During the pending investigation, child welfare learned that the father planned to leave the state again with his daughter. The DCP investigator took protective custody of Fiona in January 2012. The Department indicated the father for Substantial Risk of Injury and Inadequate Supervision for the fourth investigation and Inadequate Supervision for the fifth investigation.

Fiona was placed in a specialized foster home. Within two weeks of the placement, she demonstrated sexualized behaviors that included sticking items in her vagina. She also described incidents of sexual molestation and penetration by her father. Fiona's pediatrician, Dr. Ford, also saw her in February 2012, within two weeks of placement, for an evaluation and refill of her psychotropic medications. Fiona's foster parent, Mrs. Gill, reported Fiona's sexual behaviors and noted she had been very aggressive. Dr. Ford also documented that Fiona told her she "plays with her cookie and it gets red." Per Dr. Ford, Mrs. Gill was very concerned about Fiona not having her psychotropic medications and wanted this doctor to restart these medications. Dr. Ford did not feel "comfortable" starting the medications (Clonidine, Lamictal, and Adderall) on such a "young child" and recommended they keep the psychiatric appointment made by DCFS with Dr. Holloway. No examination regarding sexual abuse allegations was documented to occur during this visit. However, Dr. Ford did recommend keeping Fiona in a "safe environment, monitor the other children around her as she is likely to act out behaviors done to her with them, and get therapy started as soon as possible."

Fiona began seeing a psychiatrist, Dr. Holloway, in March 2012, who prescribed Adderall and Clonidine for her ADHD. He continued to see her monthly and increased her medication in June 2012 "without appreciable change." Dr. Holloway also wrote a letter addressed to the court in June. He recommended that visits with Fiona's father be discontinued until such time that the father receives the services outlined in the family service plan as the visits appeared detrimental to Fiona's emotional growth and stability.

In April 2012, Fiona began seeing Ms. Ingram, Licensed Professional Counselor with Phi Foster Care Agency. Her therapy goals included reducing aggressive behavior and addressing safe boundaries. Nevertheless, Fiona's foster parents requested her removal at the end of May 2012 due to escalating behaviors after visits with her father, including increased sexualized behaviors. The foster family agreed to care for Fiona until the agency located an appropriate placement. The agency was in the process of locating a new home when Fiona was hospitalized.

In July 2012, Fiona's foster parents called the CARES line for increasingly difficult behaviors. She allegedly ripped out her own hair, bit herself, and exhibited aggression towards members of the foster family and the family dog. The foster mother reported that Fiona would masturbate to point of urination and that she also made statements that she wanted to kill her foster brother. According to the foster mother, Fiona also reportedly tried to hang herself from the ceiling fan. The SASS screener approved Fiona for hospitalization and noted that the foster mother could not emotionally support, supervise, or safely monitor Fiona.

Fiona was hospitalized at Great Lakes Psychiatric Hospital for eight days. She attended individual therapy as well as speech and occupational therapies. Hospital records documented that Fiona did not exhibit any sexualized or aggressive behaviors while hospitalized. Staff also noted that she had not seen her father for approximately nine days prior to admission. She was

discharged to a new specialized foster home with diagnoses of ADHD, ODD, and Mood Disorder NOS. She received prescriptions for Clonidine and Adderall. It was recommended that Fiona continue psychiatric care with Dr. Holloway. Additionally, Dr. Holloway wrote a letter documenting that it did not appear to be in Fiona's best interest to continue to visit with her father. A referral was made to Acme Community Mental Health Provider for a sexual victimization assessment and treatment. Phi Foster Care Agency would continue to provide individual therapy.

Ms. Johnson, MA, Licensed Clinical Professional Counselor evaluated Fiona at Acme Community Mental Health Provider twice in August 2012 and once at the beginning of September 2012 to assist in the development of an intervention plan related to Fiona's history of being sexually victimized. Referral for this evaluation indicated that Fiona had been displaying signs of sexual abuse since entering foster care in January 2012. Prior to coming into care, Fiona reportedly inserted pencils into her vagina. While in her foster home at the time, Fiona reportedly had inserted utensils, a stroller handle, and a toilet paper handle into her vagina. She reports doing it because it "feels good." Ms. Johnson reportedly talked with Fiona about living with her father and brother and she reported, "They would hold her down by the hair and penetrate her with their penises." Specifically, she said her father and brother would "put their bad stick into her cookie." As a result of this evaluation Ms. Johnson reported "repeatedly disrupting placement would further exacerbate trauma and attachment symptoms for this child and could undo the gains she is making behaviorally." She further recommended "visitation with her father should cease for a period of at least three months for the time being, or at minimum, substantially decrease to no more than once per month, to determine if Fiona's functioning can substantially improve without regular engagement with her perpetrator. Even in supervised visitation both verbal and nonverbal cues may be used to remind abuse victims of prior abuse and serve a coercive function." However, visits continued sporadically until January 2013 when Gamma Foster Care Agency made a critical decision to suspend visits. Fiona's father fought this decision and the court reinstated visits within two days. Fiona continued to receive weekly individual therapy, although she had a change in therapist at the end of January 2013 when she began seeing Ms. Klein, Licensed Clinical Professional Counselor.

In the fall of 2012, Fiona began kindergarten and qualified for special education services for emotional and learning disabilities. She received speech, occupational, and physical therapies as well as an aide in the classroom and a weighted vest to assist with attention. The school noted some improvement in her behaviors but she continued to require frequent redirection and had difficulty staying on task. Both the Acme Community Mental Health Provider evaluation and the Lambda Community Mental Health Provider evaluation reported that Fiona's attention and hyperactivity issues were more likely related to her FAS, sensory difficulties, and other traumas than to ADHD, as she did not seem to respond well to her stimulant medication. Her current foster family also reported improvement in her behaviors and felt that their structured home helped Fiona tremendously. They noted that they had the same routine seven days a week and Fiona only showed defiance and behavioral difficulties after visits with her father. They noted it would take approximately a day to get "Fiona back on track." Fiona had nightmares where she screamed out in the middle of the night, she would masturbate more frequently, and she made a penis out of play-doh and placed the object into her mouth at a family party. Her foster mother often used redirection as an intervention but Fiona continued to have sexually inappropriate behaviors and boundary issues.

Fiona's case transferred to Gamma Foster Care Agency in October 2012 due to a conflict of interest with the current foster mother and Fiona's previous agency.

Fiona began to thrive in her foster placement, where she had been living for approximately nine months. She was enrolled in ballet and soccer. Fiona's caseworkers, of whom she had three in three months, documented no issues in the home. However, according to the client service plan, Fiona was placed with her half-sister at the end of April 2013, at the recommendation of the Guardian ad Litem and the father's attorney. Her medication was also changed at that time. Dr. Holloway prescribed Depakote and discontinued the use of Adderall. She lived with her adult sister and her sister's two children for just over 30 days when the sister's power was shut off. She was subsequently placed in a respite home for approximately one month, at which point she has hospitalized, in June 2013, for a second time. Fiona also changed caseworkers an additional two times during those two months.

While hospitalized at Midwest Psychiatric Hospital, Fiona's medications were changed once again: she was started on Tenex and Clonidine was discontinued. She was also administered Thorazine on three different occasions. There was no documentation in Fiona's case file as to why Fiona was re-hospitalized, as there were no case notes from the end of May 2013 through the beginning of July 2013. Only two case notes were documented during this time period. One for June 20, 2013 (created on August 11, 2013) stated, "I saw Fiona on 5/24, 5/30, 6/6, 6/20." A note for July 10, 2013 (created on August 11, 2013) stated, "I saw Fiona on 7/1, 7/5, 7/8, 7/10." It is unclear if this indicates that the worker saw Fiona while in the hospital.

She remained hospitalized until the beginning of July 2013, when she was discharged to a new specialized foster placement. She lived in this home for a month, as which point she moved back to the previous foster family's home in which she had thrived before her removal and placement with her sister. Based on the records, Fiona had a difficult time adjusting to being back in this placement and she continued to act out sexually and behaviorally. She also continued to have visits with her father, approximately four hours per week.

At the end of September 2013, CWS Ms. Lewis, supervisor Ms. Moore, DCFS psychologist Dr. Nelson, and Clinical reviewer Ms. Randolph conducted a clinical/quarterly staffing for Fiona. Fiona's therapist, Ms. Owens, attended via phone. The case manager documented a summary of the staffing. When the Department took custody of Fiona in July 2012, she self-disclosed to her foster mother at the time she was sexually molested by her father. Ms. Randolph questioned why the father continued to be allowed visitation and was informed visitation remained court ordered for four hours a week. She was also informed the judge dropped the allegations of the father being a sexual perpetrator and would not let Gamma Foster Care Agency refer him for a sexual perpetrator evaluation. Ms. Randolph suggested speaking with the assigned DCFS attorney to intervene. Ms. Randolph also suggested if Fiona's father and mother were married to attempt to get the divorce order and asked about the mother's whereabouts. The case manager noted she was informed that the mother refused services. Ms. Randolph suggested a diligent search for the mother and an attempt to contact her. Ms. Randolph also requested a list of the placements and the reasons why Fiona moved. She requested that Dr. Holloway conduct an up to date psychiatric evaluation. Ms. Lewis discussed Fiona's behavior at school and at the foster home. Ms. Randolph suggested a behavioral specialist go the school to address her aggressive behavior in the classroom. It was also recommended that Fiona receive sexualized behavior therapy.

In January 2014, approximately five months after being placed in her foster home, the foster parents issued a 14-day notice due to feeling that their home "was no longer therapeutic for Fiona." They felt Fiona's behaviors had consistently gotten worse since she had returned to their home. Her foster mother stated, Fiona "has had only two positive and encouraging moments. Recently, Fiona has begun inserting objects into her vagina and masturbating frequently. However, Fiona refrains from sexualized behaviors in public." Per case notes, "Fiona has been extremely defiant refusing to follow any rules and instead doing the opposite of what is being requested. Fiona has destroyed other children's toys as well as her own Christmas presents. Fiona pushed down a two-year-old family member with whom she had always been affectionate and kind." Reportedly, the foster family "hoped that the 'old, sweet Fiona' would resurface but now feels this will not occur."

Fiona was moved to a temporary specialized placement that month and a CIPP was held five days later. Because not all of the necessary documentation was available at the time, a follow-up CIPP was held seven days later. At the second CIPP, it was agreed upon that Fiona was in need of more intense services and residential placement was approved. Her medications were changed once again in February 2014: Adderall was resumed and Tenex was discontinued. She was placed with Omega Foster Care Agency in March 2014. Her current medications include Clonidine, Depakote, and Adderall.

Since her placement in foster care in January 2012, Fiona has had 14 different caseworkers, including 13 since her case transferred to Gamma Foster Care Agency in October 2012. Upon discharge from her second hospitalization, Fiona continued to receive services through school; it is important to note that she was repeating kindergarten. She also continued to receive outpatient therapy but her sexual victimization therapy had been discontinued. It was requested that this resume at the DCFS clinical staffing in September 2013 but this did not occur prior to her CIPP. Parental rights have not been terminated at the time of this report.

<u>Multiple Transitions and Multiple Hospitalizations (2 Children)</u>

Keandra

Keandra's family had a history with DCFS. In 2006, the Department indicated her father for sexual exploitation of non-relative; the father was 24-years-old and the victim was 16-years-old. In 2009, both parents were indicated for Environmental Neglect and Inadequate Supervision to then two-year-old Keandra and her one-year-old and two-month-old siblings. During the 2009 investigation, it was documented that the mother was aware of the father's status as a sex offender. She and all three children moved in with relatives. The mother began services with a community agency and the Department closed the investigation with no additional services.

Keandra entered foster care in November 2010, at the age of four, after she disclosed that her father came into her room in the middle of night, got into her bed naked, and rubbed against her. Her mother refused to allow the children to stay with relatives under a safety plan so the Department took custody of Keandra and her two younger siblings. Her father was indicated for Sexual Molestation of Keandra and both parents were indicated for Risk of Sexual Harm. According to the investigation, the mother knew that Keandra had reported her father's molestation, but she believed Keandra lied. The Department also initiated an investigation of the

relatives that allowed the father to live in the home despite knowledge of his registered sex offender status. The father was never prosecuted for sexual molestation of Keandra.

Keandra was placed in two different relative foster homes in her first two months in foster care, reportedly due to her increasingly aggressive and non-compliant behavior. She was then moved to a traditional foster home and remained there for approximately five months prior to hospitalization. She received individual therapy through Delta Community Mental Health Provider to address her sexual abuse. She began SOC services in December 2010. Keandra began an early education program that developed their own educational curriculum in February 2011. At a developmental screening in April 2011, she reportedly qualified for services because of delays in all areas except social skills. That month, she also received a diagnosis of ADHD. A psychiatrist prescribed Ritalin to address symptoms of inattention, distractibility, and irritability.

The day before her hospital admission, in June 2011, Keandra reportedly harmed several children at daycare. Her foster mother reported that she had a history of scratching herself, speaking with an imaginary person who comes into her room at night and sleeps with her, and hurting animals. Her foster family believed her behavior had grown out of control and described her as a "food hoarder." SASS approved Keandra for hospitalization, citing high levels of aggression for two consecutive days; she had hit a boy with a stick and stepped on another boy while he was napping. She reportedly also choked a girl and dragged her to a pole to bang her head against it. The record was silent as to whether school staff corroborated this information.

Keandra was hospitalized for 10 days and discharged to the same home. She was also approved for specialized foster care. Her therapist, biological parents, and foster parents participated in staffings during hospitalization. The SASS worker also participated in hospital staffings and planned to provide weekly therapy. The SASS file did not contain documentation of any follow-up therapy sessions. She was discharged with diagnoses of PTSD, ADHD, and a prescription for Ritalin. Keandra's referrals upon discharge included SASS follow-up services, Delta therapy, medication monitoring, and SOC services.

At the beginning of August 2011, the psychiatric hospital admitted Keandra for a second time when her foster mother reported that Keandra heard voices that told her to do bad things and that she only slept two to three hours per night. The school also reported that she had disruptive behavior. The psychiatrist prescribed her Clonidine to assist with sleep and impulsive behavior. Her discharge diagnoses included ADHD and Mood Disorder. She attended the hospital's partial hospitalization program until the end of the month. Hospital staff recommended that visits with her father cease; shortly after Keandra's hospitalization, all visits with her father ceased. During the case, the father was referred to complete a sex offender program; however, the father did not participate in services and misrepresented findings of a sexual perpetrator evaluation, claiming that he had been evaluated as low risk to re-offend. Neither parent completed counseling, parenting, or substance abuse services.

SASS deflected Keandra for psychiatric hospitalization three times in February 2012: Her foster parent contacted SASS for services because of aggression, not sleeping, self-harm, aggressive thoughts, and defiance. Keandra was psychiatrically hospitalized for her third and fourth times at the end of February 2012 to the beginning of March (12 days), and from the end of March 2012 through the beginning of April (10 days). The foster mother reported continued problems with

aggression and Keandra threatened to kill herself by swallowing bricks. The foster family reported during her fourth hospitalization that she could not return to their home. Keandra received discharge diagnoses of PTSD, ADHD, and Rule-Out Dissociative Disorder, and she received prescriptions for Ritalin and Clonidine. Two days after her fourth discharge, her psychiatrist prescribed a seven-day supply of Risperdal.

The agency placed Keandra in a new specialized foster home in April 2012. She continued therapy with Beta Foster Care Agency and Delta Community Mental Health Provider. The foster mother stopped giving Keandra her medication because she believed it did not help; it is not clear if the foster mother tapered the medication. The CAYIT team recommended a neuropsychological evaluation but the consulting psychologist denied this and approved a psychological evaluation. She undertook the evaluation in July 2012. According to the evaluating clinician, Keandra made "miraculous improvement" in her new foster home. The court terminated parental rights in May 2012. Her therapist at Delta determined she met her treatment goals and closed her case at the end of August 2012. Two months later, in October 2012, Beta Foster Care Agency discharged her from therapy after her therapist resigned. The therapist noted that she had made progress in her placement and neither the therapist nor her new foster parent had observed any dissociating. Beta Foster Care Agency referred the foster parent to Iota Community Mental Health Provider for continued therapy services. The agency referred the foster parent to online services through the Department Training Institute and the Child Traumatic Stress Network. Her school reported that Keandra continued to perform well academically and the school believed her current foster home was a good placement. The foster family adopted Keandra in October 2014 and the Department closed her case.

Xander

Xander entered foster care at four years old after a failed intact service case related to his family's substance abuse and mental health issues. Xander's mother and stepfather have a long history of involvement with DCFS: they both reported a history of Department involvement as children. The mother was also involved with the Department as a teenage mother. She gave birth to her first child at age 15. This baby was in the NICU for several weeks and then placed in DCFS custody. The baby died at the age of six months due to SIDS. It is unclear why the infant was placed in custody as the investigation has been expunged. The mother had a second child at age 17. She voluntarily gave this child to her mother and stepfather, who later adopted the baby.

Xander's mother, father, and stepfather all had a history of substance use and mental illness. His 28-year-old mother had a history of substance use and mental illness beginning at age 14, when she received a diagnosis of depression after the death of her first child; she received a prescription for Xanax. Records indicated that the mother also had prescriptions for Celexa, Abilify, and Doxepin as a young adult. She attempted suicide at the age of 20. The 25-year-old biological father reported using cocaine, meth, marijuana, and alcohol. He reported three past psychiatric hospitalizations with diagnoses of ADHD and Bi-Polar Disorder. He had been prescribed several psychotropic medications including Xanax, Lortabs (painkiller), Valium (anti-anxiety), Geodon (second generation antipsychotic), and Risperdal. He also reported one past suicide attempt. The 31-year-old stepfather reported using meth and had two prior psychiatric hospitalizations for issues with mood swings and depression.

Xander participated in 0-3 services through an early intervention program to address developmental delays, prior to his involvement with the Department, until his third birthday. He reportedly received developmental, physical, and occupational therapies. Neither his mother nor his intact worker ensured that he attended a pre-kindergarten program. Prior to the open intact family case, Xander had also been receiving psychiatric services for medication monitoring. Dr. Rangel had prescribed him Ritalin, Adderall and Clonidine. In a SACWIS note dated June 2010, Dr. Sawyer, another psychiatrist, reportedly wanted to prescribe Risperdal but there was no other documentation regarding this.

The Department opened an investigation involving the family in August 2008 after the mother allowed her paramour, a registered sex offender, to live in the home with then three-year-old Xander and a five-year-old sibling. The paramour had been convicted of sexual molestation in another state, at the age of 18. His related victims were five and eight years old. Xander's mother reported not knowing that he was a sex offender. The paramour moved out of the home during the DCP investigation. He was indicated for Substantial Risk of Sexual Abuse/Sex Offender has Access and closed the case with no services needed.

Eight months later, in April 2009, the hotline received a second call alleging that the mother, who was now married to the same paramour, allowed him to live in the home. The family moved out state during the investigation. The Department indicated the mother and paramour/stepfather for Substantial Risk of Sexual Harm/Sex Offender has Access. The Department closed the investigation without any further services and notified authorities in the state to which they had moved.

The family returned to Illinois in December 2009, the Department once again investigated allegations of the mother allowing her husband to live in the home, and both the mother and stepfather were indicated for Substantial Risk of Sexual Harm/Sex Offender has Access. Additionally, the stepfather was indicated for Cuts, Welts, and Bruises to the six-year-old sibling after slapping him in the face. The Department indicated the mother for Inadequate Shelter. The Department opened an intact family case and referred the parents for parenting classes, mental health services, and substance abuse services. They did not successfully complete any services during the intact case. At the opening of the case, the biological father was incarcerated for manufacturing meth. He had several prior convictions for assault, weapons, and meth.

In February 2010, Xander's mother called SASS regarding his "out of control" behaviors. SASS deflected him from hospitalization and no follow-up SASS services were documented. Records obtained from the SASS agency did not contain any documentation of Xander's deflection. According to the case manager's documentation, SASS "just filled out paperwork, they didn't do anything for him."

In May 2010, during the intact case, the Department investigated another allegation that the mother allowed the children contact with her husband. The parents were indicated for Substantial Risk of Sexual Harm/Sex Offender has Access again. Allegations against the mother and biological father, who had recently reunited with the family after release from prison, were also indicated for Substantial Risk of Injury after a domestic violence incident and the stepfather's misuse of alcohol. The Department continued to provide intact family services but none of the adults were compliant. The court awarded the Department guardianship of the children in June

2010, but custody remained with the mother. The mother and stepfather separated shortly after the court date, and the mother and her two children moved in with her parents.

The agency placed the boys in a shelter in July 2010, after the mother failed to obtain suitable housing or participate in any of the recommended services, because the agency could not locate a foster home placement for Xander and his older sibling. Xander's mother reported that she took Klonopin at the beginning of 2010 and experienced suicidal ideation shortly after DCFS removed her children. She also reported use of alcohol, meth, and marijuana and required hospitalization once after the children were removed for excessive drinking and use of benzodiazepines and diet pills.

At the beginning of August 2010, four days after placement in the shelter, Xander required restraint eight times in a 90-minute period. He reportedly bit, kicked, spit, pulled the hair of staff, and threw food and utensils. Shelter staff called SASS who approved psychiatric hospitalization.

Xander remained hospitalized for 22 days. He participated in individual and group therapies, and received Ritalin, but the medication reportedly had a paradoxical effect. The psychiatrist discontinued Ritalin and prescribed Risperdal. The hospital also requested permission to administer Tenex but had not received a response by the time of Xander's discharge at the end of August 2010. He moved to a new specialized foster placement.

Upon discharge, Xander's case transferred to Beta Foster Care Agency, as they would monitor him in his first placement. He began a pre-kindergarten program at Head Start and began individual play therapy with an agency therapist. Xander's psychiatrist discontinued all psychotropic medications in October 2010 to get "a clearer picture of his behaviors" since he had been on psychotropic medications since he was two years old. Both his maternal grandmother and Head Start staff reported disruptive behaviors and increased aggression at the time.

At the end of March 2011, staff at Head Start called the CARES line after Xander became combative, aggressive, banged his head, and threatened to kill himself. He was hospitalized at Huron Psychiatric Hospital (out of state) and discharged three weeks later, near the end of April 2011. He was prescribed Tenex and Trazodone HCL and was diagnosed with Conduct Disorder. He was placed in a new specialized foster home upon discharge. At the end of May 2011, his case transferred to Gamma Foster Care Agency for case management. His therapy services were also transferred to Gamma. The case record provided to the OIG did not contain any therapy notes from Gamma staff and SASS records did not indicate that Xander received any follow-up services.

Five months post-discharge, Xander was hospitalized at Huron Psychiatric Hospital again. In a SACWIS note from September 2011, it was reported that when the caseworker arrived for the in-home visit, Xander was in his room and was not allowed to come out. He reportedly expressed a desire to kill himself and his teacher prior to the visit. The caseworker noted that after they spoke, Xander went outside to ride his bike to wait for SASS. There is no further documentation as to why SASS decided to hospitalize. He was hospitalized 19 days and discharged to the same foster home. He was prescribed Focalin, Zyprexa, and Benadryl for sleep.

At the beginning of October 2011, the same day as his discharge from the second hospitalization at Huron Psychiatric Hospital, Xander was hospitalized again. He was admitted to Theta Community Mental Health Provider as a result of suicidal ideation, hitting foster parents, spitting, kicking and urinating on the floor. He reportedly was sent home from Huron Psychiatric Hospital without medications and the foster parents were unable to get his prescriptions filled that afternoon. He was admitted at 2:45 a.m. Hhe was not accompanied to the hospital and rode alone with EMT. Per the EMT, Xander masturbated most of the ride to the hospital. He was discharged after 14 days with a diagnosis of Mood Disorder NOS, ADHD, and ODD with prescriptions for Tenex and Zyprexa. He returned to the same foster home.

Approximately two days after discharge, Xander was hospitalized for the fifth time after reportedly punching a child at school and threatening to kill his brother and stab him with a toy. He also reportedly ate non-food items, including chalk, shaving cream, and crayons. He was noted to have poor sleep and continued to use Benadryl as a sleep-aid. Records indicate that SASS was called at 12 p.m. His caseworker was also called and went to the home to meet with Xander Upon her arrival, she documented that he was "high strung" but was able to calm down and went outside to ride his bike. Records also indicated that EMS was not dispatched until 6:50 p.m. Xander was "sleeping in bed" when they arrived at the home at 8:10 p.m. He was awakened and transported to Erie Psychiatric Hospital. The foster parent reportedly told EMS, "good luck with this one." He was hospitalized for five days and discharged back to the same home. He reportedly was to be discharged after four days but DCFS was unable to pick him up on the day of discharge so his stay was extended by one day. He was diagnosed with Mood and Behavioral Disorders NOS, Rule-out Severe ADHD, Rule-Out IED and ODD, Rule-Out Adjustment Disorder vs. Depression vs. Bipolar Disorder, Rule-out history of Abuse and Neglect. He was not given any medications upon discharge as the treating physician documented that

> Efforts were made to adjust medications (i.e. titrate Zyprexa, discontinue Tenex and start Ritalin LA and Clonidine); however, as usual with patients that are in the custody of the State of Illinois consent to change medications was denied and recommendations to increase the Zyprexa was received instead. This is not the appropriate treatment for this patient at this time per my opinion therefore arrangements were made for patient to be discharged back to his custodians (the state of Illinois) with instructions for them to seek treatment as they see fit.

He was once again discharged to the same specialized foster home but was moved approximately six days later. No documentation was found for why he was moved. He stayed in this new home with no difficulties until the end of November 2011, when he was placed at Omicron Diagnostic Program and Residential Program for a 90-day Diagnostic Evaluation.

Xander remained at Omicron Diagnostic Program and Residential Program until the middle of April 2012, when he was transferred to Omega Foster Care Agency residential center with a targeted discharge date of spring 2014. He continued to take Seroquel and Clonidine for diagnoses of PTSD, ADHD, and Mood Disorder. He continued to receive special education services and was placed in a therapeutic day school. While he previously tested in the borderline range for IQ, more recent testing indicated a Full Scale IQ of 82.

In May 2012, child welfare staff made a critical decision to stop visits between Xander and his brother as they exacerbated each boy's behaviors. Xander had not seen his mother since he was admitted to Omega Foster Care Agency, although he maintained sporadic phone contact until June 2013, when all contact with his mother ceased. In January 2013, the father was charged with aggravated battery and unlawful use of a weapon after allegedly stabbing a man. Parental rights were terminated for both his mother and father in December 2013.

Xander began to see an obesity specialist in December 2013, was placed on a restricted diet, was given Vitamin D supplements, and was given a mandate to exercise 60 minutes per day. In January 2014, his permanency goal was set for adoption. He was discharged from the Omega Foster Care Agency in August 2014 to a pre-adoptive foster placement.

PSYCHOTROPIC MEDICATIONS

Using a medication to help modify unwanted behaviors does not necessarily translate into a lifetime of medication requirement. In many cases, the medications involved are simply a catalyst used to increase the effects of behavioral therapy, and can eventually be removed once those therapies have begun to work. In the event that the use of a psychotropic medication is discontinued, it should be tapered off in a gradual manner in order to avoid withdrawal and rebound symptoms. Too often, the children reviewed here were not provided with appropriate behavioral interventions. A call to CARES for the hospitalization of a young child should automatically trigger effective first-line non-chemical interventions.

Although the use of psychotropic medications in a young and vulnerable population is a concern, such use has not been prohibited. Psychotropic medications maintain a level of danger and severity among adult populations and have thus been studied extensively for safety, efficacy, and long-term effects. The same cannot be said about analysis of their use among children. Given the logistics, cost, and ethical concerns to be considered for such studies, data available on the subject is incomplete.

Treatment regimens prescribed to the children in this study varied from pharmacologic monotherapy (single drug) to varying levels of polypharmacy. The American Academy of Child and Adolescent Psychiatry (AACAP), writes that while it is nearly impossible to establish a strict set of guidelines to be followed in every case, for every patient, at all times, practice parameters are nevertheless a useful tool that clinicians should use in order to guide the treatment decision-making process (www.aacap.org).

Medication Issues

Each of the 32 records had information to create a more complete picture of each child, but the information was rarely coalesced across systems, as there was no centralized source of critical information. Eight of the 32 children reviewed had serious medication issues.

Jason

Jason, whose relative foster home was chaotic, received a number of diagnoses and medication prescriptions. After being moved, he was eventually taken off medications with the exception of

a stimulant to help him focus in school. He received a diagnosis of PTSD following a clinical review and evaluation.

OIG investigators found that Jason's psychiatrist placed him on medications without the approval of the DCFS Guardian. According to Medicaid data, Dr. Stuart, a neurodevelopmental pediatrician, prescribed Risperdal, Clonidine and Trileptal in June 2012 without obtaining consent from the DCFS Guardian. Jason remained on Trileptal for one month. The UCP psychiatrist was never aware that Jason had been prescribed Trileptal.[53] The UCP database shows that in July 2012, consent was requested and obtained from the guardian for Clonidine but consent for Risperdal was not requested or obtained until December, six months after he began taking it.

Rule 325 states that DCFS wards may not be prescribed psychotropic medication without the prior approval of the DCFS Guardian. Despite the DCFS Guardian consultant noting the lack of approval, there is no record of this changing. This practice reveals the ability of the physicians to make decisions regarding the child's care without regard for the review process. Though the consultants in UCP have a practice of reminding doctors of Rule 325, both orally and in writing, there are no practical consequences to deter the prescribing physician.

The lack of context in which the consultant psychiatrist makes a decision can also be problematic. The child's regular psychiatrist has some contact with the patient, talks to the foster parent, and chooses a treatment strategy that they feel is appropriate. The DCFS Guardian consultant evaluates the request for medication based on written reports of the child's behavior, some of which may be exaggerated symptoms reported by a stressed foster parent.

OIG investigators reviewed the UCP internal database and found documentation of the consulting psychiatrist's concerns. Jason's database entry contains a notation about a high dose of antipsychotic medication that was prescribed, in which the DCFS Guardian consultant questioned if the child has developed akathisia (uncontrollable movements). The Guardian consultant also noted that they requested a referral for a psychiatric consultation. The question regarding akathisia is not answered in the database and it is documented that the child has not received a psychiatric consultation.

Once Jason was evaluated by clinicians at a child evaluation and research center in March 2013, he was given a diagnosis of PTSD and determined to not meet criteria for a diagnosis of ADHD. Jason was subsequently removed from all medications and placed in a specialized foster home. The foster parent and the school did not report continuing behavioral difficulties. He received a prescription for a mid-level dose of Ritalin in January 2014 to assist with focus in school, but no longer required an IEP or any additional interventions.

The fact that Jason no longer required as much medication as he had been prescribed raises questions about the role his environment played in necessitating his need for medication. The child's original relative foster home was chaotic, with numerous stressors in the form of possible physical abuse by his grandparents and sexual abuse by his older sibling. In a review of his SASS and clinical case files, it appears that the child's interactions with his grandparents

[53] See section on Zoey on page 91 for more information on the prescribing practices of Dr. Stuart.

triggered much of his behavioral difficulties. The grandparents' ability to care for Jason and his siblings came into question during his care, yet it took several years for the children to be permanently removed from their care.

Based on the SASS and clinical case reports, the child's diagnoses include Impulse Control Disorder prior to hospitalization, ADHD at the time of discharge, and eventually PTSD later in his care. The UCP data lists his diagnoses to include ADHD, PTSD, ODD, Substance-related Disorder, Mood Disorder, Severe Emotional Disorder, Intermittent Explosive Disorder, and Bipolar Disorder. The associated symptoms included tantrums, aggressive behaviors described as harm to other children and cruelty to animals, violence, impulsivity, self-harm, rage, destruction of property, sleep disturbance, pressured speech, agitation, mania, hyperactivity, inattentiveness, and need for restraints on numerous occasions. This list does not seem to correlate with the rest of the clinical picture described throughout Jason's care. The inconsistency partly illustrates the collaborative difficulties within the case review process. Given the described symptoms, justification can be made for any of the medications used throughout his care, as well as the medication recommendations made by the DCFS Guardian consultant. Practice parameters and additional evidence exists that support the use of the various medications in question for a number of the possible diagnoses that this child received (Pliska, 2007; Cohen, 2010; Steiner, 2007; Connolly, 2007; McClellan, 2007; Birmaher, 2007). That is to say, each of the medication regimens are justifiable depending on which set of provider information is followed.

Adverse Reactions (7 Children)

Adverse reactions are described as a response to a therapeutic drug that is unwanted, unexpected, or excessive and that results in temporary or permanent serious harm or disability, admission to a hospital, transfer to a higher level of care or prolonged stay, or death.[54] A side effect is often used to refer to a drug's unintended effect that occurs within dosage in the therapeutic range.[55] The UCP database included information regarding seven children taken off of psychotropic medications because of "adverse or side effects."

Child	Discontinued Medication	Discontinued Reason
Aiden	Adderall	Adverse or side effects-Severe rebounding off of stimulant
Xander	Stimulant	Adverse or side effects
Shannon	Topamax	Adverse or side effects
Flynn	Risperidal	Adverse or side effects-Increased Prolactin levels
Liam	Ritalin	Adverse or side effects-Increased aggression
Sean	Tegretol	Adverse or side effects-Extreme sedation and vomiting
Zoey	Trileptal	Adverse or side effects

[54] Davis Drug Guide, Nursing Central (2014). Unbound Medicine
[55] Tarloff, 2012

Zoey

At four years old, Zoey required hospitalization at Xi Hospital, then transferred to a children's hospital after an adverse reaction to Trileptal. She remained hospitalized for 16 days and received a diagnosis of DRESS syndrome, a severe cutaneous adverse reaction.

Drug Reaction with Systemic Symptoms (DRESS) usually presents three to eight weeks after the use of the culprit drug, and is characterized by fever, skin eruption or rash, prominent eosinophilia (elevated level of a type of white blood cell related to fighting off specific infections), activation of lymphocytes (one of the major types of white blood cells involved with the body's general immunity), and multi-organ involvement (e.g. liver, kidneys, lungs, skin). It occurs in approximately one in 1000 to one in 10,000 drug exposures, with an estimated mortality rate of up to 10%.[56] DRESS syndrome has been most commonly related to the use of anticonvulsant medications, such as Trileptal.[57] Diagnosis of DRESS syndrome requires a strong level of suspicion and several levels of both exclusion and inclusion of signs and symptoms.

Dr. Stuart prescribed Trileptal as an off-label medication to address aggressive and defiant behaviors. Notes from the UCP database indicate that according to medical progress notes Dr. Stuart reported he planned to try Trileptal if an EEG indicated temporal lobe spiking (note dated 2/7/2012). A later progress note (dated 2/28/2012) did not have EEG results but indicated that a trial of Trileptal would be started. There is no indication in Zoey's medical records or Medicaid billing that an EEG was done. Database notes indicate that Tripleptal was approved conditionally, that is, if she has a seizure disorder. She also had prescriptions for Clonidine and Tenex at this time. While the consulting psychiatrist had approved requests for Clonidine, there were no consents for her prescriptions for Trileptal and Tenex that were filled on February 28 and March 1, 2012. The case manager requested consent for the medication on March 16, 2012, two weeks after Zoey had already started taking the medications.

Zoey was admitted to Xi Hospital on April 18, 2012 after her foster father reported that she had vomited, and had difficulty walking and speaking. Initial medical testing revealed elevated liver enzymes and all medications were ceased (Trileptal, Clonidine and Tenex). While hospitalized, Zoey had seizure-like activity. The admitting physician noted that Trileptal had been associated with DRESS syndrome but because she had no rash or elevated eosinophils, they did not pursue the diagnosis. On April 22, the neurologist started Zoey on a low dose of Lamictal, an anticonvulsant also linked to DRESS syndrome, because of continued episodes of apparent seizure activity. Zoey developed a fever and rash that same day. The medication was discontinued the following day, after three doses. Zoey was transferred to a children's hospital on April 25 so an Infectious Disease physician could further evaluate her case. An extensive infectious, autoimmune, oncologic. and hematologic work-up was completed with no cause of her symptoms identified. The doctors concluded that she had DRESS syndrome either from Trileptal or Lamictal administered at Xi Hospital. She was discharged from the hospital on May 4, 2012 with prescriptions for Clonidine, Benadryl, and ibuprofen. Hospital staff educated the foster family on DRESS syndrome.

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[56] Buck, 2012 and Abonia, 2011
[57] Kress, 2011

Eli

There are questions about the appropriateness of Eli's hospitalization and treatment. Records indicate that the child did not act out in the hospital and the foster mother's reports of acting out in preschool were untrue. The initial reasons for hospitalization are labeled as "increasingly aggressive behaviors," and include such allegations as fire starting, harm to animals, and inappropriately sexualized behaviors. The circumstances surrounding these behaviors were vague in the records. For example, it was reported that Eli "attempted to set the bathroom on fire." However it appears that a candle was already lit in the bathroom, and the child, rather than intentionally starting a fire, and presumably acting out of curiosity, lit paper towels in the flame and attempted to dispose of them in the trash can. In addition, it was reported that the child tried to drown the family cat. More exploration would have found that the child and his sibling were playing with the cat. They tried to put the cat in the toilet to see what would happen when the toilet was flushed.

The report of fire-setting led the hospital psychiatrist to request Tenex to control his "fire setting and aggressive" behaviors. The child had not previously been on any medication. The DCFS guardian did not approve the request, and instead asked for the justification of Tenex over an antipsychotic. As previously mentioned, evidence exists to support the efficacy of antipsychotics in treating aggression (Patel, 2013) so this may be the reason the consulting psychiatrist asked the hospital psychiatrist to consider an antipsychotic. As the case records note, due to the delay of requests and approvals for medication, the child's symptoms improved and medication was no longer considered necessary by the time an approved medication was selected. The consulting psychiatrist indicated that Eli was high risk and requested DCFS Clinical's involvement.

It is unclear what effect Eli's abuse, at such a young age, has had on his behavioral tendencies. It is well understood that children with a history of such stresses as abuse, neglect, or abandonment may present with a variety of symptoms, even when they are no longer exposed to direct threat (Stirling, 2008). Therefore, the child's behaviors must be evaluated and treated in the context of his history of victimization. The child's hospitalization discharge diagnoses of Mood Disorder and PTSD provide further evidence to support this point. These diagnoses do not indicate a disregard for social norms and the rights of others as a diagnosis of Disruptive Behavior Disorder, which includes ODD and Conduct Disorder, would. As such, it's possible the child could have benefited from less intensive forms of therapy and counseling rather than psychiatric hospitalization. He received both therapies during and after his hospitalization, which eventually resulted in successful control of his behaviors, improved performance in school, and absence of any further difficulties.

Hunter

Hunter first entered the DCFS system at less than one month of age and was admitted for his only hospitalization when he was four years old. Throughout his care, he maintained a diagnosis of ADHD and Bipolar Disorder. The case record reports behaviors consistent with an ADHD diagnosis but not necessarily behaviors that support a Bipolar label. Hunter had a reported family history of mental illness: his mother was diagnosed with both Bipolar Disorder and Schizophrenia, and she was prescribed several medications to treat of both conditions. The accuracy of a Bipolar Disorder diagnosis is uncertain given Hunter's young age. The American

Academy of Child & Adolescent Psychiatry released practice parameters for the approach to such conditions in children. Of note, "Preschool children who present with mood and behavioral concerns must be carefully assessed for other contributing factors, including developmental disorders, psychosocial stressors, parent-child relationship conflicts, and temperamental difficulties" (McClellan, 2007). Some of these contributing factors would have played a part in Hunter becoming a DCFS ward. It is unclear to what extent he was evaluated before he was diagnosed with Bipolar Disorder.

SASS evaluated Hunter at least twice before approving him for hospitalization in May 2010. He was deflected from hospitalization both times. SASS was called the first time following episodes of increased aggression, violence to himself and others, and other actions of defiance and apparent loss of control, as listed in his clinical case files. It was determined that Hunter was of no imminent danger to himself or others. At the time of the second SASS evaluation, he was advised to keep a previously scheduled appointment with his psychiatrist, to take place one week later. At the time, his psychiatrist submitted a request for approval of Trileptal, but the consulting psychiatrist denied the request and recommended Lithium, Depakote, or Tegretol (approved to treat adult and pediatric seizure disorder, with off-label use for adult Bipolar Disorder and pediatric migraines). The psychiatrist did not feel comfortable administering these medications on an outpatient basis, and requested that Hunter be admitted. The child was hospitalized and prescribed Depakote.

Hunter remained in the hospital 26 days. It appears that the administration and monitoring of medication was the reason for his hospitalization, but he was placed on a psychiatric unit rather than a medical floor. If the reason for hospitalization was for medication therapy, monitoring the child and his behaviors throughout his initial medication treatment, it seems plausible that Hunter could have been managed in a standard, non-psychiatric, children's hospital setting (Masters, 2014; Case, 2007; Leon, 2007; Glick, 2002). Given the stress of the inpatient setting in general, and the vulnerability of such a young child, the environment of a non-psychiatric setting would be a better choice. Both the child's psychiatric hospitalization records and his clinical records contain information that suggests he may not have required psychiatric hospitalization. The foster parents acknowledge that the behaviors he displayed on multiple visits were either beyond his control, such as wetting himself, or "typical of any four-year-old." His progression after discharge also supports the idea that a psychiatric hospitalization may have been inappropriate.

In October 2011, UCP received another request for approval of Trileptal. The contact query notes phone calls to the prescribing physician explaining that there was more data on the safety and efficacy of Lithium for children of Hunter's age and no data for Trileptal. The prescribing physician reported that they recommended Trileptal because blood draws were very difficult for five-year-old Hunter and the foster parent, and they wanted to go with the least invasive treatment to increase compliance. Hunter had trials of Risperdal and Seroquel in the past. The consultant approved Trileptal upon receipt of that information but cautioned that the child should be evaluated to see if both Abilify and Trileptal are needed or if polypharmacy can be reduced to avoid the long-term side effects. The consultant also advised sodium level monitoring.

Despite inconsistent follow-up and compliance with the child's medication and therapy over the following two years, Hunter's behaviors remained stable and manageable, and his foster parents

completed adoption in March 2012. Prescriptions for Abilify, Trileptal, and a stimulant had been filled within the six months prior to adoption.

Xander

Xander's first hospitalization, in August 2010, lasted 22 days. He was in a hospital in a neighboring state. SASS was first called in February 2010, while he was still in the care of his mother. After coming into care in June 2010, he was placed in a shelter. Shelter staff called SASS for his aggressive behaviors, leading to his first hospitalization. The UCP database contains requests for approval of Risperdal, Clonidine, and Tenex. Prior to his hospitalization, in August 2010, UCP received a request for approval of Clonidine with a diagnosis of ADHD. The consulting psychiatrist asked why the child was only getting Clonidine with a diagnosis of ADHD. According to the UCP database, a doctor who treated Xander before he had become a ward had done multiple trials of stimulants and found paradoxical effects. Clonidine was approved for seven days. Once Xander was hospitalized, the hospital psychiatrist requested approval for Ritalin; the consulting psychiatrist informed the requestor of previous paradoxical response. The hospital psychiatrist also requested Risperdal, noting that though hesitant to request an antipsychotic, it was a matter of safety. Xander had become so aggressive that he pulled out the hair of shelter staff. The psychiatrist felt that poor parenting and poor nutrition played a large role in Xander's presentation and that he could eventually do well with a structured and consistent environment, but needed acute stabilization. The Tenex was added toward the end of Xander's hospitalization, noting that it was a better choice than a stimulant for treating the ADHD because of past response.

Patel et al. (2013) discuss available pharmacologic therapies for treatment of pediatric ADHD with associated aggression. Considering the use of Tenex for treatment of ADHD in children, they note that it has proven useful for reducing hyperactivity, increasing frustration tolerance, and decreasing irritability (Patel, 2013). However, researchers also noted "incidents of sudden death in children who were taking Tenex with a stimulant medication" (Patel, 2013). Patel et al. (2013) also discuss the efficacy of atypical antipsychotics such as Risperdal to treat aggression and find that this class of drugs in fact shows great efficacy, are often prescribed with stimulants in order to treat aggressive behaviors, and have even been shown to reduce disruptive behaviors independent of concurrent stimulant use (Patel, 2013).

Xander was psychiatrically hospitalized four additional times. Records from the hospitalizations, SASS, and UCP contain some discrepancies. During the second hospitalization, after reported combative and aggressive behavior, Xander was given a diagnosis of Conduct Disorder and prescribed Tenex and Trazodone. The medications are documented in the UCP database but the diagnosis listed at that time is not Conduct Disorder; it is ODD. While Disruptive Behavior Disorder NOS can be considered an overall category classification that includes both Conduct Disorder and ODD, Conduct Disorder is a more extreme diagnosis that typically includes the violation of social norms and basic rights of others.

During Xander's third hospitalization, he received prescriptions for Focalin, Zyprexa, and Benadryl, which was eventually discontinued. The SASS case summary did not list his diagnoses at the time, but according to the UCP data, his updated diagnoses included Mood Disorder NOS, and ADHD NOS. Additionally, there is a note in the UCP database at the beginning of the

hospitalization that medications he was previously taking, Abilify and Tenex, would be discontinued once he began taking Zyprexa. It was also noted that Zyprexa is associated with an adverse effect of metabolic syndrome, and therefore markers of such side effects should be monitored closely.

On the same day that Xander was discharged from his third hospitalization, he was readmitted after reportedly expressing suicidal ideations and displaying aggressive and violent behaviors. Case summaries report that he was placed on Zyprexa and Tenex again during this fourth hospital stay. The UCP database noted the consulting psychiatrist's request for further information. A brief nurse's note indicated the use of Tenex for ADHD symptoms and the explanation that Zyprexa was placed on hold at the time of admission, with a plan to resume use at bedtime.

The child's next hospitalization began only two days after his fourth discharge. He reportedly displayed violent behaviors both at school and at home, "threatening to kill his brother and stab him with a toy." Additionally, the child was noted to be eating non-food items such as chalk, shaving cream, and crayons. The child was reported to be "high strung" by the evaluating SASS case manager, but he was able to calm himself enough to go outside and ride his bike during the visit. By the time Emergency Medical Services (EMS) arrived at the foster home to retrieve the child, he was asleep in bed and had to be awakened for transport. The UCP data regarding this hospitalization indicates it was reported that the child's general behavior during this time was violent, aggressive, agitated, and accompanied by mood swings. Diagnoses included ADHD, Conduct Disorder, and Mood Disorder. There is mention of ineffective responses to both Abilify and Zyprexa and the subsequent discontinuation of both medications. The consulting psychiatrist notes the need for behavior modification treatment. There is a request for a new prescription for Risperdal, which was approved with instructions to monitor markers and any changes indicative of metabolic syndrome. The Risperdal was discontinued during the hospitalization and he was discharged on no medication. A request for Tenex was received the day after discharge and was subsequently approved.

While there is only one incident of reported consumption of non-food items, it could indicate an underlying disorder with possible neurologic, psychiatric, and behavioral effects, such as pica. Results of basic blood work and lab tests from this hospitalization are all within normal limits, effectively ruling out any such condition, but there is no mention of specific intention to investigate the possibility. There also appears to be a distinct difference between the child's reported behaviors at home and in the hospital, raising questions about the thoroughness of evaluation that resulted in Xander's hospitalization. It seems plausible that a child who is calm enough to be sleeping or safely riding a bicycle might not be in an unstable emotional state requiring immediate hospitalization.

There was a supplementary note from Xander's treating psychiatrist in the case summary that states, "efforts were made to adjust medications (i.e. titrate Zyprexa, discontinue Tenex and start Ritalin and Clonidine); however, as usual with patients that are in the custody of the State of Illinois consent to change medications was denied and recommendations to increase Zyprexa was received instead. This is not the appropriate treatment for this patient at this time per my opinion therefore arrangements were made for patient to be discharged back to his custodians

(the state of Illinois) with instructions for them to seek treatment as they see fit." The psychiatrist did not include further explanation regarding why they felt such treatment was inappropriate.

Greta

Greta entered the DCFS system at 44 months of age. Similar to other children included in this investigation, she was brought up in a chaotic environment early in life. In addition to a family with history of mental illness, she is at an increased risk of developing psychiatric issues herself; Greta's mother has past diagnoses including Bipolar Affective Disorder and Depression, has been involved in episodes of domestic violence, and has an extensive history of substance use consisting of marijuana[58], LSD, cocaine, prescription pain pills, and meth. Greta was diagnosed with ADHD upon her entry into care. Reported behaviors included hour-long tantrums that required restraint to prevent her from hurting herself, aggression towards foster family and peers at preschool, hurting the family pet, and self-injury.

In December 2009, a few months prior to the child's first hospitalization, a request was submitted by the Theta Community Mental Health Provider facilities for both Ritalin and Risperdal. The DCFS consulting psychiatrist denied the request for Risperdal and recommended Ritalin with an evaluation of the effects before considering an antipsychotic medication. In March 2010, Theta Community Mental Health Provider submitted a second request for Risperdal, noting that they were considering discontinuation of Ritalin. The request was approved. The consulting psychiatrist additionally made strong recommendations for parent education of the foster parents. Six months later, the child's psychiatrist sought approval for Concerta, an extended release formulation of the stimulant used in Ritalin, as well as a renewal of Risperdal. Both requests were approved by the consulting psychiatrist. At the time the request was submitted, it was noted that the child had already begun taking Concerta. The child was back in her mother's care, though the Department retained guardianship, and the facility mistakenly believed the mother could consent to the medication. The caseworker informed the facility that consent from the DCFS Guardian was still needed.

Greta's clinical case summary indicates that she received several additional medications throughout her six hospitalizations in approximately three years. Her diagnoses included ADHD, Mood Disorder, ODD, RAD, and Bipolar Disorder. The prescribed medications are appropriate for the respective diagnoses; for example Ritalin for ADHD, Risperdal for Mood Disorder, and Lithium for Bipolar Disorder. Greta began her fourth hospitalization in September 2010. Reasons for admission included severe hyperactivity, impulsive behavior, and increased aggression, resulting in diagnoses of ADHD and ODD at the time of discharge. The only prescription listed for her care at that time was Tenex. Tenex could be justifiably used for both disorders, but is typically more effective for combined therapy in the extended release form, Intuniv (Findling, 2014). Greta eventually responded well to structure and non-medication treatment. Despite the appropriateness of the medications for her diagnoses, they did not remedy the chaos of Greta's early life.

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[58] Mother reported use of marijuana as self-medicating for her depression.

Brooke

Brooke entered the DCFS system at 55 months old and was first hospitalized within four months. She was admitted with a diagnosis of Impulse Control Disorder after displaying defiant and aggressive behaviors in her foster home, aggressive and homicidal gestures towards her siblings, and alleged hallucinations in which someone named Tiny "took over her body." Diagnoses throughout her care included ADHD, ODD, Impulse Control Disorder, and RAD.

In addition to her psychiatric diagnoses, she was also born with a congenital condition known as Leopard Syndrome. This is a genetic disorder that can cause a number of defects in childhood, including "Lentigines, ECG conduction abnormalities, ocular hypertelorism, pulmonic stenosis, abnormal genitalia, retardation of growth, and sensorineural deafness (Tartaglia, 2011)." It is unclear which manifestations Brooke experienced, but the disorder provided an additional level of difficulty to finding appropriate medications to treat her psychiatric conditions. Stimulant medications, which would typically be first-line therapy for a number of the aforementioned conditions, must be avoided for children with Leopard Syndrome due to cardiac vulnerability. This is noted in the UCP database, as the consulting psychiatrist assured cardiology clearance and discussed the use of an extended release anti-adrenergic with titrating for safety.

Further examination into Brooke's case reveals that many of her difficulties can be connected to the stressful situations her caretakers created. Brooke's biological mother exposed her and her siblings to a number of abusive and neglectful situations, affecting Brooke's behavioral and social interactions. She was removed from the home at four years old following several investigations into the mother's care for failed compliance with therapy services, possession and use of meth, and court mandated reengagement into personal therapy services. Brooke and other siblings also reported episodes of sexual abuse by their mother, including inappropriate touching and accompanying the mother to hotel rooms and witnessing her engaging in sexual activity.

As early as June 2011, after Brooke had been placed into foster care, a clinician evaluating her for reported incidents of inappropriate language, sexualized behaviors, and recurrent suicidal and homicidal statements noted that "the child's hyper-vigilance is related to chaotic environment with her biological mother." She was diagnosed with Adjustment Disorder with Mixed Disturbance of Emotions and Conduct and referred for weekly sessions of both individual and family counseling. Brooke was hospitalized within a month of that evaluation.

Brooke's relative foster home placement was problematic as well. Her initial hospitalization began after the foster mother reported violent behaviors and homicidal ideations toward Brooke's younger sister. The evaluating SASS clinician reported hearing Brooke's desire for her sister to be dead, as well as the report of "hallucinations" of someone named Tiny "taking over her body." One month after returning to her relative foster home, her older brother was also psychiatrically hospitalized. The foster mother reported that after beginning kindergarten in the fall of 2011, Brooke continued to have behavior difficulties at school, but the school did not corroborate these reports. Additionally, the escalation of the child's behaviors which resulted in her second hospitalization arose when the foster mother ran out of Brooke's medication and did not maintain the treatment regimen. During the hospitalization, staff determined the foster home could not provide the necessary support Brooke required. Despite her reported homicidal ideations and "hallucinations" about Tiny, the only official diagnoses she received following

each of the hospitalizations were Impulse Control Disorder, ODD, and ADHD. Once Brooke was placed in a stable environment, three placements later, received consistent therapy services, transitioned to a new school, enrolled in new extracurricular activities including swimming and tumbling, and steps were taken to terminate her biological mother's visitation and parental rights, Brooke did very well and only required a single medication for the duration of her treatment.

Liam

Liam entered the DCFS system at 55 months of age, and his first hospitalization occurred within three months. His biological mother had a total of 12 children, and seven separate DCP investigations were opened over the span of just one calendar year before Liam was placed in foster care in December 2011. Given the large size of Liam's household, he was at risk of exposure to a chaotic environment. The investigations uncovered evidence of the children living in squalor, physical and sexual abuse within the family, and family history of mental illness.

At the time of Liam's initial hospitalization, he had already been recommended for trauma-focused therapy. According to the UCP database, during the first week of hospitalization in March 2012, Liam had been referred for trauma-focused therapy but it had not yet begun. The therapy services did not begin until five months after his discharge.

The child's reported behavioral symptoms before hospitalization included "aggressive behaviors toward siblings and foster mother, suicidal threats, attempt to jump out of a moving vehicle, and auditory hallucinations." According to hospital records, Liam described the auditory hallucinations as "a devil sits on my shoulder and tells me things in my ear." The description of a devil sitting on his shoulder shares a resemblance with an image commonly seen in cartoon shows in which an angel and a devil sit on opposite shoulders and try to influence the character's actions. While it is unclear how much this "hallucination" affected Liam's diagnosis and treatment plan, the fact that it is mentioned and labeled a hallucination appears to indicate that it was given some level of consideration as a true representation of a psychiatric issue. However, neither the clinical case files nor the UCP database list auditory hallucinations as a symptom requiring treatment.

Liam was hospitalized for 52 days. He was initially prescribed Ritalin but it was switched to Tenex when he reacted to the stimulant with increased aggression. He was given emergency doses of Thorazine for rage and aggression twice while in the hospital.[59] Liam eventually began participating in treatment. He remained on the one medication, Tenex, and was successfully maintained on Tenex alone throughout his wardship.

Medication Mismanagement

As numerous questions remain unanswered regarding the effects of psychotropic medication on children, the use of these medications requires strict monitoring and adherence to prescription instructions and guidelines. Most psychotropic medications function by influencing the activity of neurotransmitter pathways. By either blocking or promoting the production of specific neurotransmitters, behaviors correlated to the affected neurotransmitter can be amplified or

[59] Psychiatrically hospitalized DCFS wards are not allowed to have standing PRN (as needed) medication prescriptions. Instead hospital staff is expected to notify the DCFS Guardian of use of emergency medication.

decreased. Since some level of "memory" exists, in that these pathways adapt to the restriction or amplification and proceed to function at the modified level, any further changes must be made gradually so as not to cause any sudden disruption and subsequent behavioral issues.

OIG Investigators found instances of the caretakers involved mismanaging the children's medications. Several episodes occurred in which the adult in charge of dispensing a child's medication missed a dose, did not refill a prescription, provided additional doses, or decided that the child no longer needed the prescribed medication and stopped administration altogether. Available evidence describes the adverse effects of medication mismanagement in adults (Zipusky, 2014; Cerovecki, 2013; Moncrieff, 2013; Kisicki, 2007; Spencer, 2007). It can be inferred that similar effects should be considered when using similar medications on children. Three children specifically demonstrated the shortcomings of medication mismanagement.

As previously noted in the analysis of Jason's case, an episode occurred in which his grandmother called SASS complaining about his behavior, but indicated she provided him with an extra dose of his clonidine, which relieved his symptoms before they could arrive to evaluate him. While the extra dose of medication may in fact have relieved the child's behavioral difficulties, it should not be dispensed on an "as needed" basis.

Clonidine is a centrally-acting, alpha-2 adrenergic agonist medication originally approved for the treatment of hypertension (elevated blood pressure). It is also approved for treatment of ADHD and Tourette syndrome in children, though the mechanism of action is unknown. Dosing instructions for this medication are specific and based on the patient's weight, in order to avoid adverse effects from overdosing. Considering the mechanism of action involved, and its direct correlation to cardiac activity, it is no surprise that the serious adverse reactions associated with clonidine use include cardiac related issues, such as severe hypotension (abnormally low blood pressure), syncope (passing out), bradycardia (lower than normal heart rate), AV block (cardiac conduction difficulty), and even death (Spiller, 2013). Not only are there dangers in overdosing on this medication, but abrupt cessation of Clonidine can also cause severe side effects, including various withdrawal symptoms and rebounding of hypertension symptoms to a greater severity than what was initially being treated.

Given the dangers of both overdose and withdrawal, Clonidine use should be monitored carefully, especially in children. Fortunately, Jason did not experience any dangerous effects from the additional dose he was given. If his behaviors were out of control, and any additional medication was necessary, that decision would have been more appropriate for a medical professional with the ability and knowledge to monitor and treat adverse effects.

Aiden received pharmacologic therapy that included such medications as Ritalin, Tenex, Intuniv ER, Adderall, Clonidine, and Risperdal, all with extensive possible adverse effects. More specifically, with the exception of Ritalin, all of these medications can have significant withdrawal symptoms. However, as noted in his clinical case files, in the fall of 2013, Aiden's foster parents did not follow his prescribed medication regimen and the child went four weeks without any medications. This abrupt discontinuation of medications put the child at great risk for severe withdrawal symptoms, most commonly presenting as a worsening of the initial symptoms being treated (Calarge, 2014; Faraone, 2013; Fein, 2013; Fitzgerald, 2013; Ruggiero, 2012; Rabin, 2010; Cox, 2008; McGough, 2006).

Perry is the third child who experienced abrupt discontinuations of his medication regimens. Perry's foster mother "ran out" of his medications after his first hospital discharge and he was required to undergo additional lab tests before his prescriptions could be safely renewed.

These three examples display the need for more oversight and instruction on proper medication usage for the caretakers involved with this special group of foster children. Foster parents should be offered support and education that emphasizes the importance of consistent monitoring, proper dosing, and dangerous effects of the medications. Since various medications used in psychotropic therapy can be dangerous if used incorrectly, it is of paramount importance that the caretakers involved in these children's well-being are made aware of the importance of these medications' proper use. Medical professionals involved in a child's care should be the only ones to make any changes to a child's medication regimen, including medication discontinuation.

Polypharmacy Risks

Use of psychotropic medication has steadily increased over the past 10 years (Olfson, 2002). Treatment options are in a constant state of flux caused by changing drug formulations, dosing practices, and costs. While this can result in increased regulation and monitoring, that is not always the case (Olfson, 2002). *Polypharmacy* describes variations of drug treatment regimens. It often encompasses such terminology as *copharmacy* (the pharmacologic treatment of different disorders with two or more medications), *combined pharmacotherapy* (the use of more than one medication to treat one disorder), and *concomitant pharmacotherapy* (the use of two or more medications for either the same or different psychiatric symptoms or disorders) (Zonfrillo, 2005). Along with overall increases in medication usage, polypharmacy has also shown a consistent rise (Comer, 2010; Zonfrillo, 2005; Vitiello, 2004; Zito, 2003; Safer, 2003). This raises concerns about multiple medication regimens, including appropriateness of indications, monitoring of safety profiles and adverse effects, follow-up care, discontinuation of certain medications, off-label uses of medications and combinations, and long-term effects of treatment regimens.

An initial examination of the list of medications these 32 children had been prescribed revealed a variation among quantity of prescriptions, drug classes used, and symptoms and diagnoses warranting the prescriptions. These children received one to four medications at once, not including instances of "as needed" administration (Pro re nata, PRN) or emergency dosing of additional drugs. The number of prescribed medications is a concern. Studies show that in several cases of psychiatric therapy, the risks of drug interactions and general dangers of polypharmacy outweigh the benefits of such combinations (Vitiello, 2009). While this is a general statement on treatment, it reveals a need to review the necessity of certain treatment options. There should be a discussion of the considerations resulting in the treatment plan. Without question, there are cases in which multidrug regimens are appropriate and necessary. Some of the cases in this investigation may in fact fit into that category, but the decision should consider the child's environment and development as well.

Examination of these cases revealed limited discussion of taking caution to decrease adverse effects from the involved medications. A basic examination of the various drug combinations prescribed to several of the patients in this investigation did not reveal any absolute contraindications or life-threatening adverse effects (epocrates.com). There are also no strict guidelines prohibiting any of the combinations prescribed to the children in this report. However,

cautionary warnings do exist for numerous combinations, advising either consideration of other medication options or monitoring for specific adverse effects. The consulting psychiatrists occasionally raised questions. Xander's case is the only one in this investigation in which a clear warning was presented regarding the "massive obesity" he developed, possibly because of his antipsychotic prescriptions. It is difficult to determine whether the development of an adverse effect is the result of a polypharmacy phenomenon or simply the direct result of a specific medication, which highlights the need for screening and review practices to facilitate monitoring. Several studies speak to prescribers' tendencies toward numerous multidrug regimens and the commonplace lack of monitoring that goes along with them. While the amount of psychotropic medications being prescribed to children is increasing, the screening and evaluation processes have not displayed a parallel growth trend (Vitiello, 2009).

When several different clinicians are involved in these children's care, variations in management protocols can happen. While this is expected, such variations should remain within standard of care, or at least within clinically justifiable constraints. The majority of the cases here display some level of treatment strategies based on reports of behavior from a single source, often a stressed foster parent. It is not the intention of this investigation to criticize any medical treatment strategies or to condemn the efforts of any clinicians involved in the care of these young children. The intention is to note the benefits of an additional level of consideration for environment and development, treatment monitoring for this age group, and the unique circumstances of their hospitalizations as wards of the State of Illinois.

Appropriate monitoring throughout the treatment plan often makes follow-up care easier to facilitate. Given the risks of psychotropic medication regimens, monitoring is even more important. After review of these 32 case files, investigators found at least two instances of eventual medication discontinuation without the necessity to resume treatment. It is possible that the children who displayed a resolution of symptoms following discontinuation of their medication were successfully treated with the drug regimen. On the other hand, these cases do cause one to consider whether or not the drug regimens were required in the first place.

Zito et al. (2008) found that over 40% of the time, children in foster care settings undergoing psychiatric treatment received at least three medications at once. In a separate study, they described a trend of increased use of multiple psychiatric drug classes among Medicaid-insured children aged two to four years old (Zito, 2007). While no direct causal relationship has been displayed indicating that children who are in the foster care system or who have Medicaid coverage are automatically predetermined to receive an increased or excessive number of prescriptions, the trend is undeniable (Burcu, 2014; Kreider, 2014; Matone, 2012; Constantine, 2010; Essock, 2009; Zito, 2007; Martin, 2003; Patel, 2002). Similarly, while these studies do not indicate a lower standard of care, they are indicative that an extra level of consideration is required for this population. By maintaining consistent, thorough documentation of treatment activity and established justification for strategies outside the typical standard of care, it will be possible to avoid future speculation of appropriate care for such a unique patient population.

Thorough documentation and appropriate justification of treatment strategies is a theme that continues throughout the discussion of the three cohorts. Within the area of pediatric psychiatric therapy, in which there exists a paucity of medication studies for the age group, off-label prescription therapies are fairly common (Jureidini, 2013; Penfold, 2013; Naylor, 2007).

Documentation and proper monitoring are paramount, even when dosing guidelines do exist for medications that are commonly used, but not initially intended, for psychiatric therapy. For example, Clonidine is a central acting alpha agonist, originally approved to treat hypertension. Since 1985, its use has expanded to treatment of ADHD and Tourette syndrome, and its long-acting formulation has recently received Food and Drug Administration (FDA) approval for those uses (Nguyen, 2014). Pediatric dosing guidelines exist for Clonidine's additional indications, but anecdotal evidence reveals its increasing use as a sleep aid for children (Nguyen, 2014). Within our investigation, Clonidine was used for both ADHD and sleep assistance therapy. In both uses, better documentation and justification for use of that medication specifically would allow improved monitoring and assessment. Furthermore, Clonidine is simply one drug on a long list of medications worthy of further review. A number of antipsychotic medications were used in several cases for off-label therapies without any specific FDA-approved pediatric dosing regimens. This supports the need for standardized protocols of documentation and review of treatment strategies for this population.

The long-term effects of psychotropic medication regimens are another important consideration. The naïve stages of brain and neurologic development in this age group cause concern about what effect pharmacologic therapy will have. Most of the medications under consideration generate therapeutic effects via influence on neurotransmitter production and release. Studies have not yet determined whether modification of neurotransmitter activity in the developing brain results in future changes. Zonfrillo et al. (2005) conducted a review of studies on long-term psychotropic medication effects in children, and found that research was scarce. Such research is inherently difficult due to an inability to develop necessary study parameters. Researchers would first need to find adults with a history of psychiatric treatment as children and conduct a retrospective review of the patients' medical records to include analysis of medication and therapy regimens, adverse effects, and additional confounding factors. Changes in medication formulations and development of newer medications further complicate matters, as current treatment regimens do not necessarily mirror those from even a decade ago. If a long-term study were conducted to investigate the effects of various types of psychotropic medications on young children, 10 to 20 years of monitoring would be necessary to generate definitive results. Ultimately, this serves to reiterate the wealth of unknowns that still exist regarding the treatment strategies under consideration and the efforts that would be necessary to answer those unknowns.

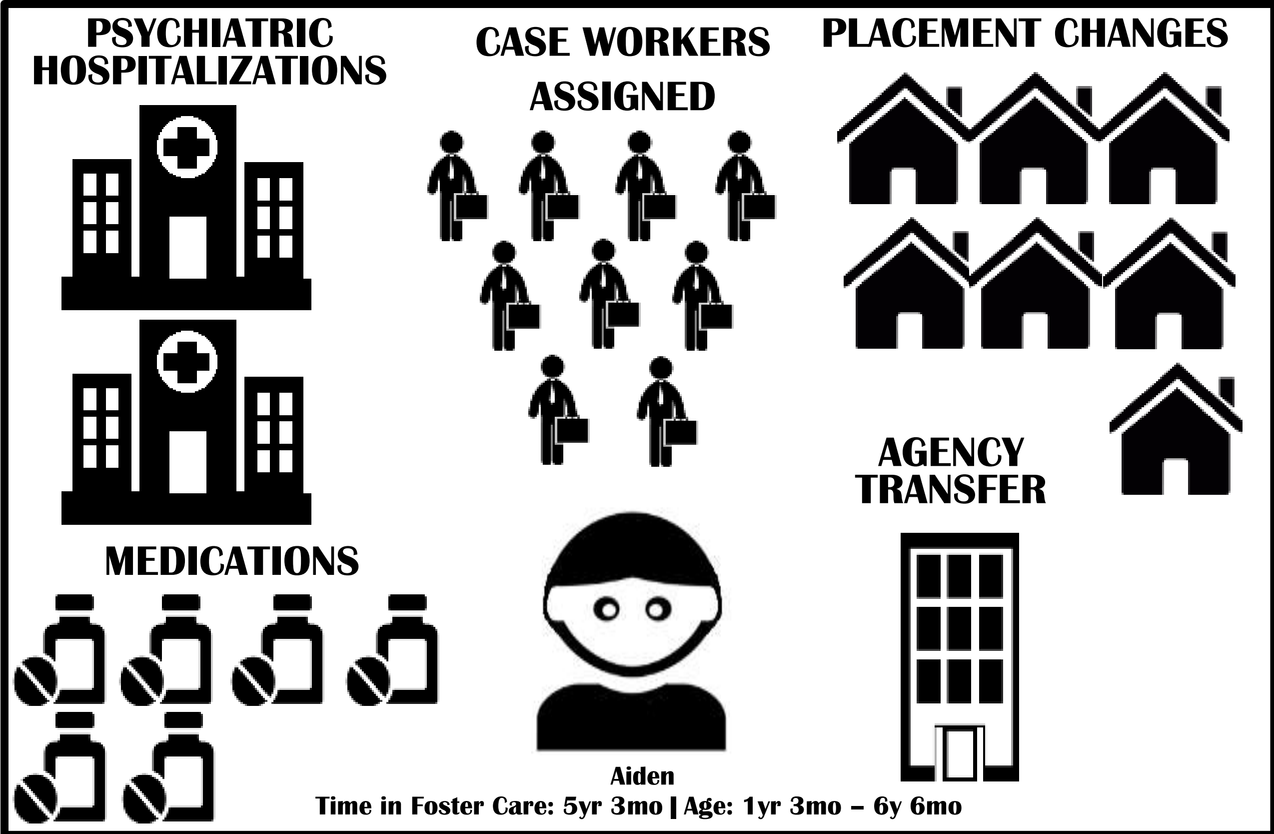
The examination into this specific population raises questions about the appropriateness of psychotropic treatment for children. A clear protocol of review and justification should be followed in to ensure proper care, especially in cases involving polypharmacy. While multidrug regimens are sometimes warranted, clear documentation of the prescriber's thought processes and reasoning that resulted in the chosen treatment plan should be demonstrated for each and every case. The majority of the cases included in this investigation display a severe lack of such discussion and therefore raise concern about the suitability of the given drug regimens. Another shortcoming in these children's care is the lack of discussion and monitoring of adverse effects. Without proper discussion and notation of consideration of adverse effects, it is impossible know that clinicians monitored possible developments accordingly. Without clear documentation, it becomes difficult to determine the definitive source of said events if adverse effects do develop in the setting of multidrug treatments. Our investigation of these 32 cases also sheds light on the lack of research of long-term psychotropic medication treatment for children. While both FDA-approved and anecdotally based treatment regimens may serve as effective therapies for the

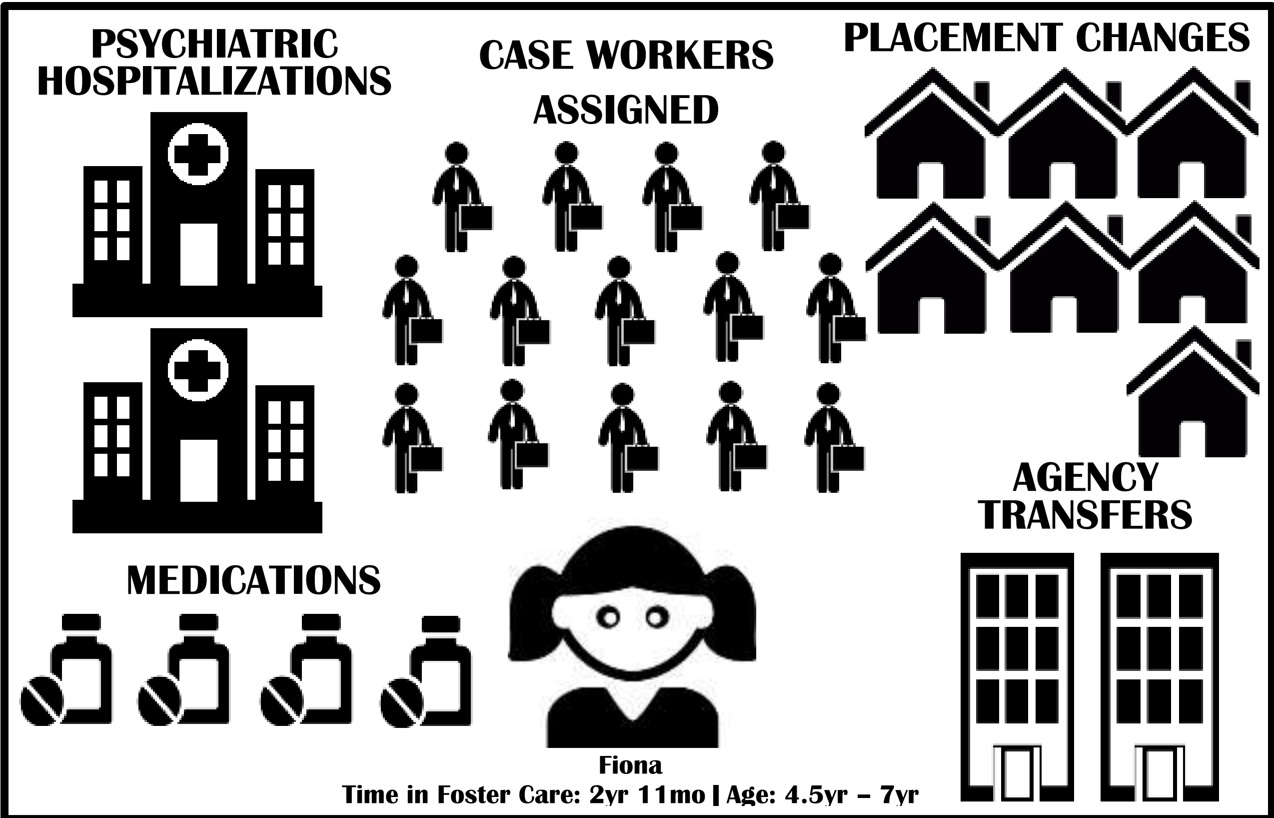
various conditions encountered, it remains a risky undertaking when the influence of pharmacologic intervention on future neurologic development is unknown.

TRANSITIONS

Rubin et al. (2004) found that children who experienced more placement changes also experienced more hospital visits; that 75% of the hospital visits occurring within three weeks of a placement change occurred after, rather than before, the change. This suggests a temporal relationship in which placement change precedes, and may contribute to, attachment distress and increased aggressive behavior, which will likely result in hospitalization.

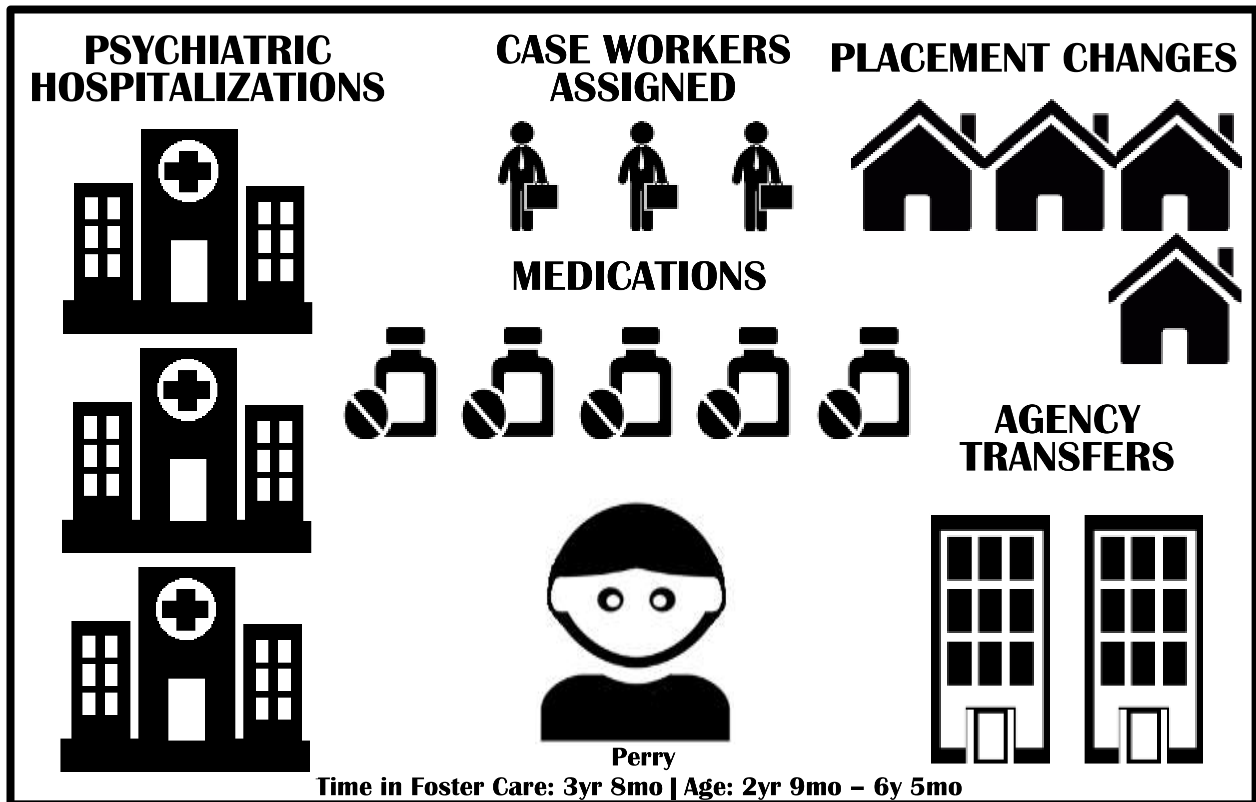
In this investigation, 25 of the 32 children (78%) had at least one placement transition. Two children experienced seven placement transitions each, the most in this investigation. One of these children, Aiden from *Cohort One*, experienced four failed placements (both traditional and relative) before a failed return home and an eventual return to foster care. The child had been removed from his third placement after the foster mother was indicated for abuse. Within three weeks of his return to foster care, Aiden was hospitalized for the first time. The other child with seven placement transitions, Fiona from *Cohort Three*, had also experienced failed traditional and relative placements. Fiona's second hospitalization occurred within a month of placement in her fourth foster home within a 17-month period. (See graphics on next page for transitions of Aiden and Fiona).


PSYCHIATRIC HOSPITALIZATIONS
CASE WORKERS ASSIGNED
PLACEMENT CHANGES
AGENCY TRANSFER
MEDICATIONS
Aiden
Time in Foster Care: 5yr 3mo | Age: 1yr 3mo – 6y 6mo


PSYCHIATRIC HOSPITALIZATIONS
CASE WORKERS ASSIGNED
PLACEMENT CHANGES
AGENCY TRANSFERS
MEDICATIONS
Fiona
Time in Foster Care: 2yr 11mo | Age: 4.5yr – 7yr

Placement Transitions Related to Child Abuse and Neglect

Eleven of the 25 children (44%) who experienced placement disruptions were moved due to allegations of abuse and neglect in their foster home. The foster care agency removed four-year-old Perry (*Cohort Two)* and his two-year-old sister after the foster parents reported being unable to handle Perry's escalating behaviors. During an afternoon home visit, the case manager determined that the foster mother had been drinking alcohol and initiated a licensing investigation. The licensing worker substantiated licensing violations and allowed the foster parents to close and surrender their license. The children were placed in a second home and remained there for two months before the foster parents requested their removal citing Perry's continued behavior problems. In January 2013, the children were placed in a third foster home where Perry and his sister disclosed physical and sexual abuse in their original foster home. The former foster parents denied the allegations and the Department indicated an unknown perpetrator for sexual abuse of Perry's sister. Four months later, the Department initiated a second investigation against the same foster parents after Perry reported his former foster father knocked him down and rubbed his penis. The former foster father denied the allegations. The DCP investigator unfounded the investigation noting Perry did not disclose reliable information that rose to the level of abuse. Perry had a third hospitalization nine months after removal from his original foster home, after he made statements that he wanted to kill his former foster parents with a knife and wanted to cut off their faces. Throughout his hospitalization, Perry made statements about wanting to kill his former foster parents. a specialized placement could not be located When Perry was ready for discharge, so he remained in the shelter for 75 days until a new specialized placement, his fourth placement, was identified.



CRITICAL ANCILLARY SERVICES

Although admission to a psychiatric inpatient unit may be necessary to manage risks when communities do not have viable alternatives, Marsenich (2002) found no evidence supporting the view that hospitalization led to long-term, positive outcomes relative to other care options. We need to increase intensity or quality of services and placements in the community to bridge the gap. This includes nurturing greater collaboration between hospitals, foster parents, child welfare staff, and community mental health providers before, during, and after hospitalization to assure that we provide foster children with the best community care in a timely fashion.

Occupational Therapy and Sensory Integration Services

Traumatic experiences in early childhood can lead to disruptions in neurological development. For instance, children begin learning self-regulation as early as the first year of life so the "consistency and predictability of the caregivers" heavily influence a child's successes in self-regulation (Duncan P., Hagan J., Shaw J., 2008, p. 46). Occupational Therapy theories also posit that, "infants may demonstrate social-emotional disorders because cognitive (understanding of social interaction) or psychological functions are limited or because environmental constraints (e.g., maternal depression or child abuse) limit development" (Case-Smith, 2013, p. 395). Therapies and supports that target these skill deficit areas can improve children's social and behavioral outcomes.

What is often lacking from traditional therapy and educational supports, however, is intervention targeted for sensory disorders that arise from early sensory deprivation and stress. Many children who have experienced severe childhood trauma or neglect have recognized developmental and learning disabilities. Baranek (2002) argues that in addition to these difficulties, it is likely that these children also suffer from Sensory Modulation Disorders (SMD) because the "rate of comorbid SMD," for this population, "is estimated to be from 40% to 80%" (as cited by Miller L., Coll J., Schoen S., 2007, p. 229). According to Dunn (2007), children or adults with, or at risk for, mental illness may, "respond to sensory input in more intense ways, resulting in performance challenges" including behaviors like tantrums, withdrawal or aggression (as cited in Arbesman, M., Bazyk, S., 2013, p. 130). Occupational therapists have unique knowledge and intervention techniques that can target sensory processing disorders that affect social, emotional, and physical function (Arbesman, M., Bazyk, S., 2013, p. 130). Early intervention should therefore include Occupational Therapy services for youth at risk of developing problematic behaviors in order to treat difficult behaviors and prevent placement disruptions.

Research has demonstrated that Occupational early intervention services for infants and families can improve cognitive and motor outcomes in addition to "social relationships, reasoning, problem solving, feeding, dressing and other self-care" (Case-Smith, 2013, p. 380). Unique, touch-based interventions reduce behavioral difficulties, increase on-task behavior, and decrease aggressive behavior in young children (Case-Smith, 2013, p. 397). These interventions can include parents in order to increase the mother's and father's ability to provide necessary social and emotional support for the child and to reinforce the new skills the child is learning (Case-Smith, 2013, p. 401). In addition to touch-based interventions, sensory programs also aim to assist the child in all environments including the school. Creating a structured, predicable routine that involves, "sensory strategies to regulate his or her arousal level and behavioral responses to

sensation throughout the day" can alleviate disruptive behavior patterns and promote appropriate behavior (Davies, P., Koenig, K. P., Schaaf, R., Watling, R., 2011, p. 36).

Twelve children (36%) were noted to have difficulties with sensory integration and/or received occupational services. The majority of the children received occupational services as part of their individualized education plan through the local school district. One autistic child and one child with a pervasive developmental disorder received occupational therapies outside the classroom. Three children had recommendations for services or evaluations, but never received occupational services. Four-year-old Greta received a recommendation for an occupational and sensory evaluation to address her inattention, impulsivity, and sensory issues; the case record contains no indication she received the evaluation. Greta did receive special education services because of her behaviors. Casey received a recommendation for occupational therapy but services had not begun at the time of his hospitalization. He attended a pre-kindergarten program after his discharge and no longer required occupational services. Fiona received an evaluation where the psychologist noted that her emotional dysregulation was more likely related to her diagnosis of Fetal Alcohol Syndrome and sensory integration difficulties than her diagnosis of Bi-Polar Disorder. The psychologist's recommendations included occupational therapy. Review of Fiona's case record revealed that her special education services included occupational therapy and that she wore a weighted vest in the classroom to assist with attention. There was no indication that she received any occupational services outside of school or that a referral was made for supplemental occupational therapy.

System of Care Services

Children placed in either traditional of relative foster homes are eligible for SOC services if they are at risk of placement disruption.[60] If a child receives specialized foster care, the DCFS SOC Administrator can approve services if there is the risk of placement disruption. SOC services provide short-term intervention and supports to children and their caregivers when the child is experiencing emotional and behavioral problems.

Of the 32 children, 27 (84%) experienced at least one placement disruption, but only 15 of the 32 children (47%) ever received SOC services to assist with stabilization of their foster care placement. Seven of the 15 children who received SOC services remained stable in their foster placement and achieved permanency, including one child who returned home.

Four-year-old Bryce returned to his relative foster home after hospitalization. He had been living with the same relative for seven months before his hospitalization. The agency referred Bryce for SOC services within one month of discharge. He met with the SOC worker on a weekly basis to address anger control and promotion of social and peer interactions. The SOC case closed in August 2010 after the foster parent reported an improvement in his behavior. Bryce's biological father died in March 2011 after an accidental overdose. His mother relapsed at the time and never re-engaged in services. The foster parent reported an increase in Bryce's aggression and fights with his peers following his father's death. The agency referred Bryce to SOC services that included providing the foster parents with support and education regarding trauma and its effects

[60] DCFS Procedures 301.66.

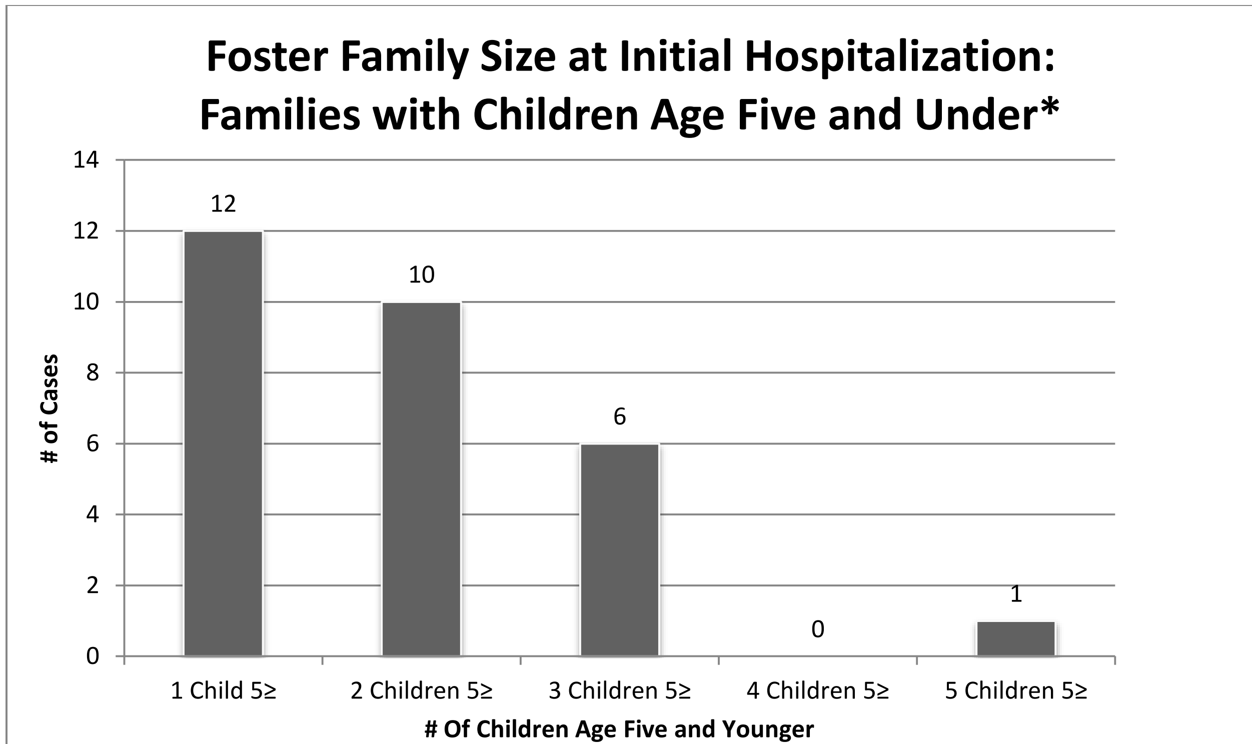
on children. Bryce had weekly SOC services for five months. Bryce remained with his relatives, who obtained subsidized guardianship.

Jason, who was placed in relative foster care with his grandparents, received weekly SOC services prior to his hospitalization to assist his grandparents with Jason's behaviors. His SOC therapist worked with his individual therapist and developed a behavior modification plan for the grandparents to use in the foster home. After his discharge and return to his grandparents' home, Jason continued to have behavior problems and the agency referred him for SOC services again. His SOC therapist consulted with an ABA therapist who provided recommendations that included a music player with headphones and visual charts. The SOC therapist also followed up with TAP, which designed a play schedule. The SOC therapist also purchased a membership to the community recreation center that included an indoor swimming pool that Jason enjoyed.

Respite

The Department and Private Agencies are responsible for providing respite services to foster families as prescribed in DCFS Rules and Procedures. Review of the case records revealed that only 11 of the 32 children (34%) received respite services at some point during their foster care placement. Fifteen of the 32 children were placed in a foster care home with at least one other child under the age of five prior to their initial hospitalization. There was an overwhelming failure to recognize the need to provide a resource for childcare to foster parents, who often cared for children with challenging externalizing behaviors.

Review of the case records revealed that foster care agencies denied one foster family respite (Maya) or never followed through with recommendations for respite. Maya's foster mother requested respite services from the Omega Foster Care Agency but the agency denied her request. At the time of the foster mother's request, the agency had placed four foster children in the home in addition to the couple's two children. Five of the six children were under the age of five and the foster father worked full-time, often long hours. SASS deflected Brooke prior to her hospitalization after the foster mother reported she made statements about wanting to die and that she and her older siblings had been sexually acting out. The SASS therapist planned to provide weekly services in the foster home and recommended that the agency provide respite services. There was no record that the foster parent ever received respite. Six weeks later, Brooke was approved for her first hospitalization. While she would return to her relative placement, she would go on to a have a second hospitalization related to her behaviors in the foster home. Brooke did not return to the foster home after her second hospitalization. In the spring of 2013, after Sean's fourth hospitalization, the Rho Foster Care Agency case manager noted concern about the traditional foster parent's stress level and planned to explore the possibility of respite care. However, the record did not contain any information that the agency ever secured respite services for the foster parent.



* Five children were not included in this calculation: three were in a shelter before hospitalization and did not have a foster family; two belonged to foster families with other children but the number of children and their ages could not be confirmed.

Extracurricular Activities

Community-based activities provide children with opportunities for the development of social skills and learning. Involvement in such activities can also provide children with access to caring adults, skill-building activities, and positive peer interactions. The DCFS Clinical conveners who conducted staffing for all the children after their hospitalization included multiple recommendations to case managers to enroll the children in extracurricular activities. Eleven children had recommendations for a referral to extracurricular activities as part of the clinical staffing. DCFS clinical conveners noted that extracurricular activities would assist the children with structure, self-esteem, and social skills and would also provide academic and behavioral support. However, only three (27%) of the recommended 11 children had documentation of enrollment in an extracurricular activity in their case record. Five additional children participated in extra-curricular activities while in foster care, totaling eight of the 32 children. The eight children participated in activities such as gymnastics, ballet, soccer, and summer camps. One child's SOC therapist purchased the foster family a membership to the community recreation center that included an indoor swimming pool.

BIBLIOGRAPHY

1. Practice parameter on the use of psychotropic medication in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry. 2009; 48(9):961-73.

2. National Institute of Mental Health Multimodal Treatment Study of ADHD follow-up: changes in effectiveness and growth after the end of treatment. Pediatrics. 2004; 113(4):762-9.

3. Abonia JP, Castells M. Drug allergy in pediatric patients. Pediatr Ann. 2011 Apr;40(4):200-4. doi: 10.3928/00904481-20110316-07.

4. Aman MG, Bukstein OG, Gadow KD, Arnold LE, Molina BS, McNamara NK, Rundberg-Rivera EV, Li X, Kipp H, Schneider J, Butter EM, Baker J, Sprafkin J, Rice RR Jr, Bangalore SS, Farmer CA, Austin AB, Buchan-Page KA, Brown NV, Hurt EA, Grondhuis SN, Findling RL. What does risperidone add to parent training and stimulant for severe aggression in child attention-deficit/hyperactivity disorder? Journal of the American Academy of Child and Adolescent Psychiatry. 2014; 53(1):47-60.e1.

5. Aman MG, Arnold LE, McDougle CJ, Vitiello B, Scahill L, Davies M, McCracken JT, Tierney E, Nash PL, Posey DJ, Chuang S, Martin A, Shah B, Gonzalez NM, Swiezy NB, Ritz L, Koenig K, McGough J, Ghuman JK, Lindsay RL. Acute and long-term safety and tolerability of risperidone in children with autism. Journal of child and adolescent psychopharmacology. 2005; 15(6):869-84.

6. Ananth J, Venkatesh R, Burgoyne K, Gadasalli R, Binford R, Gunatilake S. Atypical antipsychotic induced weight gain: pathophysiology and management. Annals of clinical psychiatry : official journal of the American Academy of Clinical Psychiatrists. 2004; 16(2):75-85.

7. Arnold LE, Mount K, Frazier T, Demeter C, Youngstrom EA, Fristad MA, Birmaher B, Horwitz S, Findling RL, Kowatch R, Axelson D.Pediatric bipolar disorder and ADHD: family history comparison in the LAMS clinical sample.Journal of affective disorders. 2012; 141(2-3):382-9.

8. Arnold LE, Demeter C, Mount K, Frazier TW, Youngstrom EA, Fristad M, Birmaher B, Findling RL, Horwitz SM, Kowatch R, Axelson DA. Pediatric bipolar spectrum disorder and ADHD: comparison and comorbidity in the LAMS clinical sample.Bipolar disorders. 2011; 13(5-6):509-21.

9. Arnold LE, Lindsay RL, Conners CK, Wigal SB, Levine AJ, Johnson DE, West SA, Sangal RB, Bohan TP, Zeldis JB.A double-blind, placebo-controlled withdrawal trial of dexmethylphenidate hydrochloride in children with attention deficit hyperactivity disorder. Journal of child and adolescent psychopharmacology. 2004; 14(4):542-54.

10. Bakel LA, Wilson K, Tyler A, Tham E, Reese J, Bothner J, Kaplan DW.A quality improvement study to improve inpatient problem list use. Hospital pediatrics. 2014; 4(4):205-10.

11. Barton R.Use of medication in children with psychiatric disorders. Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association. 2007; 80(11):42, 44.

12. Bhatara V, Feil M, Hoagwood K, Vitiello B, Zima B. National trends in concomitant psychotropic medication with stimulants in pediatric visits: practice versus knowledge. Journal of attention disorders. 2004; 7(4):217-26.

13. Birmaher B, Brent D, Bernet W, Bukstein O, Walter H, Benson RS, Chrisman A, Farchione T, Greenhill L, Hamilton J, Keable H, Kinlan J, Schoettle U, Stock S, Ptakowski KK, Medicus J. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(11):1503-26.

14. Brenner SL, Southerland DG, Burns BJ, Wagner HR, Farmer EM. Use of Psychotropic Medications among Youth in Treatment Foster Care. Journal of child and family studies. 2014; 23(4):666-674.

15. Bryson SA, Akin BA. Predictors of admission to acute inpatient psychiatric care among children enrolled in medicaid. Administration and policy in mental health. 2015; 42(2):197-208.

16. Bukstein OG, Head J. Guanfacine ER for the treatment of adolescent attention-deficit/hyperactivity disorder. Expert opinion on pharmacotherapy. 2012; 13(15):2207-13.

17. Burcu M, Zito JM, Ibe A, Safer DJ. Atypical antipsychotic use among Medicaid-insured children and adolescents: duration, safety, and monitoring implications. Journal of child and adolescent psychopharmacology. 2014; 24(3):112-9.

18. Cacoub P, Musette P, Descamps V, Meyer O, Speirs C, Finzi L, Roujeau JC. The DRESS syndrome: a literature review. Am J Med. 2011 Jul;124(7):588-97. doi: 10.1016/j.amjmed.2011.01.017. Epub 2011 May 17. Review. PubMed PMID: 21592453.

19. Calarge CA, Nicol G, Schlechte JA, Burns TL. Cardiometabolic outcomes in children and adolescents following discontinuation of long-term risperidone treatment. Journal of child and adolescent psychopharmacology. 2014; 24(3):120-9.

20. Case BG, Olfson M, Marcus SC, Siegel C.Trends in the inpatient mental health treatment of children and adolescents in US community hospitals between 1990 and 2000.Archives of general psychiatry. 2007; 64(1):89-96.

21. Cerovecki A, Musil R, Klimke A, Seemüller F, Haen E, Schennach R, Kühn KU, Volz HP, Riedel M. Withdrawal symptoms and rebound syndromes associated with switching and discontinuing atypical antipsychotics: theoretical background and practical recommendations. CNS drugs. 2013; 27(7):545-72.

22. Chen E, Cohen S, Miller GE. How low socioeconomic status affects 2-year hormonal trajectories in children. Psychological science. 2010; 21(1):31-7.

23. Chen H, Patel A, Sherer J, Aparasu R. The definition and prevalence of pediatric psychotropic polypharmacy. Psychiatric services (Washington, D.C.). 2011; 62(12):1450-5.

24. Chen YC, Chiu HC, Chu CY. Drug reaction with eosinophilia and systemic symptoms: a retrospective study of 60 cases. Arch Dermatol. 2010 Dec;146(12):1373-9. doi: 10.1001/archdermatol.2010.198.

25. Cohen JA, Bukstein O, Walter H, Benson SR, Chrisman A, Farchione TR, Hamilton J, Keable H, Kinlan J, Schoettle U, Siegel M, Stock S, Medicus J. Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2010; 49(4):414-30.

26. Connolly SD, Bernstein GA.Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders.Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(2):267-83.

27. Connor DF, Barkley RA, Davis HT.A pilot study of methylphenidate, clonidine, or the combination in ADHD comorbid with aggressive oppositional defiant or conduct disorder. Clinical pediatrics. 2000; 39(1):15-25.

28. Constantine RJ, Boaz T, Tandon R. Antipsychotic polypharmacy in the treatment of children and adolescents in the fee-for-service component of a large state Medicaid program. Clinical therapeutics. 2010; 32(5):949-59.

29. Cook EH, Wagner KD, March JS, Biederman J, Landau P, Wolkow R, Messig M. Long-term sertraline treatment of children and adolescents with obsessive-compulsive disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2001; 40(10):1175-81.

30. Cortese S, Holtmann M, Banaschewski T, Buitelaar J, Coghill D, Danckaerts M, Dittmann RW, Graham J, Taylor E, Sergeant J. Practitioner review: current best practice in the management of adverse events during treatment with ADHD medications in children and adolescents. Journal of child psychology and psychiatry, and allied disciplines. 2013; 54(3):227-46.

31. Cosgrove VE, Roybal D, Chang KD. Bipolar depression in pediatric populations: epidemiology and management. Paediatric drugs. 2013; 15(2):83-91.

32. Cox DJ, Moore M, Burket R, Merkel RL, Mikami AY, Kovatchev B. Rebound effects with long-acting amphetamine or methylphenidate stimulant medication preparations among adolescent male drivers with attention-deficit/hyperactivity disorder. Journal of child and adolescent psychopharmacology. 2008; 18(1):1-10.

33. Crismon ML, Argo T. The use of psychotropic medication for children in foster care. Child welfare. 2009; 88(1):71-100.

34. Crystal S, Olfson M, Huang C, Pincus H, Gerhard T. Broadened use of atypical antipsychotics: safety, effectiveness, and policy challenges. Health affairs (Project Hope). 2009; 28(5):w770-81.

35. Cummings MR, Miller BD. Pharmacologic management of behavioral instability in medically ill pediatric patients. Current opinion in pediatrics. 2004; 16(5):516-22.

36. Dean AJ, McDermott BM, Marshall RT.PRN sedation-patterns of prescribing and administration in a child and adolescent mental health inpatient service.European child & adolescent psychiatry. 2006; 15(5):277-81.

37. Dean AJ, Scott J, McDermott BM. Changing utilization of pro re nata ('as needed') sedation in a child and adolescent psychiatric inpatient unit. The Australian and New Zealand journal of psychiatry. 2009; 43(4):360-5.

38. Dean AJ, McDermott BM, Marshall RT. Psychotropic medication utilization in a child and adolescent mental health service. Journal of child and adolescent psychopharmacology. 2006; 16(3):273-85.

39. Deshmukh P, Kulkarni G, Barzman D. Recommendations for pharmacological management of inpatient aggression in children and adolescents. Psychiatry (Edgmont (Pa.Township)). 2010; 7(2):32-40.

40. dosReis S, Tai MH, Goffman D, Lynch SE, Reeves G, Shaw T. Age-related trends in psychotropic medication use among very young children in foster care. Psychiatric services (Washington, D.C.). 2014; 65(12):1452-7.

41. dosReis S, Zito JM, Safer DJ, Gardner JF, Puccia KB, Owens PL. Multiple psychotropic medication use for youths: a two-state comparison. Journal of child and adolescent psychopharmacology. 2005; 15(1):68-77.

42. Duong S, Chung K, Wigal SB. Metabolic, toxicological, and safety considerations for drugs used to treat ADHD. Expert opinion on drug metabolism & toxicology. 2012; 8(5):543-52.

43. Dusetzina SB, Weinberger M, Gaynes BN, Farley JF, Sleath B, Hansen RA. Prevalence of bipolar disorder diagnoses and psychotropic drug therapy among privately insured children and adolescents. Pharmacotherapy. 2012; 32(12):1085-94.

44. Ehrt U, Fritze F, Aarsland D. Respiratory dyskinesia as discontinuation effect of risperidone. Journal of clinical psychopharmacology. 2005; 25(6):609.

45. Eisenberg N, Spinrad TL, Eggum ND. Emotion-related self-regulation and its relation to children's maladjustment. Annual review of clinical psychology. 2010; 6:495-525.

46. Ellis BJ, Boyce WT, Belsky J, Bakermans-Kranenburg MJ, van Ijzendoorn MH. Differential susceptibility to the environment: an evolutionary--neurodevelopmental theory. Development and psychopathology. 2011; 23(1):7-28.

47. Epstein RA, Jordan N, Rhee YJ, McClelland GM, Lyons JS. The relationship between caregiver capacity and intensive community treatment for children with a mental health crisis. Journal of Child and Family Studies. 2008; 18(3): 303-11.

48. Essock SM, Covell NH, Leckman-Westin E, Lieberman JA, Sederer LI, Kealey E, Finnerty MT. Identifying clinically questionable psychotropic prescribing practices for medicaid recipients in new york state psychiatric services (Washington, D.C.). 2009; 60(12):1595-602.

49. Evans GW, Gonnella C, Marcynyszyn LA, Gentile L, Salpekar N. The role of chaos in poverty and children's socioemotional adjustment. Psychological science. 2005; 16(7):560-5.

50. Faraone SV, McBurnett K, Sallee FR, Steeber J, López FA. Guanfacine extended release: a novel treatment for attention-deficit/hyperactivity disorder in children and adolescents. Clinical therapeutics. 2013; 35(11):1778-93.

51. Farooqi M, Seifert S, Kunkel S, Johnson M, Benson B. Toxicity from a clonidine suspension. Journal of medical toxicology : official journal of the American College of Medical Toxicology. 2009; 5(3):130-3.

52. Fein DM, Hafeez ZF, Cavagnaro C. An overdose of extended-release guanfacine. Pediatric emergency care. 2013; 29(8):929-31.

53. Ferguson DG, Glesener DC, Raschick M. Psychotropic drug use with European American and American Indian children in foster care. Journal of child and adolescent psychopharmacology. 2006; 16(4):474-81.

54. Findling RL, McBurnett K, White C, Youcha S. Guanfacine extended release adjunctive to a psychostimulant in the treatment of comorbid oppositional symptoms in children and adolescents with attention-deficit/hyperactivity disorder. Journal of child and adolescent psychopharmacology. 2014; 24(5):245-52.

55. Findling RL, Frazier JA, Kafantaris V, Kowatch R, McClellan J, Pavuluri M, Sikich L, Hlastala S, Hooper SR, Demeter CA, Bedoya D, Brownstein B, Taylor-Zapata P. The

Collaborative Lithium Trials (CoLT): specific aims, methods, and implementation. Child and adolescent psychiatry and mental health. 2008; 2(1):21.

56. Findling RL, Mankoski R, Timko K, Lears K, McCartney T, McQuade RD, Eudicone JM, Amatniek J, Marcus RN, Sheehan JJ.A randomized controlled trial investigating the safety and efficacy of aripiprazole in the long-term maintenance treatment of pediatric patients with irritability associated with autistic disorder. The Journal of clinical psychiatry. 2014; 75(1):22-30.

57. Fitzgerald KT, Bronstein AC.Adderall® (amphetamine-dextroamphetamine) toxicity. Topics in companion animal medicine. 2013; 28(1):2-7.

58. Flank J, Sung L, Dvorak CC, Spettigue W, Dupuis LL. The safety of olanzapine in young children: a systematic review and meta-analysis. Drug safety. 2014; 37(10):791-804.

59. Geller B, Luby JL, Joshi P, Wagner KD, Emslie G, Walkup JT, Axelson DA, Bolhofner K, Robb A, Wolf DV, Riddle MA, Birmaher B, Nusrat N, Ryan ND, Vitiello B, Tillman R, Lavori P. A randomized controlled trial of risperidone, lithium, or divalproex sodium for initial treatment of bipolar I disorder, manic or mixed phase, in children and adolescents. Archives of general psychiatry. 2012; 69(5):515-28.

60. Geller B, Tillman R, Bolhofner K, Zimerman B. Pharmacological and non-drug treatment of child bipolar I disorder during prospective eight-year follow-up. Bipolar disorders. 2010; 12(2):164-71.

61. Gleason MM, Egger HL, Emslie GJ, Greenhill LL, Kowatch RA, Lieberman AF, Luby JL, Owens J, Scahill LD, Scheeringa MS, Stafford B, Wise B, Zeanah CH. Psychopharmacological treatment for very young children: contexts and guidelines. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(12):1532-72.

62. Glick ID, Sharfstein SS, Schwartz HI. Inpatient psychiatric care in the 21st century: the need for reform. Psychiatric services (Washington, D.C.). 2011; 62(2):206-9.

63. Greenstein D, Kataria R, Gochman P, Dasgupta A, Malley JD, Rapoport J, Gogtay N. Looking for childhood-onset schizophrenia: diagnostic algorithms for classifying children and adolescents with psychosis. Journal of child and adolescent psychopharmacology. 2014; 24(7):366-73.

64. Griffin G, McClelland G, Holzberg M, Stolbach B, Maj N, Kisiel C. Addressing the impact of trauma before diagnosing mental illness in child welfare. Child Welfare. 2011;90(6):69-89.

65. Grof P.Sixty years of lithium responders. Neuropsychobiology. 2010; 62(1):8-16.

66. Hammerness P, Surman C, Miller K. Update on adult attention-deficit/hyperactivity disorder. Current neurology and neuroscience reports. 2008; 8(6):484-9.

67. Hamrin V, Iennaco JD. Psychopharmacology of pediatric bipolar disorder. Expert review of neurotherapeutics. 2010; 10(7):1053-88.

68. Hanscombe KB, Haworth CM, Davis OS, Jaffee SR, Plomin R. The nature (and nurture) of children's perceptions of family chaos. Learning and individual differences. 2010; 20(5):549-553.

69. Hawes DJ. Disruptive behaviour disorders and DSM-5.Asian journal of psychiatry. 2014; 11:102-5.

70. Husain Z, Reddy BY, Schwartz RA. DRESS syndrome: Part I. Clinical perspectives. J Am Acad Dermatol. 2013 May;68(5):693.e1-14; quiz 706-8. doi: 10.1016/j.jaad.2013.01.033.

71. Hutchison AK, Beresford C, Robinson J, Ross RG. Assessing disordered thoughts in preschoolers with dysregulated mood. Child Psychiatry Hum Dev. 2010 Oct;41(5):479-89.

72. Jaffee SR, Hanscombe KB, Haworth CM, Davis OS, Plomin R. Chaotic homes and children's disruptive behavior: a longitudinal cross-lagged twin study. Psychological science. 2012; 23(6):643-50.

73. Jairam R, Prabhuswamy M, Dullur P. Do we really know how to treat a child with bipolar disorder or one with severe mood dysregulation? Is there a magic bullet? Depression research and treatment. 2012; 2012:967302.

74. Jensen PS, Buitelaar J, Pandina GJ, Binder C, Haas M. Management of psychiatric disorders in children and adolescents with atypical antipsychotics: a systematic review of published clinical trials. European child & adolescent psychiatry. 2007; 16(2):104-20.

75. Jensen PS. Ethical and pragmatic issues in the use of psychotropic agents in young children. Canadian journal of psychiatry. Revue canadienne de psychiatrie. 1998; 43(6):585-8.

76. Jureidini J, Tonkin A, Jureidini E. Combination pharmacotherapy for psychiatric disorders in children and adolescents: prevalence, efficacy, risks and research needs. Paediatric drugs. 2013; 15(5):377-91.

77. Kisicki JC, Fiske K, Lyne A. Phase I, double-blind, randomized, placebo-controlled, dose-escalation study of the effects on blood pressure of abrupt cessation versus taper down of guanfacine extended-release tablets in adults aged 19 to 24 years. Clinical therapeutics. 2007; 29(9):1967-79.

78. Kohlboeck G, Romanos M, Teuner CM, Holle R, Tiesler CM, Hoffmann B, Schaaf B, Lehmann I, Herbarth O, Koletzko S, Bauer CP, von Berg A, Berdel D, Heinrich J. Healthcare

use and costs associated with children's behavior problems. European child & adolescent psychiatry. 2014; 23(8):701-14.

79. Kornfield R, Watson S, Higashi AS, Conti RM, Dusetzina SB, Garfield CF, Dorsey ER, Huskamp HA, Alexander GC. Effects of FDA advisories on the pharmacologic treatment of ADHD, 2004-2008.Psychiatric services (Washington, D.C.). 2013; 64(4):339-46.

80. Kowatch RA, Youngstrom EA, Horwitz S, Demeter C, Fristad MA, Birmaher B, Axelson D, Ryan N, Frazier TW, Arnold LE, Young AS, Gill M, Findling RL. Prescription of psychiatric medications and polypharmacy in the LAMS cohort. Psychiatric services (Washington, D.C.). 2013; 64(10):1026-34.

81. Kratochvil CJ, Varley C, Cummins TK, Martin A. Less is more: inpatient management of a child with complex pharmacotherapy. Journal of the American Academy of Child and Adolescent Psychiatry. 2006; 45(5):621-4.

82. Kreider AR, Matone M, Bellonci C, dosReis S, Feudtner C, Huang YS, Localio R, Rubin DM. Growth in the concurrent use of antipsychotics with other psychotropic medications in Medicaid-enrolled children. Journal of the American Academy of Child and Adolescent Psychiatry. 2014; 53(9):960-970.e2.

83. Kress DW. Pediatric dermatology emergencies. Curr Opin Pediatr. 2011 Aug;23(4):403-6. doi: 10.1097/MOP.0b013e3283483efd.

84. Kruse JL, Davis MC. New-onset extrapyramidal symptoms following oxcarbazepine discontinuation in a child receiving risperidone. Journal of child and adolescent psychopharmacology. 2014; 24(3):166-7.

85. Lakhan SE, Kirchgessner A.Prescription stimulants in individuals with and without attention deficit hyperactivity disorder: misuse, cognitive impact, and adverse effects.Brain and behavior. 2012; 2(5):661-77.

86. Lavigne JV, Lebailly SA, Hopkins J, Gouze KR, Binns HJ. The prevalence of ADHD, ODD, depression, and anxiety in a community sample of 4-year-olds. J Clin Child Adolesc Psychol. 2009 May;38(3):315-28.

87. Lemery-Chalfant K, Kao K, Swann G, Goldsmith HH. Childhood temperament: passive gene-environment correlation, gene-environment interaction, and the hidden importance of the family environment. Development and psychopathology. 2013; 25(1):51-63.

88. Leon SC, Miller SA, Stoner AM, Fuller A, Rolnik A. Change Trajectories: Children's Patterns of Improvement in Acute-Stay Inpatient Care. The journal of behavioral health services & research. 2014

89. Linton D, Barr AM, Honer WG, Procyshyn RM. Antipsychotic and psychostimulant drug combination therapy in attention deficit/hyperactivity and disruptive behavior disorders: a systematic review of efficacy and tolerability. Current psychiatry reports. 2013; 15(5):355.

90. Loman MM, Gunnar MR. Early experience and the development of stress reactivity and regulation in children. Neuroscience and biobehavioral reviews. 2010; 34(6):867-76.

91. Luby JL, Stalets MM, Belden AC. Psychotropic prescriptions in a sample including both healthy and mood and disruptive disordered preschoolers: relationships to diagnosis, impairment, prescriber type, and assessment methods. Journal of child and adolescent psychopharmacology. 2007; 17(2):205-15.

92. Maayan L, Correll CU. Weight gain and metabolic risks associated with antipsychotic medications in children and adolescents. Journal of child and adolescent psychopharmacology. 2011; 21(6):517-35.

93. Madden C, Black B, Willsie D. Treating our youngest patients: psychotropic medications in early childhood. Missouri medicine. 2014; 111(3):207-11.

94. Mallants C, Casteels K. Practical approach to childhood masturbation—a review. European journal of pediatrics. 2008; 167(10):1111-7.

95. Martin A, Van Hoof T, Stubbe D, Sherwin T, Scahill L. Multiple psychotropic pharmacotherapy among child and adolescent enrollees in Connecticut Medicaid managed care. Psychiatric services (Washington, D.C.). 2003; 54(1):72-7.

96. Masters GA, Baldessarini RJ, Öngür D, Centorrino F. Factors associated with length of psychiatric hospitalization. Comprehensive psychiatry. 2014; 55(3):681-7.

97. Matone M, Localio R, Huang YS, dosReis S, Feudtner C, Rubin D. The relationship between mental health diagnosis and treatment with second-generation antipsychotics over time: a national study of U.S. Medicaid-enrolled children. Health services research. 2012; 47(5):1836-60.

98. McClellan J, Kowatch R, Findling RL. Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(1):107-25.

99. McClellan JM, Werry JS. Evidence-based treatments in child and adolescent psychiatry: an inventory. Journal of the American Academy of Child and Adolescent Psychiatry. 2003; 42(12):1388-400.

100. McDonagh M, Peterson K, Carson S, Fu R, Thakurta S. Drug Class Review: Atypical Antipsychotic Drugs: Final Update 3 Report Portland (OR): Oregon Health & Science University; 2010Jul.

101. McFarlane JM, Groff JY, O'Brien JA, Watson K. Behaviors of children who are exposed and not exposed to intimate partner violence: an analysis of 330 black, white, and Hispanic children. Pediatrics. 2003; 112(3 Pt 1):e202-7.

102. McGough J, McCracken J, Swanson J, Riddle M, Kollins S, Greenhill L, Abikoff H, Davies M, Chuang S, Wigal T, Wigal S, Posner K, Skrobala A, Kastelic E, Ghuman J, Cunningham C, Shigawa S, Moyzis R, Vitiello B. Pharmacogenetics of methylphenidate response in preschoolers with ADHD. Journal of the American Academy of Child and Adolescent Psychiatry. 2006; 45(11):1314-22.

103. McKinney C, Renk K. Atypical antipsychotic medications in the management of disruptive behaviors in children: safety guidelines and recommendations. Clinical psychology review. 2011; 31(3):465-71.

104. McLaughlin KA, Kubzansky LD, Dunn EC, Waldinger R, Vaillant G, Koenen KC. Childhood social environment, emotional reactivity to stress, and mood and anxiety disorders across the life course. Depression and anxiety. 2010; 27(12):1087-94.

105. McLaughlin KA, Hatzenbuehler ML. Mechanisms linking stressful life events and mental health problems in a prospective, community-based sample of adolescents. The Journal of adolescent health: official publication of the Society for Adolescent Medicine. 2009; 44(2):153-60.

106. McNicholas F, Orakwue N. Safe and judicious paediatric psychotropic prescribing. Irish medical journal. 2014; 107(2):41-3.

107. Memarzia J, Tracy D, Giaroli G. The use of antipsychotics in preschoolers: a veto or a sensible last option? Journal of psychopharmacology (Oxford, England). 2014; 28(4):303-19.

108. Moncrieff J, Cohen D, Porter S. The psychoactive effects of psychiatric medication: the elephant in the room. Journal of psychoactive drugs. 2013; 45(5):409-15.

109. Morden NE, Goodman D. Pediatric polypharmacy: time to lock the medicine cabinet? Archives of pediatrics & adolescent medicine. 2012; 166(1):91-2.

110. Morrato EH, Nicol GE, Maahs D, Druss BG, Hartung DM, Valuck RJ, Campagna E, Newcomer JW. Metabolic screening in children receiving antipsychotic drug treatment. Archives of pediatrics & adolescent medicine. 2010; 164(4):344-51.

111. Morris AS, Silk JS, Steinberg L, Myers SS, Robinson LR. The Role of the Family Context in the Development of Emotion Regulation. Social development (Oxford, England). 2007; 16(2):361-388.

112. Müller-Oerlinghausen B, Lewitzka U. Lithium reduces pathological aggression and suicidality: a mini-review. Neuropsychobiology. 2010; 62(1):43-9.

113. Murphy AL, Gardner DM, Cooke C, Kisely S, Hughes J, Kutcher SP. Prescribing trends of antipsychotics in youth receiving income assistance: results from a retrospective population database study. BMC psychiatry. 2013; 13:198.

114. Naylor MW, Davidson CV, Ortega-Piron DJ, Bass A, Gutierrez A, Hall A. Psychotropic medication management for youth in state care: consent, oversight, and policy considerations. Child welfare. 2007; 86(5):175-92.

115. Nevels RM, Dehon EE, Alexander K, Gontkovsky ST. Psychopharmacology of aggression in children and adolescents with primary neuropsychiatric disorders: a review of current and potentially promising treatment options. Experimental and clinical psychopharmacology. 2010; 18(2):184-201.

116. Nguyen M, Tharani S, Rahmani M, Shapiro M.A review of the use of clonidine as a sleep aid in the child and adolescent population. Clinical pediatrics. 2014; 53(3):211-6.

117. Obradović J, Bush NR, Stamperdahl J, Adler NE, Boyce WT. Biological sensitivity to context: the interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. Child development. 2010; 81(1):270-89.

118. Olfson M, Crystal S, Huang C, Gerhard T. Trends in antipsychotic drug use by very young, privately insured children. Journal of the American Academy of Child and Adolescent Psychiatry. 2010; 49(1):13-23.

119. Olfson M, Marcus SC, Weissman MM, Jensen PS. National trends in the use of psychotropic medications by children. Journal of the American Academy of Child and Adolescent Psychiatry. 2002; 41(5):514-21.

120. SENTIA: a systematic online monitoring registry for children and adolescents treated with antipsychotics Palanca-Maresca I, Ruiz-Antorán B, Centeno-Soto G, Jiménez-Fernandez S, García-Murillo L, Siles A, Villagrá S, Blasco-Fontecilla H, Iruela-Cuadrado L, Roman-Riechman E, Avendaño-Solá C, Correll CU. Springer Plus. 3:187.

121. Panagiotopoulos C, Ronsley R, Elbe D, Davidson J, Smith DH. First do no harm: promoting an evidence-based approach to atypical antipsychotic use in children and adolescents. Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie canadienne de psychiatrie de l'enfant et de l'adolescent. 2010; 19(2):124-37.

122. Patel BD, Barzman DH.Pharmacology and pharmacogenetics of pediatric ADHD with associated aggression: a review. The Psychiatric quarterly. 2013; 84(4):407-15.

123. Patel NC, Sanchez RJ, Johnsrud MT, Crismon ML. Trends in antipsychotic use in a Texas medicaid population of children and adolescents: 1996 to 2000.Journal of child and adolescent psychopharmacology. 2002; 12(3):221-9.

124. Patteet L, Morrens M, Maudens KE, Niemegeers P, Sabbe B, Neels H. Therapeutic drug monitoring of common antipsychotics. Therapeutic drug monitoring. 2012; 34(6):629-51.

125. Pearson GS.Use of polypharmacy with children and adolescents. Journal of child and adolescent psychiatric nursing : official publication of the Association of Child and Adolescent Psychiatric Nurses, Inc. 2013; 26(2):158-9.

126. Pearson GS, Banga A. Psychopharmacology column: the use of lithium carbonate with pediatric populations. Journal of child and adolescent psychiatric nursing : official publication of the Association of Child and Adolescent Psychiatric Nurses, Inc. 2012; 25(4):232-4.

127. Penfold RB, Stewart C, Hunkeler EM, Madden JM, Cummings JR, Owen-Smith AA, Rossom RC, Lu CY, Lynch FL, Waitzfelder BE, Coleman KJ, Ahmedani BK, Beck AL, Zeber JE, Simon GE. Use of antipsychotic medications in pediatric populations: what do the data say? Current psychiatry reports. 2013; 15(12):426.

128. Persi J, Sisson M. Children in foster care: before, during, and after psychiatric hospitalization. Child Welfare. 2008; 87(4):79-99.

129. Peruzzolo TL, Tramontina S, Rohde LA, Zeni CP. Pharmacotherapy of bipolar disorder in children and adolescents: an update. Revista brasileira de psiquiatria (Sao Paulo, Brazil : 1999). 2013; 35(4):393-405.

130. Phelps TI, Bondi CO, Ahmed RH, Olugbade YT, Kline AE. Divergent Long-Term Consequences of Chronic Treatment with Haloperidol, Risperidone, and Bromocriptine on Traumatic Brain Injury-Induced Cognitive Deficits. Journal of neurotrauma. 2014

131. Pincus HA, Tew JD, First MB. Psychiatric comorbidity: is more less? World psychiatry : official journal of the World Psychiatric Association (WPA). 2004; 3(1):18-23.

132. Pliszka S. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(7):894-921.

133. Politte LC, Henry CA, McDougle CJ. Psychopharmacological interventions in autism spectrum disorder. Harvard review of psychiatry. 2014; 22(2):76-92.

134. Preskorn SH, Baker B. The overlap of DSM-IV syndromes: potential implications for the practice of polypsychopharmacology, psychiatric drug development, and the human genome project. Journal of psychiatric practice. 2002; 8(3):170-7.

135. Raghavan R, Zima BT, Andersen RM, Leibowitz AA, Schuster MA, Landsverk J. Psychotropic medication use in a national probability sample of children in the child welfare system. Journal of child and adolescent psychopharmacology. 2005; 15(1):97-106.

136. Rodday AM, Parsons SK, Correll CU, Robb AS, Zima BT, Saunders TS, Leslie LK. Child and adolescent psychiatrists' attitudes and practices prescribing second generation antipsychotics. Journal of child and adolescent psychopharmacology. 2014; 24(2):90-3.

137. Romansky JB, Lyons JS, Lehner RK, West CM. Factors related to psychiatric hospital readmission among children and adolescents in state custody. Psychiatr Serv. 2003 Mar; 54 (3):356-62.

138. Rubin DM, Feudtner C, Localio R, Mandell DS. State variation in psychotropic medication use by foster care children with autism spectrum disorder. Pediatrics. 2009; 124(2):e305-12.

139. Ruggiero S, Rafaniello C, Bravaccio C, Grimaldi G, Granato R, Pascotto A, Sportiello L, Parretta E, Rinaldi B, Panei P, Rossi F, Capuano A. Safety of attention-deficit/hyperactivity disorder medications in children: an intensive pharmacosurveillance monitoring study. Journal of child and adolescent psychopharmacology. 2012; 22(6):415-22.

140. Rynn M, Wagner KD, Donnelly C, Ambrosini P, Wohlberg CJ, Landau P, Yang R. Long-term sertraline treatment of children and adolescents with major depressive disorder. Journal of child and adolescent psychopharmacology. 2006; 16(1-2):103-16.

141. Safer DJ, Zito JM, DosReis S. Concomitant psychotropic medication for youths. The American journal of psychiatry. 2003; 160(3):438-49.

142. Saldaña SN, Keeshin BR, Wehry AM, Blom TJ, Sorter MT, DelBello MP, Strawn JR. Antipsychotic polypharmacy in children and adolescents at discharge from psychiatric hospitalization. Pharmacotherapy. 2014; 34(8):836-44.

143. Sallee FR, Eaton K. Guanfacine extended-release for attention-deficit/hyperactivity disorder (ADHD).Expert opinion on pharmacotherapy. 2010; 11(15):2549-56.

144. Sallee FR. The role of alpha2-adrenergic agonists in attention-deficit/hyperactivity disorder. Postgraduate medicine. 2010; 122(5):78-87.

145. Scahill L, Aman MG, McDougle CJ, McCracken JT, Tierney E, Dziura J, Arnold LE, Posey D, Young C, Shah B, Ghuman J, Ritz L, Vitiello B.A prospective open trial of guanfacine in children with pervasive developmental disorders. Journal of child and adolescent psychopharmacology. 2006; 16(5):589-98.

146. Scheltema Beduin A, de Haan L.Off-label second generation antipsychotics for impulse regulation disorders: a review. Psychopharmacology bulletin. 2010; 43(3):45-81.

147. Schneider C, Taylor D, Zalsman G, Frangou S, Kyriakopoulos M. Antipsychotics use in children and adolescents: An on-going challenge in clinical practice. Journal of psychopharmacology (Oxford, England). 2014; 28(7):615-623.

148. Shapero BG, Steinberg L. Emotional reactivity and exposure to household stress in childhood predict psychological problems in adolescence. Journal of youth and adolescence. 2013; 42(10):1573-82.

149. Shonkoff JP, Garner AS. The lifelong effects of early childhood adversity and toxic stress. Pediatrics. 2012; 129(1):e232-46.

150. Sikirica V, Pliszka SR, Betts KA, Hodgkins P, Samuelson T, Xie J, Erder H, Dammerman R, Robertson B, Wu EQ. Comparative treatment patterns, resource utilization, and costs in stimulant-treated children with ADHD who require subsequent pharmacotherapy with atypical antipsychotics versus non-antipsychotics. Journal of managed care pharmacy : JMCP. 2012; 18(9):676-89.

151. Sinha Y, Cranswick NE. Clonidine poisoning in children: a recent experience. Journal of paediatrics and child health. 2004; 40(12):678-80.

152. Spencer TJ. Pharmacology of adult ADHD with stimulants. CNS spectrums. 2007; 12(4 Suppl 6):8-11.

153. Spiller HA, Hays HL, Aleguas A Jr. Overdose of drugs for attention-deficit hyperactivity disorder: clinical presentation, mechanisms of toxicity, and management. CNS drugs. 2013; 27(7):531-43.

154. Srivastava A. Limited evidence for the effectiveness of p.r.n. Medications among psychiatric inpatients. Journal of psychiatric practice. 2009; 15(3):193-201.

155. Steele JS, Buchi KF. Medical and mental health of children entering the Utah foster care system. Pediatrics. 2008; 122(3):e703-9.

156. Steiner H, Remsing L. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(1):126-41.

157. Stirling J Jr, Amaya-Jackson L, Amaya-Jackson L. Understanding the behavioral and emotional consequences of child abuse. Pediatrics. 2008; 122(3):667-73.

158. Stringaris A, Baroni A, Haimm C, Brotman M, Lowe CH, Myers F, Rustgi E, Wheeler W, Kayser R, Towbin K, Leibenluft E. Pediatric bipolar disorder versus severe mood

dysregulation: risk for manic episodes on follow-up. Journal of the American Academy of Child and Adolescent Psychiatry. 2010; 49(4):397-405.

159. Stringaris A. What we can all learn from the Treatment of Early Age Mania (TEAM) trial. Journal of the American Academy of Child and Adolescent Psychiatry. 2012; 51(9):861-3.

160. Swart GT, Siman E, Stewart SL. The use of Pro Re Nata or Statim medications for behavioral control: a summary of experience at a tertiary care children's mental health center. Journal of child and adolescent psychopharmacology. 2011; 21(1):67-77.

161. Swearingen D, Pennick M, Shojaei A, Lyne A, Fiske K.A phase I, randomized, open-label, crossover study of the single-dose pharmacokinetic properties of guanfacine extended-release 1-, 2-, and 4-mg tablets in healthy adults. Clinical therapeutics. 2007; 29(4):617-25.

162. Tandon R, Jibson MD. Comparing efficacy of first-line atypical antipsychotics: no evidence of differential efficacy between risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole. International journal of psychiatry in clinical practice. 2005; 9(3):204-12.

163. Tartaglia M, Gelb BD, Zenker M. Noonan syndrome and clinically related disorders.Best practice & research. Clinical endocrinology & metabolism. 2011; 25(1):161-79.

164. Thomas T, Stansifer L, Findling RL. Psychopharmacology of pediatric bipolar disorders in children and adolescents. Pediatric clinics of North America. 2011; 58(1):173-87, xii.

165. Tillman R, Geller B, Klages T, Corrigan M, Bolhofner K, Zimerman B. Psychotic phenomena in 257 young children and adolescents with bipolar I disorder: delusions and hallucinations (benign and pathological).Bipolar disorders. 2008; 10(1):45-55.

166. Tucha O, Prell S, Mecklinger L, Bormann-Kischkel C, Kübber S, Linder M, Walitza S, Lange KW. Effects of methylphenidate on multiple components of attention in children with attention deficit hyperactivity disorder. Psychopharmacology. 2006; 185(3):315-26.

167. Urbano M, Spiegel D, Rai A. Atypical antipsychotic withdrawal dyskinesia in 4 patients with mood disorders. Journal of clinical psychopharmacology. 2007; 27(6):705-7.

168. Vitiello B, Hill JL, Elia J, Cunningham E, McLeer SV, Behar D. P.r.n. medications in child psychiatric patients: a pilot placebo-controlled study. The Journal of clinical psychiatry. 1991; 52(12):499-501.

169. Vitiello B, Correll C, van Zwieten-Boot B, Zuddas A, Parellada M, Arango C. Antipsychotics in children and adolescents: increasing use, evidence for efficacy and safety concerns. European neuropsychopharmacology : the journal of the European College of Neuropsychopharmacology. 2009; 19(9):629-35.

170. Vitiello B, Riddle MA, Yenokyan G, Axelson DA, Wagner KD, Joshi P, Walkup JT, Luby J, Birmaher B, Ryan ND, Emslie G, Robb A, Tillman R. Treatment moderators and predictors of outcome in the Treatment of Early Age Mania (TEAM) study. Journal of the American Academy of Child and Adolescent Psychiatry. 2012; 51(9):867-78.

171. Vitiello B, Riddle MA, Gayane Yenokyan, Axelson DA, Birmaher B, Ryan ND, Wagner KD, Joshi P, Robb A, Walkup JT, Luby J, Rebecca Tillman, Emslie G. Dr. Vitiello et al. reply. Journal of the American Academy of Child and Adolescent Psychiatry. 2013; 52(2):206-7.

172. Vitiello B. Research in child and adolescent psychopharmacology: recent accomplishments and new challenges. Psychopharmacology. 2007; 191(1):5-13.

173. Webster-Stratton C, Herman KC. The impact of parent behavior-management training on child depressive symptoms. J Couns Psychol. 2008 Oct; 55(4):473-84.

174. Wilens TE, Bukstein O, Brams M, Cutler AJ, Childress A, Rugino T, Lyne A, Grannis K, Youcha S. A controlled trial of extended-release guanfacine and psychostimulants for attention-deficit/hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2012; 51(1):74-85.e2.

175. Yoon EY, Cohn L, Rocchini A, Kershaw D, Clark SJ. Clonidine utilization trends for Medicaid children. Clinical pediatrics. 2012; 51(10):950-5.

176. Yoshida K, Suzuki T, Uchida H, Mimura M. Absence of evidence that the pro re nata regimen confers benefit: a review of the studies. International clinical psychopharmacology. 2013; 28(5):228-37.

177. Young JL. Treatment of adult ADHD and comorbid disorders. CNS spectrums. 2006; 11(10 Suppl 11):10-2.

178. Zima BT, Bussing R, Crecelius GM, Kaufman A, Belin TR. Psychotropic medication use among children in foster care: relationship to severe psychiatric disorders. American journal of public health. 1999; 89(11):1732-5.

179. Zipursky RB, Menezes NM, Streiner DL. Risk of symptom recurrence with medication discontinuation in first-episode psychosis: a systematic review. Schizophrenia research. 2014; 152(2-3):408-14.

180. Zito JM, Safer DJ, Sai D, Gardner JF, Thomas D, Coombes P, Dubowski M, Mendez-Lewis M. Psychotropic medication patterns among youth in foster care. Pediatrics. 2008; 121(1):e157-63.

181. Zito JM, Safer DJ, Valluri S, Gardner JF, Korelitz JJ, Mattison DR. Psychotherapeutic medication prevalence in Medicaid-insured preschoolers. Journal of child and adolescent psychopharmacology. 2007; 17(2):195-203.

182. Zito JM, Safer DJ, de Jong-van den Berg LT, Janhsen K, Fegert JM, Gardner JF, Glaeske G, Valluri SC. A three-country comparison of psychotropic medication prevalence in youth. Child and adolescent psychiatry and mental health. 2008; 2(1):26.

183. Zonfrillo MR, Penn JV, Leonard HL. Pediatric psychotropic polypharmacy. Psychiatry (Edgmont (Pa.: Township)). 2005; 2(8):14-9.

184. Zuddas A, Zanni R, Usala T. Second generation antipsychotics (SGAs) for non-psychotic disorders in children and adolescents: a review of the randomized controlled studies. European neuropsychopharmacology: the journal of the European College of Neuropsychopharmacology. 2011; 21(8):600-20.

APPENDIX

Vitamin Supplementation for Fetal Alcohol Exposure

Epidemiological Evidence of Neurobehavioral Effects of Prenatal ETOH Exposure

Bell & Chimata (2015) evaluated the prevalence of neurodevelopmental disorders in predominately low-income African-American psychiatric patients at Jackson Park Hospital's Family Medicine Clinic. Using active case ascertainment methodology, the authors reviewed 611 psychiatric records of patients who visited the clinic from May 2013 until January 2014 to identify those with *DSM-5* neurodevelopmental disorders. The sample set consisted of 590 adult patients consisting of 566 (96%) African American, 364 (39%) male, 364 (61%) female and the average age was 45 (range 19 to 78); while the 21 youths ($\leq$18 years) were all African American, 16 (78%) were male, five were female (24%) and the average age was 13 (range four to 18). Among adult sample set, 224 adults had a clinical profile consistent with neurobehavioral disorder associated with prenatal alcohol exposure. Also, ten youth met criteria for neurobehavioral disorder associated with prenatal alcohol exposure. Additionally, the mothers of the children or adult children with neurodevelopmental disorders were able to give a history that indicated the etiology of disorder (Bell & Chimata, 2015). Most reported being young mothers who did not know they were pregnant until after the first or second month and who drank during this period (Bell & Chimata). Neurodevelopmental disorders associated with prenatal alcohol exposure are a serious public health problem for lower-income African American communities on Chicago's South Side.

Metabolic Effects of Prenatal ETOH Exposure

Inappropriate feeding behaviors and poor dietary intake have been linked to children exposed to alcohol in utero. Infants diagnosed with fetal alcohol spectrum disorder (FASD) and "failure to thrive" may be related to gastrointestinal dysfunction (Werts, Van Calcar, Wargowski & Smith, 2014). Werts et al. (2014) evaluated the diet and eating behavior of 19 children diagnosed with fetal alcohol syndrome. This study is the first to associate prenatal alcohol exposure to female obesity, lack of satiety (and high snacking behavior), constipation and low vitamin D status. Werts et al., proposed the lack of satiety as an effect of poor regulation of neuroendocrine signals that control appetite and reward in the hypothalamus and ventral tegmental area. Poor dietary regulation also could be a marker for low impulse control that is often observed in those diagnosed with FASD.

The Role of Choline, Folic Acid and Alcohol in Pregnancy

Data from in-vivo research show compelling evidence for the importance of prenatal choline in children's neurodevelopment. In-vivo (animal) research assists us in determining causative factors that are inferred to in human correlational studies. Pregnant rodent dams fed a diet low in choline produced rat pups with diminished neural progenitor cell proliferation in fetal hippocampus and at same time there was apoptosis (cell death) (Ziesel, 2011; Albright, Tsai, Friedrich, Mar, & Ziesel, 1999; Albright, Friedrich, Brown, Mar & Ziesel, 1999). Choline is a major source of methyl groups in DNA; essentially, methylation helps balance and control gene expression. Epigenetic changes related to methylation cause uncontrolled gene expression in

DNA, which increase the susceptibility to autoimmune and neurodegenerative diseases, cancer, and genetic disorders.

Neonates need large amounts of choline to support and sustain growth. In utero, the fetus receives their choline supply via placenta transport from the mother's blood - that can be fortified by a healthy diet and prenatal vitamins; or deficient by using alcohol and / or drugs during the pregnancy. Choline diffusion across the blood-brain-barrier is facilitated by a bidirectional transport system. Choline and folate are crucial for cellular life as it plays an important role in cell membranes, cell signaling, lipid-cholesterol transport, metabolism, spinal cord (neural tube closure) and brain development, especially in the hippocampus, a structure involved in learning and memory (Holmes-McNary, Cheng, Mar, Fussell, Zeisel, 1996). Choline is the precursor to acetylcholine, a neurotransmitter involved in many physiological processes including but not limited to brain development (cognition, learning and memory), stress response, sleep and metabolism (digestion).

Similar mechanisms may underlie the effects observed from a diet low in choline and folate to that of fetal alcohol exposure (Zeisel, 2011). Alcohol has been shown to cause neuro degeneration and oxidative stress interferes with metabolic pathways affecting the glycolysis, Krebs cycle and fatty acid metabolism (Thomas, Warren & Hewitt, 2010; Ballard, Sun & Ko, 2012). Alcohol during pregnancy acts as teratogen - decreasing the use of folate and increasing the use of choline as a methyl donor. High risk communities (food and healthcare insecurity, low SES, high crime / community violence, knowledge deficits, etc.) are especially vulnerable to alcohol use (and abuse)- primary-care providers and prenatal clinics should be on alert for any patient who meets the diagnostic criteria for alcohol dependence and / or women who already given birth to a child with FASD. There are many other situations in which the health provider may have reason to screen for prenatal alcohol exposure or FASD and intervene, such as patients may be poor historians, data on the biological mother is unavailable, or women unaware they are pregnant during the first couple of weeks-to months and drink alcohol (Bell & Chimata, 2015). What has been demonstrated in the literature is that patients who are at risk for FASD have poor nutrition. We know that same systemic effects have been observed from poor diets and alcohol exposure (as described above). A possible solution is to incorporate a vitamin regimen to pregnant patients or children with suspected alcohol exposure to provide protection to the developing brain.

A literature review by Ballard, Sun, & Ko (2012) highlighted the importance of vitamin A, folate and choline as possible preventive interventions to fetal alcohol syndrome. Bell (2015) a profound researcher on the health disparities in the African-American communities in Chicago, reported a vitamin regimen that includes a once-a-day dose of 500 mg of choline, 400 mcg folate, 2,000 IU of vitamin A with a twice-a -day dose of 500mg of omega-3 to pregnant patients that may have ingested alcohol. While the efficacy of this regimen is under investigation, it does offer a starting point for health providers to consider when there is admittance (or suspicion) of alcohol intake during pregnancy.

Vitamin Supplementation for Prenatal Alcohol Exposure

Choline intake during the prenatal period is neuroprotective - specifically for DNA and histone methylation to regulate gene expression (Blusztajn & Mellott, 2012). Several studies demonstrated vitamin supplementation reduces the effects from fetal alcohol exposure. The most

influential is a pilot study reported by Wozinak et al. (2013). Children diagnosed with fetal alcohol spectrum disorder ages 2.5-5 years were given 500 mg of choline supplementation for 9 months showed remarkable improvements in memory, cognition and fine motor skills (Mullen Scales) and an increase in sequential memory (a hippocampal-dependent measure) vs. placebo control. Choline dosages well-tolerated with minimal side effects (56% of the participants reported a fishy odor). While the study was not adequately powered to show significance (10 patients per study group) findings are promising. Vitamin supplementation, even during preschool age, ameliorated the neurodevelopmental effects of in-utero alcohol exposure – marking a critical window for nutritional intervention. The National Institute for Alcohol Abuse and Alcoholism is funding the first study (NCT01911299) to examine the effectiveness of micronutrient supplementation among women who drank alcohol during pregnancy. The study evaluated choline supplementation or placebo over a six-week period on children (ages 5-10 years old) who were exposed to heavy prenatal alcohol exposure. Thomas (2014) evaluated whether choline supplements improved cognitive function (executive function, attention, and learning/memory) along with parent's interpretation of children's behavioral changes over the treatment period. While the results are pending, a nationally funded clinical study does demonstrate a promise in evaluating vitamin supplements as a treatment options for prenatal alcohol exposed children.

Animal studies help us bridge the gap between correlation and causation. There are several animal studies that support the premise that nutritional intervention pre or postnatal can reduce the neurotoxic deficits by alcohol exposure. Meck & Williams (2003) found prenatal choline supplementation at different stages during development increased rat pups ability to use relational cues to learn and remember. Further, Thomas, Abou & Dominguez (2009) exposed pregnant rats to ethanol during gestational days 5-20 (equivalent to first, second and third trimesters) had offspring with reduced birth weight; delays in eye openings (neurological deficits) and teeth emergence; alterations in reflexes (neurological defects) and hind limb coordination and cliff avoidance (depth perception; fear defense). Thomas et al. (2009) then evaluated the effects of prenatal choline supplementation in combination of ethanol exposure in pregnant rats. Results showed that prenatal choline supplementation attenuated the effects of ethanol on birth weight, teeth emergence, and most behavioral measures. Interestingly, behavioral performance of ethanol exposed pups treated with choline did not differ from the control group (Thomas et al., 2009; Zeisel, 2011). Moreover, blood alcohol concentrations were unchanged by choline supplementation.

Pattern, Brocardo & Christie (2013) found that omega-3 can restored glutathione levels and prevented oxidative damage caused by prenatal ethanol exposure in rats. An omega-3 enriched diet from birth until adulthood increased the levels of fatty acids and reduced oxidative stress from prenatal alcohol exposure in the dentate gyrus (part of the hippocampus responsible for memory and spatial coding) and cerebellum (responsible for motor control and cognitive function). In addition, Thomas, Idrus, Monk, & Dominguez (2010) showed that choline supplementation mitigates behavioral alterations associated with prenatal alcohol exposure in rats. Daily choline supplementation reversed spatial working memory deficits in rats that were exposed to alcohol in utero. Lending support to Thomas et al (2009) findings, Thomas et al. (2010) did not observe a decrease in blood alcohol concentrations with choline supplementation.

Sine Qua Non - Vitamin Supplementation Over Psychotropic Medication

Fetal alcohol spectrum disorder is a preventable public health problem that is the largest cause of neurodevelopmental disabilities, cognitive delays and behavioral problems (Bell & Chimata, 2015; Fuglestad, Fink, Eckerle, Boys, Hoecker, & Kroupina, et al., 2013). The findings presented here suggest supplementation with folate; choline, omega-3 and vitamin A during pregnancy or in childhood may attenuate or *reverse* deficits related to fetal alcohol exposure. Rather than administer psychotropic medication to children under six-years old who exhibit neurodevelopmental deficits as a result of ETOH in utero, vitamin supplementation is a valuable, safer alternative with minimal side effects that should be considered as first-line therapy. Unlike most pediatric medications where dose is based on the child's weight, psychotropic medications doses are not - leaving the health provider in a dilemma to find a safe, effective dose with minimal adverse effects. Psychotropic medication for children under the age of six changes the brain's neurotransmitter systems and the long-term effects are poorly understood (Fanton & Gleason, 2009). Furthermore, preschoolers metabolize most medications rapidly due to the hepatic activity during this developmental period (Fanton & Gleason, 2009) creating a wider window for serious adverse reactions.

Rally Packs Control ETOH Withdrawal

Vitamin supplementation to restore homeostasis for alcohol withdrawal is not a new concept in medicine. To ameliorate delirium tremens, patients receive benzodiapenzines (to treat psychomotor agitation), and an IV drip known as a rally pack (banana bags) containing thiamine (vitamin B-1), folate and a multivitamin supplements such as B1, B2, B6, nicontinamide and vitamin C (Kattimani & Bharadwaj, 2013) in isotonic saline with a 5% dextrose solution . Sometimes magnesium and / or potassium are added to the regimen depending on laboratory results and clinical presentation. Gastric malabsorption, chronic malnutrition and abnormal magnesium metabolism follows alcohol abuse. As a result, cellular damage from thiamine deficiency (Wernicke's Encephalopathy) may also be present in patients with chronic alcohol use. To lessen cellular damage, parenteral thiamine with glucose is administered.

References

Ballard, M. S., Sun, M., & Jo, K. (2012). Vitamin A, folate, and choline as possible preventive interventions to fetal alcohol syndrome. *Medical Hypothesis; 78,* 489-493

Bell, C. C. (2015). Prevalence of fetal alcohol exposure in low-income African-Americans. *National Association of County Behavioral Health and Developmental Disability Directors.*

Bell, C. C. & Chimata, R. (2015). Prevalence of neurodevelopmental disorders among low-income African-Americans at a clinic on Chicago's South Side. *Psychiatric Services*; 00, 1-4.

Blusztajn, J. K. & Mellott, T. J. (2012). Choline nutritional programs brain development via dna and histone methylation. *Central Nervous System Agents in Medicinal Chemistry: 12,* 82-94.

Fanton, J., Gleason, M. M. (2009). Psychopharmacology of preschoolers: a critical review of current conditions. *Journal of Child and Adolescent Clinics of North America :18* (3): 753-71.

Fuglestad, A. J., Fink, B. A., Eckerle, J. K., Boys, C. J. Hoecker, H. L., & Kroupina et al. (2013). *Neurotoxicology and Teratology, 39:* 128-132.

Holmes-McNary, M., Q., Cheng, W., Mar, M. Fussell, S., Zeisel, S. (1996). Choline and choline esters in human and rat milk and infant formulas. *American Journal of Clinical Nutrition:* 64, 572-576.

Ilcol, Y. O., Ozbek, R., Hamurtekin, E., Ulus, I., H. (2005). Choline status in newborns, infants, children, breastfeeding women, breast-fed infants and human breast milk. *The Journal of Nutritional Biochemistry: 8 (16).* 489-499.

Institute of Medicine, National Academy of Sciences USA. (1998). Choline. In: Dietary reference intakes for folate, thiamin, riboflavin, niacin, vitamin B12, panthothenic acid, biotin and choline. Washington, DC: National Academy press, p390-422. http://www.ncbi.nlm.nih.gov.proxy.cc.uic.edu/books/NBK114308/#!po=38.3333

Kattimani, S & Bharadwaj, B. (2013). Clinical management of alcohol withdrawal: a system review. *Industrial Psychiatry Journal, 22(2)* 100-108.

Meck W. H., & Williams, C. L. (2003). Metabolic imprinting of choline by its availability during gestation: implications for memory and attentional processing across the lifespan. *Neuroscience and Biobehavioral Reviews; 27,* 385-399.

National Institute for Alcohol Abuse and Alcoholism; San Diego State University. Choline supplementation in children with fetal alcohol spectrum disorders. In: ClinicalTrials.gov. Available from https://clinicaltrials.gov/show/NCT01911299 NLM Indentifier: NCT01911299

Thomas, J. D., Abou, E. J., & Dominguez, H. D. (2009). Prenatal choline supplementation mitigates the adverse effects of prenatal alcohol exposure on developmental rats. *Neurotoxicology Teratology: 31,* 303-311.

Werts, R. L., Van Calcar, S. C., Wargowski, D. S., & Smith, S. S. (2014). Inappropriate feeding behaviors and dietary intake in children with fetal alcohol spectrum disorder or probable prenatal alcohol exposure. *Alcohollism: Clinical and Experimental Research, 38* (3), 871-878.

Wozniak, J. R., Fuglestad, A. J., Eckerle, J. K., Kroupina, M. G., Miller, N. C., Boys, C. J. et al. (2013). Choline supplementation in children with fetal alcohol spectrum disorders has high feasibility and tolerability. *Nutrition Research: 33 (11),* 897-904.

Zeisel, S. H. (2011). What choline metabolism can tell us about the underlying mechanisms of fetal alcohol syndrome disorders. *Molecular Neurobiology; 44,* 185-191.

Zeisel, S. H. (2006). The fetal origins of memory: the role of dietary choline in optimal brian development. *Journal of Pediatrics: 149,* S131-S136.

Zeisel, S. H., Char, D., & Sheard, N. F. (1986). Choline, phosphatidylcholine and sphingomyeline in human and bovine milk and infant formulas. *Journal of Nutrition: 116*, 50-58.