OFFICE OF INSPECTOR GENERAL

Illinois Department of Children and Family Services

REPORT TO THE GENERAL ASSEMBLY

Pursuant to Public Act 88-0007

January 1995

Denise Kane
Inspector General

ILLINOIS DEPARTMENT
of
CHILDREN AND FAMILY SERVICES

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AND
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LETTER FROM THE INSPECTOR GENERAL

To the Governor and Members of the General Assembly:

A recent article in the Chicago Tribune reported that physicians who treat their patients with dignity and respect are less likely to be sued for malpractice. This bit of knowledge isn't surprising since societies in general function better when their members treat each other in a civilized manner. Yet, the basic civilities so necessary for our functioning appear to be driven into the background. This is particularly true in the field of child welfare.

The Office of the Inspector General has been contacted by biological, foster, and adoptive families who report that they have been treated in either an inconsiderate or mechanical manner by child welfare agencies and their employees. Prior to the existence of the OIG, these individuals received a bureaucratic response to their concerns that ignored the root of the issue, the child involved. There is something fundamentally wrong when children are lost in a system that is preoccupied with excuses for inertia and bad decision making.

The Office of Inspector General is taking a proactive role in demonstrating that this state of affairs can be changed. The development of the family conference model and mediation projects described in this annual report are examples of proactive initiatives that embrace permanency for children as the business of child welfare. While these projects are only in their early stages of development, it has become clear that many potential adoptive and biological families are capable of planning for the best interest of their children when given the opportunity and necessary support.

Close to fifty percent of the 41,161 children in care in Illinois are aged seven and under. In Fiscal Year 1994, only two percent of all wards in Cook County were moved to a permanent home through adoption. Thousands of children growing up without the stable roots of a family is a tragedy that none of us can afford to ignore. Presently, there are over three thousand children - nearly ten percent of all the children in care in Cook County - whose cases have been identified as appropriate for termination of parental rights, but whose adoptions are not proceeding due to a backlog of cases in the system in need of termination/adoption review to ensure that cases are adequately prepared for trial. In addition, at present, there is no review to determine whether the case could be more appropriately handled through family mediation, resulting in a consent for adoption or an uncontested trial, rather than through a lengthy and expensive termination hearing. In addition to the three thousand cases previously identified, more families who have had children in their care for years report that they are willing to adopt yet the children's cases remain in a limbo with no adoption

screening dates. The new Chief Judge of the Cook County Circuit Court, the Honorable Donald O'Connell, has committed to assigning as many judges as necessary to assist in moving these children into a permanent adoptive family. Director McDonald has removed artificial barriers to permanency by allowing children adopted through the OIG permanency initiatives to continue to be eligible for DCFS college cash assistance and scholarships.

I am confident that legislators will lend their support to make permanency a reality for many more Illinois children. However, this reality can only be achieved when child welfare caseworkers in both the public and private sector operate in good faith and infuse permanency planning into every aspect of their work with families. This good faith must be demonstrated through fundamental casework rooted in sound decision making and an investment in each child's future.

Moreover, professionals should follow the example set by extended family members in the Kinship Permanency Initiative. These family members collaborated in order to provide permanency plans for their kin; thus demonstrating that consents for adoptions can be mediated among family members without embitterment. Mediation eliminates the need for time consuming termination trials. Likewise, through the involvement and the support of extended families members, many fragmented families can be rehabilitated enabling children to return home to stronger families. It is up to us to reach out and elicit the help of extended family members.

Similar to the medical profession, within the field of child welfare there are developing technologies and unanswered questions. While there is no panacea for the array of problems within our child welfare system, these complexities must not cloud the basic and acceptable "good practices" which provide underlying social work principles and approaches to the majority of child welfare issues. Director McDonald has asked that the Office of Inspector General join Richard Calica of the Juvenile Protective Association in assisting the Department in articulating the foundations of good practice for child welfare in Illinois. It is critical that everyone in the child welfare system recognize and follow good practices.

Caseworkers who remain committed, perform competently, and think creatively in the face of bureaucratic adversities and monumental societal problems assure me that we can improve the lives of Illinois' children. I ask all the citizens of Illinois to join in our efforts to make a way for our state's most vulnerable population.

Respectfully Submitted,

Denise Kane
Inspector General

Preface to the Annual Report

The Office of the Inspector General of DCFS (OIG) has been in operation since July 1993. During the past 18 months, the OIG has gone through a period of rapid growth and development. In order to appreciate the development of the OIG it is necessary to consider a period of time extending past the boundaries of Fiscal Year 1994. This annual report will include information from November 1993 to November 1994 although some of this data is more properly classified as FY95 data. This report of the activities of the OIG includes recommendations made to the Director regarding employee discipline and systemic reform. In addition, an examination of investigative procedures, initiatives and studies sponsored by the OIG is contained in this report.

I. INTRODUCTION TO THE OIG

On June 24, 1993, Governor Jim Edgar signed Public Act 88-0007 into law, thus creating the Office of the Inspector General for the Illinois Department of Children and Family Services. The OIG fulfills a number of mandated responsibilities. The charge of the OIG is to investigate allegations of misconduct, misfeasance, malfeasance and violations of rules, procedures or laws by any employee, foster parent or contractor of DCFS.

The office responds to and investigates complaints filed by the state and local judiciary, foster parents, biological parents and the general public. Additionally, the OIG investigates deaths of all Illinois children with whom DCFS had prior involvement. At the request of the Director or when the OIG has noticed a particularly high level of complaints in a specific division of DCFS, the OIG will conduct a systemic review of that division. Investigations yield both recommendations regarding the particular subject of the investigation and recommendations for systemic changes within DCFS. Further, the OIG monitors compliance with all recommendations.

The Office of the Inspector General can be reached by telephone at **(312) 433-3000** and is located at **2240 West Ogden Street** in **Chicago,** directly across from the Cook County Juvenile Court building. The location, apart from other DCFS offices, promotes independence and objectivity and increases the OIG's ability to monitor efficiently investigations that are related to Cook County Juvenile Court. An adjunct Springfield Office is located at 406 East Monroe Street. The Springfield Office houses the OIG Foster Parent Hotline as well as two OIG investigators who handle down-state cases. The OIG Foster Parent Hotline is **1-800-722-9124.**

A. OIG/DCFS Vital Statistics

DCFS has experienced increased caller activity to the Child Abuse Hotline **1(800)252-2873.** As a result, Department of Child Protection (DCP) investigators, DCFS caseworkers, Purchase of Service (POS) agencies and caseworkers have witnessed increased demand for services. The OIG seeks to maintain the quality of services by fostering accountability and promoting responsible service provision.

- Nearly 550 complaints have been registered between January and December 1994. Approximately 131 of these complaints were initiated through the OIG Foster Parent Hotline. (See page 6 for a further discussion of the OIG Foster Parent Hotline.)

- There were 369,309 calls to the State Central Register/Hotline in FY94. DCFS has experienced a 28% increase in call volume since 1991.

- The total family/child caseload which includes intact families and non intact families for FY94 was 56,128. This number represents 54,130 total children. The amount of total children in active caseloads increased 39% from FY91.

- The total number of children placed in substitute care was 41,161 in FY94. This represents a phenomenal increase of 43% from just three years earlier when 23,777 children were placed in substitute care.

- DCFS licensed 29,451 total agencies and foster parents in FY94. Of this number, 16,939 were day care centers, day care agencies, day care homes, foster homes, group day care, group homes, relative foster homes and emergency shelters. The total amount of licensing for private institutions was 12,512.

- The total number of children in non-relative foster care in Illinois for FY94 was 13,861. There were 22,631 or 55% of all children in substitute care placed in the homes of relative foster care providers.

- The total number of adoptions in Cook County for FY94 was 523. This represents less than 2% of the total number of Cook County children in substitute care, 30,746. Other Illinois counties combined for a 5% adoption rate (514 of 10,415 children.) Over 3,000 cases have been identified as appropriate for adoption but are backlogged in adoption screening in Cook County.

B. Personnel

The OIG was originally established with three and one-half staff members - the IG, an administrative assistant, an investigator and a part-time attorney. Additional staff were hired incrementally. Current OIG employees include: the IG, an executive assistant, an 800-line and contractual administrative assistant, six full-time investigators and two attorneys. The OIG has contracted with nine specialists and three interns who provide the OIG with consulting services. The OIG has contracted with a copying company for two assistants to provide certified copies of case files and other documents used in investigations.

The OIG has experienced a number of difficulties assembling its professional team. In FY94 the OIG was operating on a limited budget. The State requirements of posting jobs, notifying individuals on the eligibility lists and conducting countless mandatory interviews to fill each position delayed the hiring process. It is not uncommon to have six months pass between the determination of a job opening and fulfilling the pre-hiring requirements of the bureaucracy. As a result, the IG's ability to develop an adequate staff to meet investigatory mandates has been hampered by the restrictive nature of the Central Management System's (CMS) job titles and the expanded duties of the OIG.

Additionally, the job titles created by CMS for DCFS do not match professional needs of a professional internal investigatory office. The existing titles do not allow for the hiring of a multidisciplinary team of individuals with the education and experience that prepares them to: analyze documents including medical records, mental health records, agency contracts, or caseworker notes; interview all professionals involved in a child's case; review applicable laws, rules, and procedures; and make individual and systemic recommendations that reflect good social work practice. CMS rules are designed to objectify the interview process, to ensure non-biased treatment. Though non-biased treatment of interviewees is a worthy goal, certain CMS rules prevent interviewers from realizing qualitative differences. For instance, it appears that CMS rules forbid interviewers from crediting a degree from one university any higher than that of another university or college. These and other bureaucratic attempts to impose objectivity on what is essentially a subjective process have hampered the ability of the OIG to hire the personnel it needs to operate.

While CMS guidelines restricted the IG from hiring the staff it needed, the role of the office expanded and necessitated additional staff. The OIG has been asked by the Director to investigate the Administrative Case Review process within DCFS. In addition, the Director requested that the OIG recommend changes in the system in order to ensure compliance with federal mandates and that the system

genuinely operates as an internal quality assurance program. The Director also asked the OIG to be involved in both developing recommendations for an overall reform of agency practice and procedure and proposing a system for monitoring private agencies that contract with the Department. These important efforts consume a large amount of the OIG staff's time and energy.

II. OIG INVESTIGATIVE PROCESS

In 1994, the OIG began to develop internal operating procedures to address its relations with the public and to codify its investigative processes. The procedures are still in draft form. The following information represents the basic developing outlines of the internal operating procedures for the OIG; their implementation depends on the ability of the OIG to hire additional staff. In October, the procedures were submitted to the Attorney General for comment.

A. Intake

An intake administrator reviews all complaints received by mail, telephone, or in-person and determines whether the child is in imminent physical danger or imminent danger of being removed from a placement or parent. If the child is in immediate danger, the intake administrator contacts the complainant and instructs the complainant to report the abuse, neglect or dependency to the Child Abuse Hotline. The intake administrator then assigns the case to an OIG investigator. If appropriate, the intake administrator contacts the supervisor and field manager to request a report to the DCFS Hotline. If the OIG declines to accept the Request for Investigation (RFI), the intake administrator will direct a letter to the complainant explaining the reason for declining to investigate.

If the child is not in immediate danger of removal or harm, the intake administrator instructs the complainant to complete a RFI and submit any related materials or documentation. Upon receipt of a completed RFI form, the intake administrator enters the complaint into the OIG database, opens a case file by number and acknowledges receipt of the complaint by letter to the complainant. After reviewing the RFI, the intake administrator determines the appropriate initial response:

- Assign to an investigator;
- Assign to other OIG personnel;
- Refer to Ombuds Office;
- Refer to other state agency;
- Refer to mediation;
- Refer to DCFS for investigation and monitor progress;
- Conduct investigation; and

- Decline to accept with statement of reasons.

The initial response is entered on the database. If the initial response was to refer the investigation to another office or agency, the intake administrator will maintain the investigation on open case status and monitor the referral. When the referral office or agency accepts the referral, the intake administrator either closes the investigation or maintains the investigation on monitor status.

B. Confidentiality

Both the information gathered during an investigation and the results of an investigation are confidential and are not disclosed to the public, including the complainant. While conducting investigations, care is taken to conceal the identity of the complainant. Any request for disclosure of information, reports or results outside the OIG, in connection with a referral or otherwise, are documented and must be approved by a supervisor. The OIG's reports are not distributed outside of the agency without the consent of the Inspector General.

C. Investigations

Cases are investigated chronologically according to the following priority levels:[1]

Level 1 - Investigations of violent deaths of Department wards.
Level 2 - Investigations where immediate intervention is required to protect the child or other children.
Level 3 - Investigations where intervention is required to assist the child.
Level 4 - Investigations into worker or private agency misconduct where the outcome of the investigation will not affect the child.

D. Impounding

The OIG is charged not only with investigating misconduct but also with the responsibility of conducting investigations "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." In order to conduct thorough investigations, investigators often must impound files. Impounding decreases the incentive and opportunity for individuals to tamper with pertinent records and ensures the accuracy and reliability of information.

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[1] Cases of an emergency nature, cases that can be completed quickly and cases that relate to another pending investigation or systems analysis, may be completed non-chronologically. Level 2 or 3 cases may convert to level 3 or 4 once intervention has been accomplished.

Once an investigator determines it is necessary to impound relevant DCFS or private agency case files, the investigator will consult with OIG supervisors and legal counsel. The DCFS office or private agency may be given advance notice of the OIG investigation. Whenever there is a risk that the files may be tampered with, however, the files are impounded immediately. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Additionally, individuals with a demonstrated need for information contained in files may make copies of the necessary portions of the files in the presence of the investigator. Impounded files are returned as soon as practicable.

E. Criminal Investigations

If evidence indicates that a criminal act may have been committed, the OIG will notify the Illinois State Police, Attorney General or other appropriate law enforcement agency. If another law enforcement agency elects to investigate, the OIG will close that portion of the OIG case referred but retain the case on monitor status. If the law enforcement agency declines to prosecute, the OIG file will be reopened.

F. OIG Report

The OIG's reports are submitted only to the Director of DCFS, pursuant to statute. The OIG report contains a summary of the complaint, a historical perspective on the case including a case history and detailed information about prior contact with DCFS. An analysis of the findings is provided along with recommendations. DCFS has 30 days to respond to the OIG's recommendations or initiate implementation of the OIG's systemic recommendations. POS agencies are given an opportunity to respond to recommendations before reports become public. All confidential information is deleted from reports before they are released to the public.

III. OIG FOSTER PARENT HOTLINE

In accordance with Public Act 88-007, a statewide, toll-free telephone number **(1-800-722-9124)** for foster parent access was installed in October 1993. Foster parents have called the hotline to request assistance in addressing the following concerns:

- Child Abuse Hotline information;
- Child support information;
- Foster parent checks for in-state and out-of-state foster parents;
- Youth College Fund payments;
- Problems accessing medical cards;

- Complaints regarding DCFS case workers and supervisors ranging from breaches of confidentiality to general incompetence;
- Special fees for out-of-state child welfare agencies;
- Requests for clarification of the statutory language, "best interest of the child;"
- Licensing questions; and
- General questions about the OIG.

Many calls also raised concerns that implied systemic problems. Therefore, the OIG is looking closely at agency rules and procedures to ensure that the best interests of the children of Illinois are served.

Since January of 1994, the OIG foster parent hotline has received 362 calls. Of those, 231 calls were either directed to other agencies or referred to various offices within DCFS. The remaining 131 calls resulted in OIG investigations, many of which resulted in recommended modifications to the policies and procedures of DCFS. Several foster parents and others who have utilized the hotline see the service as a valuable connection with DCFS to track the status of their case, receive regular updates and relay additional information.

In addition to foster parents, the OIG hotline has received calls from children in the system inquiring about what benefits they will be entitled to when they reach their college years. These children also voiced their concerns about their treatment while in DCFS custody. The hotline is an effective tool that enables the OIG to: communicate with concerned persons; respond to the needs of foster children; and to address the day-to-day problems that care providers often encounter.

IV. DEATH REVIEW

To fulfill its mandate, the OIG investigates all cases in Illinois in which a child has died, where the child was a ward of DCFS, the subject of an open abuse or neglect report or the subject of a closed abuse and neglect report within the last twelve months. There are approximately 200 such deaths each year. Death reviews were previously handled internally by the DCFS Administrative Review Team (ART). The ART completed four death review reports in fiscal year 1993.

The Inspector General intends to alter the focus of death investigations, the format for reporting the results of investigations and the process for recommending changes. In reviewing the reports of the ART, the OIG determined that the reports failed to address the breadth and scope of child deaths in Illinois. Current ART reports have been criticized by the Child Fatality Review Team because they tend to be overly technical - identifying non-compliance with particular rules and procedures without focusing adequate attention on underlying causes or formulating

recommendations for systemic change.

The prevalent over-emphasis on Department rules and procedures perpetuates the Department's isolation and fosters the belief that only Department employees are responsible for the well-being of children in Illinois. A more useful analysis considers whether practices should be changed so that Department employees, working with individuals from other disciplines, would be able to pinpoint situations in which death is a possibility or likelihood. By identifying the characteristics that have led to a death in the past and by utilizing the experiences of a variety of professionals, Department employees will be in a better position to prevent future deaths.

In investigating child deaths, the OIG works closely with the Cook County Child Fatality Review Team. The Review Team was established by a group of concerned professionals to study child deaths in Cook County. In April of 1994, the General Assembly provided a statutory basis for the Review Team's authority to assist the Department in protecting children as well as providing for the development of child fatality review teams throughout the state. The current Review Team is comprised of a group of highly skilled and committed professionals who meet monthly to bring their experience and expertise to bear in analyzing child deaths in Cook County. The Review Team includes physicians, law enforcement specialists, social workers, psychologists and other experts.

The presently established Review Team examines Cook County cases. The OIG is assisting in the development of additional Review Teams throughout the state and anticipates that these teams will be operating by the end of FY95. The OIG will ensure that all members of the Review Teams have access to the original sources of information in the case. If a particular death investigation requires expertise in an area not represented by the team, such expertise will be recruited to assist in that investigation. The Review Team's input is critical in assisting the OIG to analyze deaths categorically and to determine causation in particular cases.

The purpose of the review is:

- To identify the cause(s) of child deaths;
- To increase the effectiveness of child protection, public health, prevention, intervention, investigative and legal services;
- To share information about advances in the fields of investigation, intervention, prevention and the prosecution of child maltreatment;
- To improve public policy;
- To recommend a course of action to the DCFS Director and the Inspector General; and

- To identify trends and problem areas within DCFS that need to be addressed for the protection of children.

In developing this approach to utilizing the Review Team, the OIG considered the relative isolation in which DCP investigations are currently conducted. Often other disciplines can offer expert advice that is not within the realm of knowledge or training possessed by child welfare workers. Accordingly, the Review Team is assisting the OIG in developing a list of experts that can be called upon in the course of a DCP investigation. Rather than criticize investigators after the fact for their failure to utilize a comprehensive approach, the OIG, along with the Cook County Child Fatality Review Team, hopes to make such expertise readily available to the investigators.

V. RECOMMENDATIONS

An investigation will generally yield two types of recommendations. First, the OIG will recommend action to address the specific problem presented by the investigation. These recommendations include disciplinary action for particular employees, when necessary. Second, the OIG will examine the root causes of the problem and recommend systemic changes within the Department that may prevent the problem from recurring. During the past year, the OIG made the following recommendations to the Director:

A. Systemic

1. Foster Care Placement and Adoption Practices

The OIG investigated the policies, practices and procedures relating to foster care and adoption programs. This investigation revealed that the Department fails to utilize available resources to determine appropriate placement alternatives for a child. The number of annual adoptions for DCFS wards in Cook County is only 2% of the total population of children in substitute care. The Department is often the primary source of delay in adoption proceedings. Caseworkers and supervisors fail to consider the child's best interest in making adoption decisions and often arbitrarily discourage adoptions even when there is no other permanent option for the child.

One of the cases investigated by the Inspector General as part of the study of adoption practices involved two sisters who had been in the same foster home for seven years. Two years after placement, Department workers questioned whether the foster parents would like to adopt the girls. The foster parents stated that the wished to adopt them. Nevertheless, the girls were subsequently subjected to six bonding assessments and psychological evaluations due to the

adoption workers' position that the adoption should not proceed and her willingness to expend Department funds to support that position. In total, these evaluations cost over $9000. The Department paid for five of the six unnecessary evaluations and the Office of the Public Guardian paid for one. In addition to the expense of these assessments, the five year delay in proceeding to adoption resulted in continued casework and courtroom staff expenditures. More importantly, the girls were denied the security of knowing that they were a permanent part of the family. Instead, they were constantly questioned and observed by professionals regarding their most personal relationships.

In addition, the OIG investigation uncovered several instances in which the Adoptions Unit failed to advance adoptions or interfered with adoptions in derogation of agency rules and procedures. Specifically, a good deal of time and energy were spent in attempting to disrupt adoptions when non-significant problems were identified in the backgrounds of adoptive parents. As in other areas of investigation, the OIG found that Adoptions Unit personnel had become enmeshed in a bureaucratic application of rules and as a result were often incapable of a common sense application. In other instances, the OIG found that the Department rules providing that foster parents of one year or longer shall have preference over all others in adoptions, were methodically ignored.

The OIG found that the Adoptions Unit routinely interfered with transracial adoptions regardless of the length of time in which the child had been in the transracial placement and the harm to the child that may be caused by the disruption of placement. Additionally, the OIG investigation found that in determining the child's best interest, caseworkers often underestimated the harm to the child from disruption of placements.

The OIG made the following recommendations which are designed to facilitate more appropriate placement decisions and adoptions of children in DCFS care:

- Department personnel must adhere to the Rules and Procedures;
- Failure to adhere to the Rules and Procedures must be disciplined; and
- The Department must institute monitoring systems to ensure that upper level management personnel do not undermine Department policy.

The Director took these recommendations under advisement and has assured the OIG that an organizational restructuring of the Adoptions Unit will occur within the next 90 days.

The following recommendations from the investigation into adoption

practices have been, or are in the process of being, implemented by the Department:

- Within the first six months of placement, caseworkers should convene an Extended Family Conference to determine the best available placement for the child, to develop a permanency plan for the child and to explore voluntary surrender of parental rights, when appropriate. For a more complete discussion of the Family Conference Model see page 28.

- A move from a home should always be based on the determination that the child will be harmed more by staying in the home than by the trauma of moving. New training is being developed for caseworkers and supervisors which emphasizes the importance of permanency planning and minimizing the number of disrupted placements for children.

- Currently, there is no formal mechanism for workers assigned to the same home to share useful information. Therefore, when several caseworkers are assigned to a single foster home, the workers for each child should meet at the home of the children at least every six months. This meeting would provide support to the family and enable the exchange of information between the workers. Additionally, this sharing of information would facilitate the provision of wrap-around services to wards to help prevent future crises. The OIG is working with the Department in restructuring casework assignments and coordination of cases between workers.

- When a child has lived with a foster family for an extended time, extensive psychological or bonding assessments are not needed to determine whether the child is bonded to the foster family. Workers should possess the skills necessary to visit the home and properly assess whether the child is bonded to the family. When a child is indeed bonded to the family and the home meets the other adoption criteria, there is no need to expend Department funds for further bonding assessments. The OIG is working with the Department and outside experts to develop a protocol for identifying when bonding assessments and psychological assessments may be necessary.

- The Department must develop and implement an aggressive recruitment strategy for attracting minority foster and adoptive parents. Minority coalitions, as well as adoptive and foster parents, should be involved in the planning and implementation processes.

Additionally, the Department must identify specific barriers that prevent minority families from becoming foster and adoptive parents and then develop strategies that will break down these barriers.

- Respect and appreciation for foster parents must be built in to caseworker training.

- Nonbiased Foster/Adopt Review Panels must be created to hear disputed cases. These Review Panels must be composed of foster/adoptive parents, child-welfare specialists, psychologists and legal experts from outside and within the Department. These panels must be culturally and racially diverse. The OIG recruited Dr. Jeanne Robinson to develop such a panel to provide outside consultation for caseworkers and supervisors confronted with difficult foster care or adoption decisions. The caseworker will be asked to present the problem to the panel in an objective manner. A foster parent advocate will review the caseworker's presentation beforehand to ensure that a balanced picture is presented.

- Private agency contracts should contain adoption conversion clauses. This would allow agencies to convert automatically the contract from a foster care contract to an adoption contract in a particular case. This recommendation was made in accordance with the recommendation made by the BH Adoptions Panel.

- The OIG found that an inordinate amount of time and energy is spent in determining whether to grant adoption subsidies when, in the final analysis, subsidies are granted 96% of the time. The Department must adhere to its own guidelines and criteria when administering subsidies. Qualification for subsidy must be based on the criteria for the subsidy. If the child falls within the criteria, regardless of the means of the foster family, the child is entitled to the subsidy. This decision should be made by the Department's fiscal personnel rather than by the adoption administrators. The Department should assemble a Medical Review Board for subsidy decisions that require medical expertise.

- A major barrier to adoption identified by the OIG is the serious concern of potential adoptive parents about future expenses for undiagnosed mental health problems of the child that may manifest themselves at a later date. The OIG recommended that the Department convene a task force with representatives from the insurance industry, appropriate state agencies, adoptive parents associations and adoption

agencies to develop supplemental insurance mechanisms that will help the child and the family cover the cost of potential in-patient and out-patient mental health services.

2. Childcare Payment Services

The OIG received many complaints regarding late payments for day care services. Many of these complaints involved relative foster care providers who were experiencing difficulties in obtaining payment for their private day care providers. The complaints received in this office related directly to systemic problems within the Office of Child Development and the use of voucher payments for private day care providers.

The Office of Child Development assumed the responsibility for administering voucher payments for private day care providers. However, many private day care providers were ill-equipped to handle the extended delays in payment. The transition to coordinating and administering these payment services was poorly planned and consequently overwhelming to the staff. Additionally, an unexpected growth in the number of foster children requiring individualized payment services, combined with general request backlogs and departmental errors created extended delays in payment.

Moreover, many delays in payment resulted from the involvement of caseworkers in processing the paperwork required for the receipt of payment. Frequently the Office of Child Development did not receive the necessary paperwork from the caseworker until well after the provision of day care services had begun. The system operated with a blanket limit per provider per year and any payments in excess of this limit must be made pursuant to a contract with that provider. This requirement placed a further burden on the system since completing the paperwork and obtaining approval contracts were time consuming processes.

In an attempt to rectify the growing problems resulting from the systemic overload, the Office of Child Development began implementing an automated system. The automation process is now in progress; however, the Office of Child Development is experiencing payment processing delays due to the incompatibility of the old MARS/CYCIS computer system with the new Childcare computer system. The office staff had to enter payment information into the two systems.

The OIG in conjunction with the Office of Child Development have formulated the following recommendations for modifying the current system to meet the special needs of relative foster care providers:

- Either increase the blanket limit allowed per provider or convert it to a

per child limit, consistent with the Department of Public Aid policy, so that the need for contracts is decreased and additional administrative delays are avoided;

- Accelerate the computer programming efforts toward compatibility and single entry for payment processing, thereby significantly decreasing the processing time involved;

- For DCFS relative foster parents, implement a system where a special service fee is administered to the relative foster care provider so that the relative may pay the day care provider directly;

- For private agency relative foster parents, provide funds to private agencies who act as administrators for their foster parents and allow these agencies to make payments to the day care providers directly;

- Retain the voucher system for day care centers that are administered by large agencies that can accommodate delays in payment.

3. DCP Teams

The OIG recommends that the Central Office Deputy have line authority over specialist managers in each region who have direct responsibility for all Child Protection Services (CPS) teams. Additionally, the management matrix for the Department should include an accountability system for feedback between Child Protection Investigators (CPI) and Child Welfare Specialists (CWS) to ensure child safety and family support. Comprehensive services for children and families must be built within the context of the local community, in the area of Local Area Networks (LANS), to provide a unifying framework for building a quality assurance infrastructure. The Central Office Deputy will work with the Deputy of Operations to guarantee that accountability and feedback between DCP and CWS occurs.

Under this framework, each DCP team will be composed of six workers and one supervisor per team. Each team will require one clerical staff person. In addition, each team will have an assigned Community Risk Manager. The Risk Manager will be considered a hands-on manager and will perform the following functions for the team:

- Review appropriate investigations for possible deflection to community resources based on LANS, such as the Department of Mental Health and Developmental Disabilities, the Department of Health and Human Services or the Department of Drug Abuse and Substance Abuse.

- Determine the available resources within the community and assess which services are lacking.

- Advocate for targeted resources within LANS communities to prevent the need for protective custody.

- Assure that service development is closely linked with identified risk reduction.

- Coordinate a post-investigation staffing with the DCP worker, CWS (state or private) caseworker and family. This staffing should occur in the family's home. The CWS worker should be present when the DCP investigator explains to the family the need for services. This staffing should review the need for opening the case and allow participants to attempt to develop an amenable service plan. This negotiated plan would be in place, until a reassessment occurs, to alleviate the present crisis relating to the child's safety.

- In selected cases, a family conference should be convened. This should include extended family members, both biological and psychological, as well as a caseworker who would facilitate the development of a family plan for protection of the child. When appropriate, the caseworker should also encourage the voluntary surrender of parental rights.

- Ensure compliance with legislative and judicial mandates.

- Act as a liaison between DCP and deflection agencies.

- Monitor deflected cases or a stratified sample of a team's deflected cases to ensure continuity and implementation of needed services.

Furthermore, a stratified system of response should be developed in order to allow DCP investigators to adapt to the variety of complaints received. A stratified system of response would ensure the efficacy of investigations, particularly responses to serious allegations of risk of harm and death cases. Each team should have a system of applied training and consultation similar to the model being developed in Cook County by the Juvenile Protective Association.

This training must include a focus away from an "incident" approach to an integrated, comprehensive and long-term welfare approach to children and their families. Additionally, through the local LANS system, a confidential pro-bono professional review team should be developed where mandated reporters can

present concerns regarding disagreements with DCP investigations. At present, the OIG is working with outside professionals to include these recommendations in the plan to reform the current practices and procedures of the Department.

4. Cellular Phones

The Director requested that the OIG investigate the practice of DCFS employees acquiring cellular telephones with the understanding the Department would reimburse them for all DCFS related calls. Some workers had initiated attempts to obtain cellular phones from one company rather than from another company which had already established corporate rates that applied to all state employees.

The OIG investigation revealed that caseworkers and investigators often need to be able to contact their supervisors for immediate consultation. Yet this is not always possible due to the unavailability of public telephones in many areas of the city. The OIG recommended that because of the necessity of immediate contact and the fact that workers are often unable to access public telephones, workers should be allowed to use their cellular telephones for official DCFS business and should be reimbursed for the expense of those work-related calls.

Further, the OIG recommended that DCFS management design a mechanism for facilitating communication between field and management personnel. The OIG suggested the implementation of a suggestion box through which workers could give honest feedback to management.

5. Confidentiality Issues

The OIG has received complaints regarding improper disclosure of mental health information and improper access to confidential DCFS files by both DCFS and private agency workers. Further investigation revealed that many workers are confused about the application of confidentiality rules in day-to-day practice. In addition, confidentiality rules do not allow for sharing of confidential information among professional consultants. In response, the OIG developed a new form for consent to release of information that provides workers with instructions on the back of the form to guide them in the daily use of consent forms. In addition, the OIG recommended a joint panel of DCFS and mental health professionals be convened to address redeveloping the laws surrounding disclosure of mental health information.

Further, the OIG recommended that DCFS administrative personnel should be cautioned about releasing information to individuals who do not have authorization for access to confidential information. The OIG also recommended clarification of

procedural operations with respect to the hiring of employees with past accusations of child abuse and how such allegations should be assessed.

6. Provision of Services

An officer of the court requested an investigation by the OIG regarding the lack of counseling services provided to a ward who was the suspected victim of sexual abuse. The ward had been in the care of DCFS for 3-1/2 years and had received no counseling services. Upon entry into the system the ward did receive a psychological evaluation that revealed he was a poorly oriented child, however, no evidence of sexual abuse was found. The ward was placed in specialized foster care.

The OIG recommended that the ward be referred for counseling services immediately. Current evaluations of the ward do not reveal any dysfunction relating to issues of sexual abuse or any other area. The OIG recommended that the private agency workers and the other contracted workers be monitored periodically to determine if the services provided to clients are appropriate and timely. The OIG also recommended that in developing client services plans, DCFS workers and supervisors should focus greater attention on whether the services match the client's needs. Moreover, DCFS should employ a case transfer system which ensures case continuity between workers and clients.

B. Disciplinary Action

The OIG recognizes that a large portion of DCFS and private agency workers and supervisors are committed, hard-working individuals, who perform a tremendous and extremely difficult job for the children of Illinois. Decisions to discharge a particular worker are not made lightly. The disciplinary process can serve not only to remove inadequate employees from the job ranks, but also as an educational tool, to assist all employees to achieve high performance standards.

The disciplinary process generally consists of increasingly severe penalties for inadequate job performance. Therefore, discipline is administered in stages. For the first incident reflecting poor performance, discharge will only be recommended in extreme cases. The low number of discharges recommended and affected by the OIG reflects this progressive system for disciplining employees. In addition, other issues may influence the OIG's ability to recommend discipline. Misconduct in a particular case may be due more to systemic problems such as poor training, high caseloads or poor supervision. Moreover, a supervisor's failure to discipline the worker in the past may impede the Department's ability to discipline the worker when the OIG learns of past misconduct.

1. Termination of Employment with DCFS

a. Child Protection Investigator

The OIG received a complaint that a Child Protection Investigator had abused his power for personal gain, falsified time records in order to obtain over-time payment and engaged in a sexual relationship with a client. The OIG investigation revealed that the DCP investigator was previously assigned as the investigator on the client's Child Abuse and Neglect case. In addition, while the client was legitimately qualified to receive Norman Funds to assist her in securing housing, the DCP investigator represented to the client that he was using his position to circumvent the system for her and that he could lose his job if his actions were discovered.

The DCP investigator took the client to a hotel room which he acquired at a discounted state-rate by presenting his government identification card. The DCP investigator proceeded to charge this hotel visit to DCFS. In addition, the DCP investigator received overtime payment for the time he spent there.

The investigation fully substantiated these allegations. As a result of these findings the OIG recommended immediate discharge of this employee. The worker was formally discharged, however, at the fourth level of the disciplinary appeal process Central Management Services (CMS) accepted a resignation from this worker in lieu of discharge.

b. Caseworker

The OIG, pursuant to a court order, conducted an investigation of a complaint of malfeasance of a caseworker. The complaint alleged that the DCFS caseworkers involved with the family had failed in their responsibility to service, monitor, and report to juvenile court regarding the status of the children and birth parents.

The OIG recommended that prior to closing a case, written documentation should include an analysis of the initial issues surrounding the neglect or abuse with respect to the current functioning of the family. While the original caseworker's performance was inadequate, the OIG did not recommend discipline or discharge since the caseworker had an extremely high case load that prevented her from properly servicing the family. Additionally, her job performance with respect to her other cases was good.

The OIG recommended, however, that the subsequently assigned caseworker be discharged. This recommendation was based on his consistent mishandling of cases. This caseworker had a history of inappropriate behavior, of failing to service his cases adequately and to document his casework properly. Additionally, he consistently demonstrated a poor work attitude. This worker was discharged. He is presently appealing the discharge.

The OIG also recommended that both supervisors be trained to administer proactive clinical supervision and that supervisors be conversant in disciplinary procedures. The OIG recommended that the supervisor should be disciplined for his failure to follow disciplinary procedures. This supervisor received a one day suspension. Although the OIG recommended that the subsequent supervisor be disciplined for failing to supervise the caseworker properly or to monitor his performance, the subsequent supervisor was not disciplined. The OIG also recommended that the Department evaluate its promotion procedures to ensure that any employee, having just completed a disciplinary suspension, is not promoted until the employee demonstrates that the problems giving rise to the suspension have been eliminated.

c. The Wallace Case

The first case investigated by the OIG was DCFS involvement with a family prior to the brutal death by hanging of three year old Joey Wallace. The OIG recommendations in the case were issued in a July 1993 report. The substance of the Wallace investigation and recommendations were included in the FY93 final report. However, the appeal process for some of the employees recommended for discipline extended into FY94. The OIG recommended that one caseworker be discharged with respect to the Wallace case. In addition, the OIG concurred in the decision to discharge one supervisor and one administrative case reviewer. To date, the Department and the OIG are awaiting a final decision from the appeal arbitrator regarding the caseworker and one supervisor. The other supervisor's termination has been upheld by the arbitrator.

2. Suspension / Probation

a. Falsified Employment Applications

The OIG encountered an instance where an employee had falsified her applications for employment and promotions with the Department. On three occasions this employee lied about her educational status. The OIG recommended that this employee not only be suspended but also demoted.

The employee was given a 20 days suspension.

b. Child Protection Investigator

Following the death of a ward of DCFS, the OIG conducted an investigation into the judgment of a Child Protection investigator and his compliance with established DCFS procedures. The investigation revealed that the investigator had recently completed training and was not receiving appropriate supervision. The investigator had previously investigated three reports on the infant, one including a spiral break of the infant's femur. The investigator, however, neglected to interview the reporting physician involved in this case. Additionally the investigator failed to conduct a thorough review of the hospital records or to assess the household for risk factors.

The family under investigation was the subject of a previous CANTS report which stated that members of the household had a propensity for violence. Despite these strong indicators of substantial risk to the child, the investigator determined the report to be unfounded. The investigator allowed the child to remain in a dangerous environment which resulted in the child's death.

The OIG recommended that this investigator be continued on probation with close monitoring for six months. The investigator was placed on an extended probationary period. Additionally, the OIG recommended that the supervisors involved receive written reprimands for failing to supervise a new employee properly. These supervisors were subsequently required to participate in counseling.

The OIG also recommended a review by the Cook County Child Fatality Review Team of the hospital involved. Although noting that the child's spiral fracture was suspected abuse, the attending physician failed to request a full skeletal x-ray of the infant. The Child Fatality Review Team requested a meeting with the hospital administrators regarding the inadequacy of their present practices and procedures for documenting and evaluating suspicious injuries. To date, this hospital has not responded to the authority of the Child Fatality Review Team.

c. Caseworker - Child Welfare Specialist II

The OIG received a complaint of nonfeasance regarding a caseworker who had not properly filed a neglect petition in court. Repeated attempts to contact this caseworker to rectify the deficient petition were unsuccessful.

Additionally, the caseworker had screened in two children but had failed to screen in the remaining sibling who was exposed to identical risks.

The investigation revealed that the caseworker's paperwork was so substandard that a new caseworker could not properly service the family. Moreover, the caseworker failed to perform the basic duties of a child protection investigator. This inadequate performance level resulted in direct harm to DCFS wards. The investigation also revealed the supervisor was aware of the caseworker's poor performance but failed to follow through with threatened disciplinary action.

The OIG recommended the caseworker be discharged. A pre-disciplinary hearing regarding this recommendation is pending in this case. In addition, the OIG recommended that the supervisor be given further training on implementing disciplinary rules.

d. Caseworker

The OIG investigated an allegation of sexual abuse raised by two wards of DCFS. The children alleged that their former caseworker's spouse had sexually abused them. This investigation revealed that although the children were no longer assigned to her, the original caseworker arranged for placement of the children in the home of her cousin. The caseworker visited the children often and the children frequently stayed the night at the former caseworker's home. Additionally, the former caseworker allowed her spouse, who had been previously convicted of aggravated criminal sexual assault of a minor, to have access to these wards.

The investigation revealed that the caseworker not only violated her professional duty to protect DCFS wards but also placed these wards at risk of harm by allowing her husband, a convicted child molester, continued access to children over whom she had both authority and power. The caseworker provided the opportunity for her husband to harm these wards. The OIG recommended that this caseworker be immediately terminated. The caseworker has been discharged and is currently appealing this action.

Furthermore, the OIG recommended that DCFS adopt a Code of Conduct which establishes minimum standards of behavior expected of Department employees and that these standards must be legally enforceable. DCFS should adopt a Code of Ethics that reminds employees of their professional responsibilities in both protecting children and strengthening the institution of the family. Further discussion of the OIG's work on the Ethics Panel is on page 31.

3. Referral to Personnel for Further Action

a. Inappropriate Placement of Children

The OIG investigated a complaint alleging that office politics and personal biases in a field office had interfered with the appropriate placement of two siblings. Additionally, the complainant asserted that her attempts to challenge these decisions resulted in the loss of her job and the damage of her reputation as a foster mother.

The OIG investigation revealed that the actions of the experienced caseworker (CWS III) involved in this case constituted misfeasance. The caseworker failed to perform her duties by neglecting to inform the Interstate Compact of the children's special medical needs and their entitlement to special educational services. As a result, she jeopardized the health and well-being of the children and infringed on their rights to educational services. Additionally, in court, the caseworker failed to inform the judge of the mother's continued violent behavior and her inability to give appropriate care to the children during visits. Although the caseworker had not completed a relative home study, she prematurely attempted to move the children.

Since no emergency existed in this case which required an immediate change of placement, the caseworker's failure to explore all avenues of placement for the children and to properly assess their present placement constituted misfeasance. The OIG referred this case to Personnel and recommended appropriate disciplinary action for the caseworker. The caseworker resigned before any disciplinary action was instituted.

Additionally, the supervisor in this case was recommended for disciplinary action because she neglected to properly supervise the caseworker. This failure to responsibly supervise the caseworker resulted in the above endangerment of the children. Therefore, the supervisor was referred to Personnel for appropriate reprimand. The referral to Personnel resulted in the supervisor being required to participate in counseling.

b. Falsified Employment Application

It was called to the OIG's attention that DCFS had hired a former probation officer who had been fired. This employee had falsified his employment application to DCFS. As a result, the OIG recommended that

this employee be terminated. Additionally, the OIG made a general recommendation that Personnel conduct a timely verification of all new employment and promotion applications and conduct a thorough review of personnel records. CMS conducted a hearing of this case and the worker was not terminated. The worker went on to become the subject of a subsequent OIG investigation, described above in 1.a. As a result of the subsequent investigation, the OIG again recommended discharge.

c. Child Protection Investigator

Following the death of a ward of DCFS, the OIG conducted an investigation into the judgment and compliance with established procedures by the Child Protection investigator. The investigation revealed that the investigator had made several serious omissions in the course of the performance of his duties. The investigator failed to secure hospital records for the child although the biological mother had signed the necessary consent forms. The investigator also neglected to confer with the child's treating physicians. Contacting collateral professionals involved with the child is a basic requirement for an adequate investigation.

Moreover, the investigator inappropriately determined the C/D sequence allegations of physical abuse and substantial risk of physical injury to be unfounded. As a result the investigator allowed the child to remain in an extremely dangerous environment. This decision resulted in the child's death.

The OIG recommended that this investigator and his supervisor be referred to Personnel for discharge. These employees were terminated and their terminations were upheld following arbitration. In addition, the OIG emphasized the need for proper training of investigators so they may conduct complete investigations and accurately assess risks. The OIG recommended that the Department develop a system for securing hospital records in abuse investigations to rule out the possibility of prior injuries.

d. Child Protection Investigator

In an investigation of a death of a ten year old severely emotionally disturbed child, the OIG found that a DCP investigator had advised the mother of the child that corporal punishment was allowed so long as no marks were left on the child. The OIG recommended that the investigator be suspended and study numerous articles on the effect of corporal punishment on children, specifically with regard to severely emotionally disturbed children (provided by the OIG). The recommendations of the OIG were implemented.

e. Caseworker - Child Welfare Specialist

The OIG was asked to investigate an allegation that a caseworker was neglectful in her duties. The complaint alleged that the caseworker had failed to notify the judge or other officer of the court of the mother's intention to leave the state with the children in violation of a court order.

The OIG investigation revealed that the caseworker had knowledge of the mother's intention to leave that state for several months and did not inform the court of this intention. Moreover, when the caseworker learned that the mother had in fact left the jurisdiction, the caseworker did not notify the court. The caseworker also failed to complete an Interstate Compact in a timely manner.

The OIG notified the caseworker's supervisor of the above omissions and the supervisor instituted disciplinary proceedings against the caseworker. The OIG supports the supervisor's decision to pursue disciplinary action. Additionally, the OIG recommended that the caseworker be charged with a violation of Rule 305 for not promoting a partnership between the juvenile court and the Department and for not making the court aware of the mother's intention to leave the state in violation of a court order. This caseworker was given a one day suspension.

C. Falsified Credentials

In conducting its adoption practices investigation, the OIG discovered a suspicious report written by an individual claiming to be a "Dr." Further investigation revealed that the individual had never received a Ph.D. In addition, the OIG discovered that in other cases, the same individual had submitted documents, signing off as a clinical psychologist and claiming to be a member of the NCC (a national certification for counsellors.) The individual was neither. The OIG referred the case to the Public Integrity Unit of the States Attorney's Office. The States Attorney's Office is currently considering the case for prosecution. The Department is no longer contracting with this individual.

D. Investigation by Special Request of the Governor

Governor Edgar requested that the OIG conduct a complete review of the case of the nineteen children discovered unattended in a Chicago apartment to determine the adequacy of the initial DCP investigation. The OIG reviewed all the records regarding these children, including DCFS records, school records and hospital records. In addition, the OIG coordinated its efforts with the Department of Public Aid and the Illinois State Police.

The OIG review revealed that the DCP investigation was poorly conducted. The OIG noted that the Child Protection investigator assigned to the case failed to follow DCFS procedures and recommended that she be discharged. This discharge was subsequently implemented and is proceeding through an arbitration appeal.

The OIG made several general recommendations with respect to cases involving a number of children with varying needs, including developmentally delayed children and sibling groups. The OIG recommended that DCP procedures should require collateral contacts with the programs or schools (0-3, Head Start, state Pre-Kin, and special education) these children attend, or should be attending, to assess the adequacy of the parents' follow through regarding these special needs. When siblings of a reported child are or have been in care, the investigator should contact assigned POS and DCFS field workers and gather information on the family as part of their investigation.

Moreover, investigators should inquire regarding all family members, including fathers, grandparents, aunts and uncles and prepare a genogram to illustrate the relationships. This ensures that family members who are a visiting or placement resource are identified at the front end. DCFS should also access criminal records when they are relevant to an investigation. (Pursuant to the OIG's recommendations, DCFS now has access to criminal history contained in the LEADS System, maintained by the State Police.)

With respect to the cocaine positive baby born to one of the mothers, the OIG recommended that this baby's case should proceed immediately to adoption screening on the grounds of habitual addiction. This was the mother's third cocaine baby, three of her other children were already in care due to her substance abuse. These other children were in the process of proceeding to adoption screening.

Due to allegations of sexual abuse made by the three children who had previously been in care (naming an aunt, grandmother, siblings and cousins as perpetrators) the OIG recommended that all the children be evaluated regarding their possible victimization. This evaluation was conducted at LaRabida. None of the children acknowledged sexual abuse during the evaluation.

The OIG recommended that the older child be provided a sex offender specific evaluation due to allegations by his siblings that he had sexually abused them. He denied being sexually abusive to siblings and cousins but admitted being physically abusive. The evaluation determined that the child was in need of developmental disabled services.

Furthermore, the OIG recommended that DCFS not spend resources to assess the maternal grandmother due to the fact that three children who had been placed with her had been removed. She had apparently misused DCFS funds during that time and continued to receive Public Aid for a child who was not in her home.

The OIG investigation revealed that the paternal grandmother of one of the children involved had tried unsuccessfully to engage community agencies and DCFS to help her become custodian of her grandson. Based on this knowledge and the community reaction to this case, the OIG met with community leaders. In response to this meeting, the Department agreed to fund a pilot program through Lawndale Christian Community Health Center which will offer mediation services to families in crisis.

E. Private Agency Reform

The OIG investigated a residential treatment facility for children in the southwest region of the United States at the request of an Illinois resident whose adopted child had been placed there and had run away. The child was located by the OIG investigator. The investigation revealed that the Department was contracting for substandard services with out-of-state agencies. Because of its concern for all of the Department's children placed out-of-state, the OIG launched an investigation to discover whether other agencies in other states were, in fact, equipped to accept placements from the Department. The OIG investigation revealed that the Department cannot effectively manage children placed out-of-state due to a lack of critical decision-making, contracting and contract monitoring mechanisms. This is especially troubling given the monumental growth of the Department's expenditures on out-of-state placements in the last four years. See Graph, attached hereto as Appendix A.

Among other findings, the report revealed that the current separation between the programmatic and financial audits of contracts assures woefully inadequate contract monitoring by the Department. It is clear that both the programmatic and financial audits must be combined in order to ensure that the best interests of the Department's children are protected.

In addition, during the last year, the OIG investigated programmatic concerns at two major in-state private agencies. The OIG found that there was often an overemphasis on form rather than substance in these agencies which was perpetuated by the Department's review of these agencies. While three divisions in DCFS have been devoted to "overseeing" private agencies (Contracts, Licensing

and Program Review), none conducts a qualitative assessment of the programmatic components within the private agencies. Recently, the Office of Program Review was eliminated. The OIG, with the help of outside consultants, is assisting the Department to develop a proposal for a private agency monitoring system that will examine and monitor private agencies in a meaningful way.

In the first agency studied, the OIG worked with an outside consultant to examine private agency's practices from the perspective of a child caught in the system. The child's story, attached hereto as Appendix B (with fictional names), dramatically illustrates the effects of failure to envision permanent plans for children at the outset.

The OIG also conducted an investigation of a private agency in which a child died last year. The investigation confirmed that the agency had developed a practice of prescreening abuse and neglect allegations prior to calling the Hotline. In addition, the investigation found that clinical personnel, charged with overseeing the delivery of treatment services, signed treatment plans without knowledge of components of the plans. The OIG contracted with a consultant to review the programmatic components of the agency's therapeutic group homes. The consultant found several serious deficiencies in the staffing, structure and substance of the therapeutic programs.

The practices of this private agency, though correctable, called into question the judgment of the agency leadership. The OIG recommended that DCFS not enter into a new contract with the agency until it could demonstrate adequate leadership and that it was capable of introspection and reform. The OIG also recommended that the agency contract with recognized experts to develop adequate programming and staffing to serve the needs of DCFS wards.

Many of these aforementioned recommendations represent a collaborative effort between the members of the OIG staff, Department personnel and other agency employees. The OIG is also involved in making case specific recommendations in order to resolve individual problems within the system, such as difficulties with adopting a child or visitation issues in a particular case. In addition, several complaints have resulted in a determination that no misfeasance, malfeasance or nonfeasance occurred. In this report, however, the OIG has included examples of case recommendations that portray the variety of subject areas the OIG has encountered. The OIG has focused on instances of agency or Department personnel misconduct and the far-reaching reforms the OIG has recommended.

VI. OIG INITIATIVES

A. Mental Health Task Force

The tragic death of Joseph Wallace revealed serious problems in the capacity of State agencies to collaborate with each other. Collaboration is essential to evaluate mental health appropriately and to share information. A cooperative approach ensures the health, well-being and safety of children of mentally ill parents who pose a risk of abuse or neglect. A Mental Health Task Force was formed to examine the relationship between DCFS and the Department of Mental Health, to identify major problems and to recommend solutions for these problems. In addition, the Mental Health Task Force, formed by the OIG in the wake of the Joseph Wallace investigation, agreed to act as a consulting panel to address difficult social work dilemmas concerning mentally ill parents or children.

The Mental Health Task Force (MHTF) is chaired by Dr. Boris Astrachan of the University of Illinois at Chicago and is composed of mental health professionals from both academic and private practice. The MHTF issued a final report to the Governor in May. 1994. The final report is attached as Appendix C. The first screening clinic with a parenting assessment team is in the process of being established and has received its first referral from the Department. A summary of the recommendations of the MHTF is set forth below.

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

- Develop three to four screening clinics in Cook County, to assist DCFS workers in promptly evaluating level of risk in ambiguous or complicated cases involving mentally ill parents.

- Develop Parenting Assessment Teams to perform comprehensive, methodologically sound, non-adversarial assessments of parenting capabilities and risks for use by the courts and DCFS. The parenting assessment teams should be connected to the screening clinics.

- Use the Thresholds Mothers' Project as a model for intensive case management programs for mentally ill parents who could achieve adequate parenting skills with appropriate psychosocial rehabilitation and treatment.

- Create a State Academy to train child and family welfare specialists.

B. Family Conference Model

The Inspector General has long seen the need to have the extended families of children in care involved in creating a plan for their protection and nurturing. Approximately 55% of the children in custody are already placed in the home of a relative. Extended family is defined broadly to include family members and others who play an important role in the life of the family, such as godparents, pastors or supportive neighbors.

A leading model that involves the extended family in developing a protection and care plan for their children was enacted by the New Zealand legislature. This legislation is known as The Children, Young Persons and Their Families Act (1989). The centerpiece of this Act is the family group conference. The family conference model is designed to involve the extended family in developing a solution to the family problem. The Family Conference Model focuses on empowering extended families to provide for the protection and well-being of children judged to be at-risk of abuse or neglect.

In January of 1994, the Inspector General began to adapt New Zealand's model for Illinois. The Illinois model involves all extended family members who meet with a mediator. Together the family members and child welfare agency officials make decisions about the future living arrangements for children who are at risk of coming into care. This approach allows the family to maintain some degree of neutrality and confidentiality.

Utilizing this model, the OIG has initiated the use of family conference methods within the DCFS system in the following ways:

- Kinship Permanency Planning

This project was initiated by the OIG and has evolved into a partnership including the University of Chicago School of Social Service Administration, the United Charities Legal Aid Clinic, the Chicago Bar Association in conjunction with the Expedited Adoption Program of the Children & Family Justice Center of the Northwestern University Legal Clinic, the Department and the Governor's Special Counsel. The partnership provides an opportunity for permanency for children who have been placed with relatives for many years. These relative foster parents are interested in a permanency plan for the children in their custody and many are interested in adopting the children. By involving the extended family in the decision making process and allowing parents to consent to adoption by specific individuals, it is hoped that many biological parents will voluntarily consent to adoption, obviating the need for time-consuming, expensive and often embittering termination hearings.

Initially the project is available to 150 relative foster families that were identified as appropriate for adoption or other permanency options other than long-term foster care. The families were pre-screened by private contracting agencies which reviewed relative foster families where children had resided for more than one year. These families are provided with the opportunity to meet with a mediator and create a plan for permanency for the children in their custody. Twelve families have begun the mediation process and an additional twelve are scheduled to begin in January, 1995. The majority of the families currently in mediation are proceeding toward adopting their relative foster children. A sample case follows:

> The family conference was attended by the grandmother, her granddaughter and the Department worker. The grandmother is the relative caretaker to her great granddaughter, age 12. The granddaughter has 3 siblings in care, one with a non-relative foster parent and one with another relative.
>
> One of the tasks agreed upon at the first session was that the granddaughter would try to encourage the children's mother (her sister) to attend the next family conference session, although she was not enthusiastic that there would be a positive outcome. The children's mother did attend the next family conference session and the DCFS worker candidly told the mother what DCFS would pursue in Juvenile Court. Although the mediator had to refocus the discussion from time to time, the discussion was directed toward the future of the children, not what anyone had done right or wrong in the past.
>
> One of the tasks agreed upon by the mother was to attend the permanency planning court hearing scheduled on the next day and to consider carefully her options. As a result of the mediation, she attended the permanency planning hearing the following day and signed surrenders/consents for all four children.

The key elements for success in the above mediation, as identified by the mediator, were:

- The family successfully engaged the necessary family members;
- The caseworker was persistent and forthright; and
- The mediation focused on the future and not the guilt of the past.

As this project developed it became clear that the Department's approach regarding 'surrender' vs. 'consent' needed to be reviewed. New consent forms were created that allow parents to consent to adoption by a specified individual. In the past, the only alternative to termination hearings was to require surrender of parental rights to the Department without the ability to designate the adoptive

parents. This policy created a significant disincentive for biological parents to consent to adoption. In response to this project, Director McDonald recently released a directive that reinforces the Adoption Act's empowerment of Department workers to take consents.

Adoption may alter the child's eligibility for financial aid for post-secondary education. To ensure that these financial ramifications do not deter adoptions, Director McDonald has approved continued stipends for children adopted through this project who attend college and continued eligibility for DCFS scholarships.

- Family Conference Project in Local Communities

This project grew directly out of a case referred to the OIG from the Governor's office (page 24) and the need for the Department to work cooperatively with community agencies. Two community sites are scheduled for family conference projects, one in the Lawndale community with the Lawndale Christian Community Center, on the west side of Chicago, the other in Champaign/Urbana. These projects will be run directly by community agencies and will offer family conference services to cases that come in through the hotline and from the community as well. Mediators indigenous to the community will be chosen by community agencies and will be trained and monitored by the Center for Conflict Resolution and Resource Alliance, Inc.

- Family Conference Methods for Specific Cases

The OIG has been contacted by attorneys, biological parents and foster parents who are aware of this model. These parties have requested the opportunity to resolve their permanency and adoption issues by using this approach. In response to these requests, the OIG has referred these cases to the family mediation project.

C. Ethics

A number of requests for investigation made to the OIG did not raise issues of misfeasance, malfeasance, or nonfeasance, but did raise professional, ethical issues. This prompted the need to address ethical issues through the development of an ethics program. Developed by OIG, the program's purpose is to reinforce the responsibilities of each child welfare worker. These responsibilities are based upon the core values of the field and each worker's implicit acceptance, upon entering the field, of the special professional nature of his or her relationships with clients, colleagues, DCFS contracting agencies, foster parents and society.

This is a three-pronged program which involves: (1) the drafting of a Code of Ethics which will set forth good practice principles for caseworkers, managers and

administrators; (2) the creation of a central Ethics Panel which will address ethical issues brought to its attention and provide a forum for child welfare workers confronted with ethical dilemmas in their daily practice; and (3) the creation of a continuing field education program offering area offices the opportunity to develop a consistent awareness of the ethical dimensions of their work. Brown bag lunches, discussions of relevant literature and area ethics committees will be part of this field education effort.

Since October 1994, the OIG ethics staff has been engaged in a research and interviewing process to gain a thorough understanding of the child welfare field's practice principles and the inevitable value conflicts, ethical dilemmas and ethical issues which arise in practice. "Inevitable" value conflicts and ethical dilemmas exist when a professional must choose between two or more compelling and legitimate responsibilities. For instance, a promise of confidentiality to a client may conflict with the responsibility to protect the client from harm. Moreover, an ethical conflict might arise when following agency policy is not in the client's best interest.

A case can, however, involve an ethical issue without posing an ethical dilemma. For example, a DCFS caseworker can also be a foster parent. As a caseworker she might be required to monitor the contracting agency through which she is licensed. Or, perhaps the caseworker is presently the foster parent for one child when she has previously been the caseworker for that child's siblings. This blurring of roles within the child welfare field which results in a lack of objectivity.

At present, the Department does not have any procedure or mechanism for recognizing and resolving conflicts of interest. A Code of Ethics for the Department is necessary to address these areas of ethical conflict. A Code of Ethics will accomplish the following:

- Provide a statement of the child welfare field's values and practice principles that will be subject to professional and public scrutiny.
- Ensure consistency in case evaluation and decision-making.
- Encourage child welfare workers to reframe their perspectives on practice issues.
- Add value and principle dimension to basic casework and policy formulation procedures.

Since DCFS contracting agencies will be expected to adhere to the proposed Code of Ethics, the ethics staff has also been working closely with several representatives from private agencies. These agencies share the goal of developing a comprehensive approach to child welfare ethics and will also have a role in the formation of the Ethics Panel.

D. ACR reform

In July, 1994, DCFS Director Jess McDonald asked the OIG to monitor and make recommendations for reform of the Department's administrative case review (ACR) system. This work began intensively in September, 1994.

The ACR system has evolved as DCFS's primary tool for assuring that each child in foster care is receiving adequate services while in foster care. The system, mandated by federal law, requires that every child in foster care be reviewed every six months. Based on good practice wisdom, which dictates that both parents and children receive services in the period immediately following removal of the children, and mandated by the terms of the BH Consent Decree, DCFS has also committed to review every child's case forty-five days after the child is placed in foster care to ensure that a service plan has been developed which appropriately addresses the needs of the child and family, and that services are in place.

One of the great strengths of Illinois' ACR system is its recently completed state of the art automated data system. The data system can generate a variety of reports to help the Department evaluate the performance of its workforce, target resource needs, and identify strengths and weaknesses of the service delivery system. In addition, it provides a mechanism for monitoring the ACR system itself.

Every region except Cook County shows good compliance rates for both six month and 45-day reviews. While overall Cook's compliance increased over the last year, the increases have been inconsistent. In July, 1994, DCFS began to institute a corrective action plan to increase compliance in Cook, and to effectuate a true quality assurance model throughout the state. OIG is in the process of assessing the effectiveness of the reforms under the corrective action plan. OIG also is exploring whether increased numbers of reviewers and clerical personnel assigned to schedule ACRs would ensure increased timely review of each child in care. OIG has recommended that the scheduling process be re-designed.

Next year, the OIG will evaluate, make recommendations and monitor reform efforts in several major areas:

1. Quality Assurance

   A good quality assurance system requires a system of evaluation, feedback and response. Administrative case reviewers have the authority to revise inadequate case plans and identify critical or chronic issues identified during a review. But at present, there is little to assure that caseworkers and supervisors will address the identified issues or carry out the revisions. The OIG is working with DCFS managers to design a system which requires supervisors to respond to issues raised or revisions made by an administrative case reviewer.

   In addition, the OIG supports a formal three-month supervisory staffing process during which casework supervisors document that they have fully reviewed case progress with the caseworker and that the concerns raised by the administrative case reviewer have been addressed in the case service plan.

   The focus of the federal mandate for a six month case review system was to facilitate achievement of permanence for each child in foster care. The current ACR system appears to place more emphasis on compliance and data collection, than on focusing on permanency planning for each child. The OIG is working with DCFS managers to address this concern.

2. Nature of the Review

   Current barriers to an effective review process include 1) inadequately prepared case plans, 2) poor service coordination between DCFS and private agencies which results in inadequate monitoring and service provision to parents, and 3) lack of parental participation in the review process. Over the coming year, OIG plans to address these barriers with DCFS managers and private agency staff.

3. Training and Qualifications of Reviewers

   Due to the demands of an ACR, a high level of expertise is necessary. The OIG is promoting training of current reviewers and recruitment of professional staff.

E. Repair Assistance Program (RAP)

The OIG received a complaint that DCFS was attempting to relocate 20 teen mothers and their infant children due to their poor housing conditions. The OIG asked the court appointed monitor for the Hill class action case, which concerns teen parents in DCFS care, to investigate their housing conditions. The Hill monitor reported that the problems could be more appropriately addressed through intervention and repair rather than through removal of the families.

Another related request for the OIG's intervention involved a DCFS perception that children should be removed from homes for delinquent utility bills and subsequent service terminations. The OIG responded by assisting the tenant in negotiating with the utility company. The negotiation efforts resulted in a continuation of service.

As a result of these cases, the OIG began working with Anne Burke, the Special Counsel to the Governor and the City of Chicago to develop a Repair Assistance Program (RAP) to respond to poverty-related neglect due to poor housing conditions. The assistance of Anne Burke has been instrumental in developing a partnership with the City of Chicago in developing this program. The program ensures the safety of children without direct DCFS involvement. The RAP has three main components:

- Provide assistance to tenants in negotiating with utilities for service.
- Provide assistance to tenants in using the Chicago Landlord/Tenant Ordinance and related ordinances to withhold rent for needed repairs.
- Repair conditions within homes that threaten children's safety when the hazard would otherwise require the children's removal.

The Chicago Department of Housing (CDH) has several programs that may assist DCFS families in meeting the housing needs of their children. First, CDH provides grants to landlords to make needed repairs in multi-tenant buildings. CDH also works with the Corporation Counsel's Office to have buildings put into receivership when landlords fail to correct life-threatening conditions. The appointed receiver then makes the necessary repairs and the city has a lien on the property for the amount expended. While helpful, the program can only be used when repairs do not need to be made immediately due to court delays. Additionally CDH has agreed to work with the OIG and Special Counsel to the Governor in developing a new program for immediate receiverships in cases where the building conditions threaten the life or safety of children.

F. Overdue Case Study

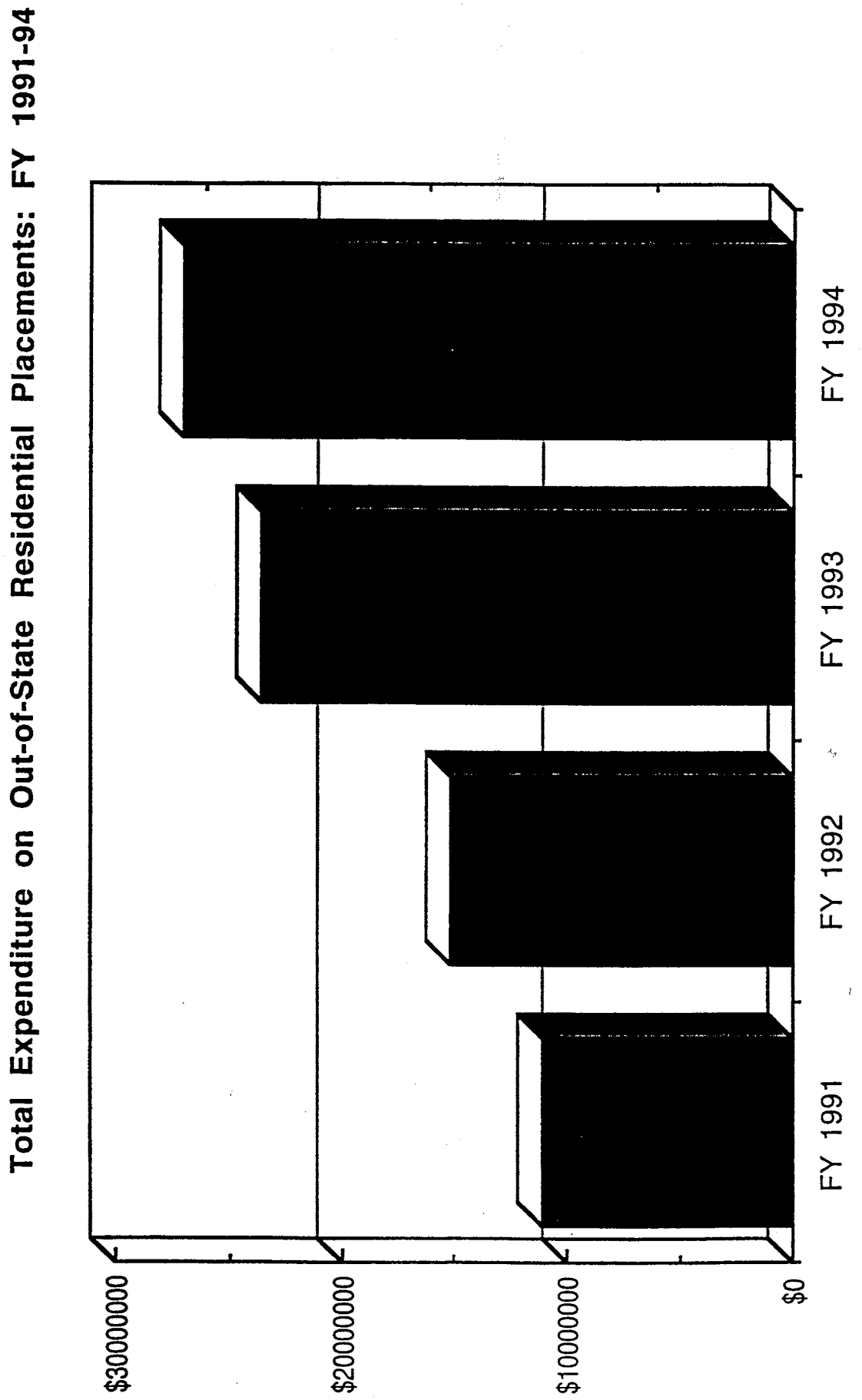
The number of overdue investigative case reports from the Department of Child Protection (DCP) rose to crisis proportions in the Cook County area. The OIG undertook to research the factors influencing the large number of overdue case investigations prior to media attention focusing on the situation. After examining the rise in calls to the hotline, worker vacancies, investigative team performances, worker safety issues, and administrative issues, the study had a several findings.

The investigation revealed that the performance of administrators and supervisors influenced the number of overdue cases. In addition, the study revealed that an unusual proportion of overdue cases originated from a particular DCFS office. The OIG undertook an investigation of that office and ultimately recommended disciplinary action. As a result of these findings, a self-initiated program was instituted by DCP to complete investigations and to reduce overdue cases. The OIG is monitoring further developments.

VII. OIG PARTNERSHIPS

The nature of the OIG necessitates the involvement of a variety of professionals and agency personnel. As a result, the OIG has coordinated investigative and research efforts with several organizations. Among the most frequently contacted agencies are the Attorney General's Office, the Department of Professional Regulations, the Federal Bureau of Investigation (FBI) , Cook County States Attorneys Office - Division of Public Integrity. The OIG also relies heavily on law enforcement personnel from municipal, state, and interstate offices. In addition, the effectiveness of the OIG's reform efforts rely on the support and cooperation of Governor Edgar, former Director Ryder, Director McDonald and the Governor's Special Counsel, Anne Burke.

The OIG wishes to extend our gratitude to attorney Ellen Mulaney. Ellen has volunteered her services to the OIG and has been instrumental in establishing the Ethics Committee. Ellen is now the Chairperson of the Ethics Panel. We also wish to thank our interns from the Civitas ChildLaw Center and the Social Work/Law joint degree program at Loyola University Chicago School of Law, the University of Chicago School of Social Services Administration, Northeastern University and the University of Illinois at Chicago Jane Addams School of Social Work.


Total Expenditure on Out-of-State Residential Placements: FY 1991-94
$30000000
$20000000
$10000000
$0
FY 1991
FY 1992
FY 1993
FY 1994

Child Welfare Practice Issues

in the case of

Ronald Turner

July 24, 1994

Child Welfare Practice Issues

in the case of

Ronald Turner

Ronald Turner (DOB 11/25/89) has been in DCFS custody since shortly after birth. His case came to the attention of the OIG when his former private agency case worker filed a complaint alleging that racial discrimination and case mismanagement by DCFS confounded her effort to become an adoptive parent for this child. Although the documentation in the case records does not substantiate her specific claims, the careful review of the records occasioned by her complaint has provided an opportunity to investigate child welfare practices in this case and to understand the role they played in the evolution of the current situation. Consideration of these practices highlights some problems within the child welfare system that impede decision making and permanency planning for children in foster care. It is instructive to examine these practices in some detail to provide a base for recommendations that can lead to constructive change in practice and planning in child welfare.

I. Child Welfare Practice - The BCS Agency

A. Safety, Security, and Stability of the Foster Home

It is well recognized that foster care is intended to provide a safe, secure, stable environment for foster children. To this end, homes are only licensed after careful home study, placements are monitored regularly for safety, and every effort is made to maintain the continuity of attachments between the child and parental figures. In Ronald Turner's case, there are many instances of departure from these principles that ultimately led to both physical suffering and disruption of continuity for Ronald.

1. Physical Abuse

While physical abuse in foster care placements is relatively rare, studies have failed to identify any clear predictive factors [Zuravin et al., 1993].This means that monitoring workers must be especially vigilant in guarding children from potential abuse. That BCS was aware of this is evident in their weekly home visiting form, which cues the worker to check the child's appearance in the first item: "Note bruises, sores, illnesses, clothing appropriateness etc.". When Ronald suffered a fractured leg in the Williams home, a body scan at the hospital revealed multiple healing fractures of 2-4 months duration of the ribs, clavicle, and shoulder. It seems unlikely, though not entirely impossible, that Ronald could have suffered these injuries without exhibiting any outward features or behavior change. Unfortunately, the records of weekly visits to the Williams home are missing, so there is no way to determine whether the worker had any suspicion of abuse. The worker did note, in retrospect, that she had taken Ronald to visit his natural family twice in the two months preceeding this incident and during those times she had noticed that the baby "did not laugh like he used to and he seemed somber and watchful". It is troubling that the worker does not seem to have considered the possible association of this behavior change with physical discomfort; there is also no evidence in the records that BCS used this incident to launch an internal investigation or to challenge agency practices.

2. Foster Home/Foster Child Match

The "goodness of fit" between foster family and foster child has long been understood as critical to the success and stability of the foster placement [Doelling and Johnson 1990]. In fact, BCS's Specialized Foster Care Program Plan [FY 90] notes the importance of providing "a foster home that best 'fits' the needs of the youth". In this case, Ronald's second foster parents, the Smiths, had specifically requested a child with emotional, rather than medical, needs. When Ronald was placed with the Smiths, however, he had just been released from the hospital following the leg fracture and was in a full body cast. This situation required repeated orthopedic clinic visits, special care, and follow-up developmental therapy. Ronald's medical needs were plainly evident at the time of placement; it is surprising that the initial request of the foster parents was ignored. Furthermore, the case record of the placement visit is missing so there is no evidence that the problem presented by Ronald's medical needs was dicussed in detail with the Smiths or that additional assistance was offered to the family to assist them with this problem.

3. Capacity of the Foster Home

The capacity of a potential foster home must be gauged by more than physical space, material support, and the good intentions of the foster family. In fact, the experience of the foster parents and the number of children in the home are decisive factors in placement stability [Boyd and Remy 1978]. As a general guideline, it has been suggested that foster families should care for "not more than two, or at the most, three babies or small children"[Spock 1946].

The licensing study of the Smith home noted their "inexperience living with a child". Because experience is so critical to stability of the home, it is difficult to understand the reasoning that led to a decision to license the home for 4 children. Although BCS followed good practice in placing only one child with the family at first (Michelle Collins) and waited to assess the stability of this placement before placing a second child (Ronald Turner), they then added a sibling group of 3 small children within 6 weeks of Ronald's placement. This action placed 5 children under three years in an inexperienced family already burdened with a child with special medical needs. By exceeding even their own dubiously determined home capacity, BCS severely overloaded the foster family. It is not surprising that this placement decision led eventually to placement disruption for all but one of these children.

4. Stabilization of the Foster Home

The importance of early secure attachment as a base for healthy emotional development and later psychological stability is well recognized in the child development literature [Bowlby 1980]. Studies of children in foster care have documented the lasting damage to children from multiple placements, including impaired personality development, chronic anxiety related to insecurity, and tenuousness in establishing relationships [Kates et al., 1991;Fein and Maluccio 1992]. Multiple placements also increase the risk of later adoption disruption [Festinger 1986]. Good practice requires that every effort be made to avoid placement disruption, particularly in the child's early years [Slette et al., 1993]. Placements must be carefully chosen to maximize the likelihood of success and strong intervention directed toward stabilization must be forthcoming when disruption is threatened.

The Smiths had been married less than a year when they initially applied for a foster care license. In the home study, the evaluator noted "the potential stresses this may have on marital communication" but did not recommend any plan to help the Smiths recognize these stresses or deal with communication problems that might arise. The Smiths apparently began to experience marital instability soon after the placement of an excessively large number of small children in their home. Although there were probably other contributing factors, the placement overload undoubtedly exacerbated the situation. Again, the lack of weekly visiting records during Ronald's placement in the home preclude information on efforts by BCS to support the marital couple through referral to marital counseling, offering respite care, or other additional services. A few months after Ronald was removed from the home, Ms. Smith was apparently encouraged to seek therapy during the Smiths brief separation, but intervention should have begun much earlier, when the initial difficulties arose. It is very likely that failure to attend more fully and quickly to this issue contributed to Ronald's ultimate removal from the home.

The abrupt removal of Ronald from the Smith home at the age of 19 months was indeed unfortunate. Chronologically, Ronald was developmentally within the "rapprochment" subphase of separation-individuation, a period many theorists believe is particularly critical in child development [Mahler et al., 1975; Masterson 1976]. Resolution of the "rapprochment crisis" at 18-21 months is thought to set the stage for the patterning of the child's later personality characteristics. Disruptions at this age can lead to enhanced separation anxiety, defensive splitting, and eventually to borderline or narcissistic personality disorder. As Mahler et al.[1975:77] point out, "one cannot emphasize too strongly the importance of the optimal availability of the mother during this subphase". Given the particular vulnerability of a child of this age, it would have been appropriate for BCS to make strenuous efforts to support the placement. If these interventions failed, a planned gradual transition to a new home, with regular follow up visits with the Smiths, would have been the next best alternative. Instead, BCS apparently moved Ronald without any recorded recognition of these factors and, according to Ms. Smith, did not allow further contact between Ronald and the Smiths.

B. Medical Care

1. Documentation

There is a well established protocol for well child care and standard immunizations. In Ronald's case this was augmented by required orthopedic visits and developmental therapy. Adherence to medical protocol should be documented in the weekly foster home visiting record and reported in quarterly progress notes; a concise medical record should be on file at all times [Klee et al., 1992]. In Ronald's case, the medical documentation is sparse and inconsistent. In fact, BCS was forced to request records from several physicians in 1994 in order to assess the care that had been provided by the Smiths in 1990-91.

2. Continuity of Care

The lack of documentation in this case led to discontinuity in medical care for Ronald. His first series of immunizations, normally given at 2, 4, and 6 months were apparently given at 6, 7, and 23 months. There is no documentation that any immunizations were given in the period Ronald was placed at the Smiths, when he was 9 - 19 months of age. Ms. Smith

has claimed that he received one immunization at the County Health Department during this period, but a subsequent request for these records could not substantiate this claim. There is also evidence, in a quarterly report, that Ronald had the measles in March 1991, when he was 16 months old. This potentially dangerous illness should have been prevented by innoculation; in 1991 the MMR was generally given at 15 months, although many pediatricians were giving a 6 month innoculation and following this later with the MMR. Ronald was not given the MMR until he was 21 months old. Thus, this lack of attention to protocol and failure to maintain accurate documentation created serious gaps in care and may also have led to unnecessary duplication of immunizations.

Perhaps the most serious lapse in continuity was the failure to provide timely testing for HIV. Soon after Ronald was taken into care, the DCFS worker, noting that Ronald's mother's lifestyle increased her risk of HIV infection, recommended HIV testing for Ronald. Testing was again recommended by the pediatrician who saw Ronald at the one year visit. The testing was not done, however, until 6/9/92, when Ronald was 2 1/2 years old. This failure represents an infringement on Ronald's right to treatment:"not testing a child who may be at risk of HIV infection deprives the child of appropriate medical care"[Boland et al.,1988:508]. It is indeed fortunate that Ronald was not HIV infected; had he been infected testing at this late age might have seriously compromised his care. Proper practice, even in 1990, was for initial testing and, if the child proved to be antibody positive, to provide more intensive followup and specialized care (e.g. IPV rather than OPV vaccine) until it could be determined whether or not the child were actually infected.

C. Home Visits and Progress Reports

Although there are no weekly visiting records for Ronald during his stay in the Williams and Smith homes, there are relatively complete records for the Smith home beginning 7/23/91 – just after Ronald's removal – for visits with Michelle Collins (even though she was placed in the home 12/28/89). There are also records of regular visits to Ronald in the Peterson and Tierney homes.

At the time of these placements, BCS apparently had two forms for each home visit: the Foster Home Visits Log and the Foster Child Visit Log. It appears that both forms were to be completed for each visit. There are, however, no Foster Home Visits Logs in the records for Ronald Turner. For Michelle Collins, only about 1/3 of the Child Visit Logs have a corresponding Home Visits Log for the period 7/23/91 - 1/20/94. The dates on some of these forms do not match and the information on others is contradictory. For example, a Home Visits Log, completed in some detail, was filed for 11/12/91; the Child Visit Log for the same date notes "visit cancelled". It is difficult to understand the rationale for these duplicate forms. Separation of these two aspects of care tends to fragment service delivery. The information about both the foster home and the child could easily be captured on one form. In any case, clear concise records are essential because they form a base for service provision [McDevitt 1993].

BCS's original Foster Home Visits Log was improved by simplification and revision in October 1991. Although the new form includes "issues discussed" and "actions taken to address issues", these items are not presented in the context of an overall plan for the visit. The completed forms in the existing record primarily report mechanical aspects of case management

(e.g. "will find out date of next ACR", "continue to try and contact caseworker"), so they provide little information on the dynamic issues within the home.

The Child Visit Log leaves much to be desired. It only lists four items: (1) child's appearance, (2) current issues addressed, (3) plan (related to issues), and (4) record of biological family/collateral contacts. Missing are health related items such as appointments and immunizations, as well as specific "ticklers" for positive or negative behaviors, mood and affect of child and family members, and changes within the foster home. In the available visiting logs on Michelle Collins, this form was frequently completed in a perfunctory manner, sometimes with the entire visit summarized by the notation "neat and clean" or other brief, vague comments. Of more serious concern is a more thorough note that describes a conversation between the worker and Ms. Smith about the potential impact of the Smiths contemplated divorce on Michelle; this lengthy note, identically worded, appears in the record on 5 different dates over the course of a year (9/17/91, 4/22/92, 5/30/92, 7/30/92, 9/28/92). Such an instance of "padding" of the records tends to call into question all of the records compiled by this worker and impugns the quality of BCS's supervision.

It is also notable that many of the Child Visit Logs do not contain any defined goals for the visit or plans for follow up. For Michelle Collins' visits, some Child Visit Logs even report "no plan" or "no plan needed". In the records on Ronald 9/17/91 - 1/14/94, fully 78 % of the forms have no entry at all in the plan section. Furthermore, when an issue is identified, there is often a lack of documentation of resolution of the issue. The record for 9/15/93 notes that Ronald is attending preschool two afternoons a week; on 11/9/93 Ronald is reported "not in school now - Ms. T is going to look for something for him in the morning - needs a nap in afternoon" but there is no note of subsequent return to a preschool program or efforts to find a suitable program through 1/18/94, the end of the period covered by the records. At times, the briefness of the notes invites confusion about the actual events. For example, on 5/9/93 the worker notes "discussed upcoming adoption" but does not indicate whether this was discussed with Ronald, then 3 1/2 years old, or with the foster parent(s), the extent or nature of this discussion, or the apparent impact of this discussion on the other participant.

Goals described in quarterly and annual reports are similarly uninformative and lack an overall plan. Goals for foster children typically focus exclusively on developmental achievements of the child, e.g. "Michelle will continue to learn to tie her shoes", "Ronald will consistently act age appropriately with his brother Charles during their monthly visits". Goals for the agency tend to simply specify contractual obligations, e.g. "Worker will monitor Ronald's placement on at least a weekly basis and more often if needed". Missing in all this documentation is regular planning to develop permanency options, support the functioning of the foster parents, or respond to the emotional adjustment, special needs, and health of the foster child within the context of a long term plan of action.

D. Permanency Planning

1. Biological Parents

The importance of contact between foster children and their natural parents is unquestioned [Schatz and Bane 1991] and the primary goal in permanency planning, defined by P.L. 96-272, is reunification of the family. Many studies have shown that early engagement of the biological parents is critical to this process [Courtney 1994, Fanshel and Shinn 1978, Katz

1990, Maluccio and Fein 1983]. Other studies have shown that parents can be accessible if a strong effort is made to reach them [Fein and Staff 1993, Stein and Gambrill 1977]. Parental visitation has been shown to be the best predictor of success in reunification [Fanshel 1975]. When parents are separated from their children or lose custody they frequently become discouraged and, if support and services are unavailable, they may give up their efforts to reunite with their children [Kates et al., 1991, Palmer 1989]. A working guideline for the "reasonable efforts" required by P.L. 96-272 to engage natural parents, developed by Seaberg [1986] requires that the worker: (1) maintain a sustained level of service activity, (2) document perserverance in efforts to engage the parents, and (3) work directly with the parents on follow-through, providing additional services to remove obstacles to follow-through.

BCS's Specialized Foster Care Program Plan [FY 90] clearly states the importance of involving biological parents:"The foster (care) worker engages the natural family in regular counseling sessions from the beginning of the child's placement"; "The child's biological parents will be contacted and included in the foster care treatment planning from the beginning". At the same time, the initiative for this involvement is left almost entirely to the parents themselves. Outreach to the parents is apparently the "case management responsibility" of DCFS and it is up to the DCFS worker to "motivate the family". BCS limits its outreach to the offer of three face-to-face interviews at either their North Suburban or West Suburban office. Knowing that most biological parents will reside quite a distance from their offices, BCS adds that their worker will supply information on public transportation routes to their offices but specifically notes that BCS does not provide funds for transportation.

This ambivalence in reaching natural parents is endemic to the system [Hess and Folaron 1991]; it reflects an unfortunate perception of the child as separate from the family. In fact, BCS's statement in the Program Plan that "the foster care worker is an advocate for the child" typifies this conceptualization. From this perspective, services to biological parents are ancillary and supportive; they tend to recede into the background in case planning. But as research has shown, work with biological parents must be in the forefront, framed collaboratively, in order to develop the partnerships that lead to solid permanency planning [Morton 1991]. It is unfortunate that BCS did not make use of this child welfare knowledge in developing their Specialized Foster Care Program; it is equally disturbing that DCFS accepted such a program as a fully appropriate plan.

In Ronald's case, the documentation of outreach is limited to a series of letters to the biological mother about visitation and two letters from the DCFS worker to the mother providing resource information on substance abuse treatment programs. Ronald's mother was seen in the hospital shortly after Ronald's birth and there is evidence that she made two visits to see Ronald during his first 20 months. Although Ronald's mother was referred to substance abuse treatment during some of these direct contacts, there is no indication that any attempt was made to develop a working alliance with her to support her capacity for parental role functioning. These activities fall far short of sustained service. As Seaberg [1986:474] points out "there is probably little disagreement that to hand the parents a list of service agencies and suggest they get in touch with them would be an insufficient level of activity". For children who enter foster care at birth entirely as a result of their mother's substance abuse, it is essential to assess the mother's capacity for investment in the child and for lifestyle change. Because personality characteristics are distorted and undermined by addiction, it is only in the context of an ongoing working relationship that these aspects of the mother's capacity

for parenthood can be properly assessed. This requires a thorough evaluation at the initial contact and intensive immediate follow up. Unfortunately, there was no mechanism for more than perfunctory contact with Ronald's mother and both DCFS and BCS soon lost track of her. Similarly, there was no documented effort to identify and provide outreach to Ronald's father. At Ronald's birth, his mother told the hospital worker that she had been engaged in prostitution and did not know the identity of Ronald's father. When Ronald was 5 months old, the father of Ronald's half-brother Charles apparently told the DCFS worker that he thought he was Ronald's father but he subsequently failed to follow through on establishment of paternity. Later, this man denied paternity of Ronald and signed denial of paternity 12/93. The failure to pursue identification of Ronald's father right from the start created ongoing confusion. Finally, when permanency plans moved toward adoption, the obligatory "diligent search" was conducted; not surprisingly, this effort, carried out 4 years after Ronald's birth, was unsuccessful. It is impossible to know whether Ronald's father could ever have been identified, but it is essential to begin a search for the father, a potentially valuable resource, immediately after birth rather than wait until the trail has grown cold.

2. Case Management

In the interest of permanency planning, these outreach efforts should be made in a time-limited fashion and documented in detail in case records. It is essential to assess the likelihood of termination of parental rights within the context of early intensive intervention in order to develop alternative options in a timely manner [Courtney 1994, Maluccio and Fein 1983, Miller el al., 1984]. Initial development of these options should begin as soon as there are any indications that reasonable efforts to reach the parents may be unsuccessful.

In Ronald's case, the failure to develop a permanency based plan at the outset has left case activity floundering. Even though he came into care under the circumstances most likely to lead to adoption (i.e. family history of all other sibs in placement, entry into care at a very young age [Katz 1990]), Ronald was 4 years old at the time of the adoption screening. It was quite evident early on that Ronald's case was moving toward adoption and that every effort should be made to place him in a preadoptive home. Once he was removed from the Smiths, however, he was placed in two successive non-adoptive homes and, to this date, he has still not achieved a permanent placement.

Without a clear permanency plan there was also no defined rationale for visits with relatives. Ronald has continued to have monthly visits with his half sibling, Charles, even though they never lived in the same home. He has also had occasional visits with other half siblings. Although it is generally good practice to maintain ties with relatives, it is important to consider visitation within an overall case plan. When the outcome of permanency efforts is uncertain it is reasonable to keep a number of options open. With time, however, these options should become more narrowed and focussed. To support a bond for a considerable period of time without any overall case plan can be potentially confusing for a child and may, as is possible in Ronald's case, only add to the number of disrupted relationships in his life.

II. Child Welfare Practice - Systemic Issues

A. Adversarial Nature of Process

The value of active collaboration and mutual respect for professional roles in child welfare planning and decision making is well established [Kates et al., 1991, Maluccio and Fein 1983, Palmer 1989]. The welfare of children in foster care suffers when adversarial proceedings undermine collaborative efforts to develop one focussed plan and a continuum of services. Frequently, however, strong emotions are evoked in adults by the vulnerability of children in substitute care. This creates polarizations that can blur professional role boundaries and increase the adversarial nature of the process.

In Ronald's case, the willingness of the GAL to make an instant determination of the suitability of a potential adoptive parent and to advance this individuals' suit by putting the case before the court abrogated established child welfare principles. This action delayed permanency planning efforts for many months; it also further polarized an already acrimonius debate.

B. Prioritization of Preferences in Adoptive Homes

Just as P.L. 96-272 provides a series of preferences in permanency planning for children, there is a critical need for a similar system, based on solid child welfare research, to define the preference for placements in adoption. Such a system would require the incorporation of a certain degree of flexibility in order to provide individualization and the balancing of a variety of factors, such as kinship, attachment, and permanence [Hegar 1993]. Outside consultation should be established for determinations in particularly complex cases. This flexibility would help this system to avoid some of the criticisms of implementation of P.L. 96-272 preferences, which have stressed the detrimental result of rigid adherence to a single protocol [Fein and Maluccio 1992].

The foundations of an adoption preferences system can already be found in the current child welfare literature. For example, several researchers have shown that the father plays a pivotal role in the maintenance and stabilization of special needs adoptions [Cohen 1981; Westhues and Cohen 1990]. Other things being equal, then, two parent families should be preferred for placement of the special needs child. Similarly, other studies have emphasized the importance to the development of self-identity of cultural matching between adoptive parent and child [Pinderhughes 1991].

Guidelines based on such a system of prioritization would have obviated much of the controversy in Ronald's case. This controversy served to distract the child welfare professionals involved from the most important issue in adoption planning: careful assessment of the potential adoptive home.

C. Home Study

It is widely recognized that adoption of children beyond infancy places unusual stress on the family system [Katz 1986]. Traditionally, child welfare professionals have relied on a thorough home study to gather information, both on the context of the child's life experience and on the interpersonal environment within the potential adoptive home. The availability of this multilevel information is critical to solid decision making and forms the base for planning

that facilitates the integration of the child into the adoptive family. Recently, there has been a trend toward abandonment of home study in favor of psychological evaluations and "bonding assessments". Bonding assessments may be useful in planning placement transitions because attachments must be recognized and managed in ways that minimize disruption to the child. But these assessments are sometimes conducted in such a way that the child's preferences play a major role in the placement decision. This is often appropriate for older children but can be quite disturbing to young children, who need the security of adult authority and are frightened when adults abdicate control. Psychological evaluations are, at best, a guide to treatment; they provide information on emotional strengths and vulnerabilities. They only capture a limited range of information, however, and may be subject to substantial error in some complex cases [Kates et al., 1991]. Psychological evaluations and bonding assessments may form a part of the information necessary in permanency planning but because adoption occurs within a broad interpersonal context, it is essential that there be a return to the more inclusive and wide ranging home study as the base for permanency decisions.

RECOMMENDATIONS

This analysis of child welfare practice identifies many specific deficiencies, in both agency activity and systemic norms, that have impaired the quality of Ronald's care and undermined the achievement of permanency. This case is instructive because it illustrates problems that are, unfortunately, widespread throughout the child welfare system. While a direct response to BCS is certainly appropriate, this analysis also provides an opportunity to develop some general guidelines for practice in the specific areas considered by the study.

I. The BCS Agency

None of the BCS practice deficiencies cited in this study are exceedingly serious. Taken together, however, these errors were compounded and indirectly contributed to physical abuse, inconsistent medical care, placement disruptions, and the failure to establish a permanent placement for Ronald. These experiences may have a deleterious effect on Ronald's long-term emotional development. In fact, a psychiatric evaluation of Ronald on 3/21/94 recommends short term treatment for Ronald once he is placed in a permanent home, to help him deal with the issues raised by his numberous placement disruptions. Studies of adolescence suggest that there may be a recrudescence of these issues as he works through the separation/individuation phase of the teen years [Blos 1962].

It should also be noted that these deficiencies in practice create a vulnerability to civil liability for the agency, since failure to provide a safe foster home, to provide treatment for biological parents, or to arrange an expeditious adoption are all potential grounds for negligence [Besharov 1984].

Although BCS's practice was not the issue that brought this case to the attention of the OIG, BCS's handling of the case created the context from which the complaint arose. To support practice improvement, the OIG's response to BCS should include:

- Critique: The results of this case analysis should be brought to the attention of the BCS director and staff. Social workers generally welcome evaluation of practice because it offers a challenge that can lead to constructive change.
- Plan: The BCS Specialized Foster Care Program Plan should reflect the best principles of practice, including required:
  - detailed and complete visiting records
  - careful monitoring and reporting of medical and dental care
  - close supervision of line workers
  - documented justification for important case decisions, such as changes in placement, exceptions to licensing capacity, and visiting plans.
  - regular planning for permanency with organized, time-limited goals
- Ronald: BCS's obligation to Ronald should include the compilation of a complete, chronological medical record that covers his life, from birth to the present time. A 'Life Book' should also be developed for Ronald, if this is not already part of BCS's standard practice. This book should contain photos and notations that document his life from his initial contact with the agency (1/31/90) until his placement in a permanent home.

II. Systemic Problems

A. Accountability

The poor quality of documentation in this case reflects a practice that is certainly not limited to this particular private agency. It illustrates the need for clearly defined expectations, uniform standards in documentation, and an established system of communication and decision making that will promote sound welfare practices. Widespread improvement in case planning and record keeping will only occur when clear expectations are incorporated in contractual obligations [Hart 1988]. This has been demonstrated in the response to new medicaid funding for specialized foster care services. Virtually every private agency has developed, or is in the process of developing, new guidelines and reporting forms to meet medicaid requirements.

Many of the pressing systemic problems identified in this report are currently under consideration by sub-committees formed in response to the B.H. Consent Decree, such as the Permanency Goal Reform Panel and the Case Record Reform Panel. Once their recommendations become part of the contractual system, private agencies will be held to uniform and clear accountability proceedures that will improve practice standards. A good example of this process has been the introduction of the "Health Passport", which is included in CWLA practice standards [Klee et al., 1992]. The use of such a record in Ronald Turner's case would have minimized the duplications and omissions in his medical care.

B. Adoption Issues

All child welfare professionals, from case workers to lawyers and judges, should receive training on the psychological issues involved in adoption and on the value of home study to the decision-making process. Such an educational effort could also increase awareness of the importance of collaboration among all parties in developing stable permanency options for children. In the current move toward more rapid attainment of permanency, it is particularly important to establish practices that will enhance positive outcomes for this option.

A panel of child welfare specialists should develop of system of prioritization for adoptions. This system, based on research findings and practice wisdom, would guide the difficult process of determining the best available adoptive placement for each adoptable child.

C. Biological Parents

There has been a widespread failure in outreach to natural parents, particularly when children are removed at birth. The early post natal period is a critical time for intervention in these cases; case work effort must be focussed on assessment, case planning, and support of bonding between mother and child. Currently, this focussed intervention does not take place because these cases are handled within the standard abuse and neglect protocol. In fact, valuable effort is wasted as workers "meet the mandate" by visiting healthy newborns in the hospital. A specialized approach for drug exposed infant cases should be developed in order to respond to these cases more effectively. This approach will require public and private agency partnerships that create joint responsibility for outreach and service to natural parents.

Intervention should include:

- psychosocial assessment of the mother, including her potential for parenting, motivation for change, and the impact of her drug use on her functioning.
- extensive efforts to identify the father of the child
- development of a contractual base for permanency planning, outreach, and supportive services.
- intensive attempts to engage the parents in a working alliance that supports their parental role.
- documentation of family history; this is useful in clinical intervention with the parents, can serve as a guide to the appropriateness of relative placement, and may become a valuable resource for the child who eventually achieves permanency through adoptive placement.

Ronald Turner's case has provided a valuable opportunity to examine a range of child welfare practice issues. As a case study, this analysis may be useful to BCS and other child welfare agencies as an educational tool. The recommendations for systematic change range from modifications already under consideration to relatively new initiatives. Child welfare is a constantly evolving discipline, as traditional practice integrates new research findings and societal changes. Case analysis has long served a useful purpose in this integrative process; envisioning the best level of practice points the way toward improvement and creates the context for change.

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Boris M. Astrachan, MD
Professor and Head

May 23, 1994

Jim Edgar, Governor
State of Illinois
401 William Stratton Building
Springfield, Illinois 62765

Dear Governor Edgar:

It is my pleasure to send you the final Report of the Mental Health Task Force Special Wallace Case Investigation Team. It was an honor to have had the opportunity to work with such an excellent group of colleagues. In developing this document staff at both DCFS and DMHDD were generous with their time and were committed to this process. In particular, the activities of Ms. Denise Kane, Inspector General, should be noted for her dedication to children and to their welfare.

We had made a commitment to hold a press conference when our report was completed and released. Mr. Ryder and Mr. McDonald had agreed that this was appropriate.

We would appreciate the efforts of your office in this period of transition in setting up such a conference and inviting members of our committee, others from government and community agencies and members of the press.

Since Dr. Jerry Dincin of Thresholds is beginning important new programs in this area, I hope that he will be invited. A number of interested individuals in the press have asked me to remember them at the time the report is completed (Sara Nordgren, Associated Press, 312-920-3627; Robert Karwath, Chicago Tribune, 312-222-3430 (3554); and Ray Long, Sun-Times, 312-321-2891). I am sorry to trouble your office with this, but I do believe that our recommendations can be effected and will be useful.

Sincerely,

Boris M. Astrachan, M.D.

cc: Mr. James Reilly, Chief of Staff
Mr. James Montana, Chief Counsel

REPORT OF THE MENTAL HEALTH TASK FORCE

SPECIAL WALLACE CASE INVESTIGATION TEAM

May 20, 1994

Report of the Mental Health Task Force
Special Wallace Case Investigation Team

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Executive Summary and Recommendations

The tragic death of Joseph Wallace revealed serious problems in the capacity of State agencies to collaborate with each other, to evaluate appropriately and share information in order to insure the health, well-being and safety of children of mentally ill parents who pose a risk of abuse or neglect. This Task Force was formed to examine the relationship between DCFS and the Department of Mental Health to identify major problems and to recommend solutions for these problems.

The target population considered by this Task Force is those families served by DCFS based upon an indicated finding of child abuse or neglect where a parent has been psychiatrically hospitalized. Over the past 8 years a minimum of 750 such cases have been identified in Cook County utilizing head of household data. Our committee estimates that over the past 8 years there are at least 1000 such cases.

Mental illness and a history of psychiatric hospitalization are not in and of themselves a reason to assume inadequate parenting competence. Accurate assessment of parenting capacities is essential. DCFS, the Courts and the Guardian ad litem require accurate, methodologically sound assessments. Data need to be collected and shared in a non-adversarial manner, serving the interests of the child.

Staff require training to help them deal with clients who may have a range of mental health problems from mild to severe, from acute to chronic, with such problems having minimal to severe impact on parenting capacity, and with some problems being amenable to treatment, and others being highly resistant to change.

DCFS in collaboration with DMHDD, community providers and university specialists, must strengthen its pre-service and in-service training programs to ensure that its staff and purchase of service staff possess the knowledge and skills requisite for effectively serving families and children in those cases in which a parent is mentally ill.

Accordingly we recommend:

1. Develop a standardized data format for use by both DMHDD and DCFS, to facilitate communication of relevant information about parenting capabilities and risks in mentally ill parents. DCFS should install a LEADS (Law Enforcement Agency Data System) terminal in order to permit rapid checking of criminal records of parents referred for evaluation.

2. Information sharing among agencies concerned with the welfare of children occurs within the framework of the Confidentiality, and the Abused and Neglected Child Reporting Act. Thus;

   a. Disclosure is mandated whenever a mental health professional has reason to suspect that a child may be abused or neglected.

   b. Whenever DCFS believes that Mental Health Services are necessary as part of the placement of a child in any setting or the return of a child to any setting, DCFS should routinely obtain written consent for release of records.

   c. As part of its contract with agencies providing mental health services to parents or other custodians, DCFS should require regular disclosure of records.

   d. DCFS and DMHDD should enter into an interagency agreement to permit sharing of relevant information concerning the treatment of persons having custody of minors whenever there is reasonable suspicion of abuse and neglect.

3. Develop Parenting Assessment Teams to do comprehensive, methodologically sound, non-adversarial assessments of parenting capabilities.

4. Develop four screening services in Cook County to assist DCFS workers in promptly evaluating level of risk in unclear cases involving mentally ill parents. Each of the screening services ought be linked organizationally to a Parent Assessment Team.

5. Use the Thresholds Mothers Project or other demonstrated effective rehabilitation programs as a model for intensive case management programs for mentally ill parents who could achieve adequate parenting skills with that form of psychosocial rehabilitation and treatment.

6. Create a State Academy for training child and family welfare specialists.

I. Introduction:

The death of Joseph Wallace at the hands of his mother, a woman with a well known history of mental illness and violent behavior, raised serious questions about the capacity of state agencies to collaborate in insuring the health, safety and well being of children with mentally ill parents who pose a risk of abuse or neglect. This case catalyzed a series of investigations of how the Department of Children and Family Services (DCFS), the Juvenile Court, public defenders, community agencies and mental health services and their interactions with one another could be improved. As part of this effort, this Task Force was formed to examine the relationship between DCFS and the Department of Mental Health and Developmental Disabilities (DMHDD) and recommend solutions to major problems.

The target population considered by our Task Force is those families served by DCFS based upon an indicated finding of child abuse or neglect when a parent has been psychiatrically hospitalized. The finding of child abuse or neglect shall have occurred either prior or subsequent to the parent's hospitalization, or both. Our committee considered the question as to whether assessment of a broader at-risk population base would be possible. We noted that early identification of at-risk parents with mild or moderate psychiatric symptoms and no history of hospital care might lead to more timely and effective interventions for such families. However, we concluded that without adequate and well-tested screening instruments, broadening our scope would lead to inundation of any system we might design, and limitation of service to the population at greatest risk. By extending the assessment process to those without a history of hospital care we might, for the few, reach more timely decisions and provide more effective interventions. However, we should need to provide many more assessments for those at relatively low risk. Thus, we concluded that in the main, specific assessment services ought be available to those, who, like Amanda Wallace, have a history of psychiatric hospital care. We propose that significant enlargement of the scope of the population service await the development and testing of screening instruments.

The Task Force has had six full committee meetings and has reviewed relevant investigative documents. Two subcommittees have had extensive meetings. One subcommittee considered the nature of clinical services necessary to assess risk and provide care for parents served by both DCFS and DMHDD. The other identified the training necessary to enhance the relevant knowledge base of workers in DCFS, the judicial system and the mental health system. Drafts of the document have been extensively reviewed and modified by members of the Task Force.

Scope of the problem:

Information available to the committee (from data collected by Chapin Hall) indicated that approximately five percent of heads of households in the DCFS system in Cook County had been hospitalized in a DMHDD facility within the past eight years. This means that a minimum of 750 current DCFS cases in Cook County have had mental illness severe enough to warrant psychiatric hospitalization in a state facility. Since the data are only for head of households, we believe that some hundreds of additional households will contain a parent or parent substitute who is located in both DCFS and DMHDD systems.

Nature of the problem:

Mental illness and a history of psychiatric hospitalization in a parent is not, in and of itself, a reason to assume inadequate parenting competence. For this reason, accurate assessment of parenting capabilities is essential. Judges and others making custody decisions need ready access to sound assessments of whether a particular mentally ill person can safely parent a particular child, and what kinds of services, if any, must be provided and accepted for the person to maintain parenting capability.

The current system is deeply flawed in its ability to provide such assessments. DCFS workers often do not know where to turn to get accurate professional assessments; nothing in their current training helps them to distinguish between methodologically sound assessments and poor assessments. When expert evaluations are obtained, they are in the context of adversarial court proceedings and have a high likelihood of being biased. Often, judges, lawyers and DCFS workers are confronted with a bewildering array of assessment techniques, perhaps coming to very different conclusions about the same patient, and they have no training to evaluate the methodologic soundness of disparate reports. Clinicians with useful information to provide often find they have no means of getting this information to judges or other decision-makers. Problems like these have led to the depiction of DCFS (Higgins, Chicago Sun-Times, December 9, 1993) as a pinball machine, in which children are bounced around from place to place, seemingly at random, eventually arriving at some destination more by chance than otherwise.

In addition to risking tragic outcomes, like Joseph Wallace's, an inefficient system risks taking an inordinate amount of time to come to decisions about child custody. In addition to being financially wasteful, this takes an enormous toll on children whose central need is for a reliable, predictable caregiver. The Task Force's aim is to propose improvements to the current system which are realistic, given limited resources.

II. Data Collection:

In reviewing the Amanda Wallace case, it is tragically clear that crucial information about the patient was not easily accessible during the judicial proceedings and to clinicians. The Task Force recommends that a specific data format should be developed for use by both DMHDD and DCFS. This format should include information on the parent's household, all children (including disabilities and any prior custody loss), methods of discipline, past psychiatric history (including hospitalizations and substance abuse), diagnoses, medications, legal involvement, social supports, etc. An example of such a data format is included as Appendix A. We recommend that this draft be reviewed by an information committee of both DMHDD and DCFS, and that it be modified by them as needed. Then it should become a required data form completed on entry into the mental health assessment and treatment system (see Assessment below) and updated regularly. It should be available to DCFS caseworkers and other relevant personnel, in a manner consistent with the confidentiality provisions of the Mental Health Code.

We strongly support the recommendation of the Inspector General that DCFS install a LEADS (Law Enforcement Agency Data System) terminal at the State Central Registry. This will permit checking of criminal records by DCFS staff.

Our committee is aware that records and communications relating to treatment received by mentally ill persons in Illinois are, in general, protected against disclosure to third parties, including employees and agents of DCFS and other persons involved in the investigation of the abuse and neglect of minors. Mental Health and Developmental Disabilities Confidentiality Act (hereinafter, "the Confidentiality Act"), 740 ILCS 110/1, et seq. (1992). While there is no evidence suggesting that the Confidentiality Act played any role in preventing the timely transmission of relevant information in the Joseph Wallace case, the Task Force is aware that there are problems concerning access to mental health records and that its other recommendations may raise issues under the Confidentiality Act. We must assure that neither agencies nor their personnel hide behind confidentiality concerns in order to slow necessary communications. In light of these problems, the Task Force makes the following observations and recommendations:

1. Disclosures are permitted under Section 11 of the Confidentiality Act "when, and to the extent, a therapist, in his sole discretion, determines that such disclosure is necessary to ... protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient, or by the recipient on himself or another..." This provision permits employees of DMHDD, community mental health agencies and other mental health providers to disclose information to DCFS when they believe a child to be at risk.

2. Section 11 of the Confidentiality Act also permits disclosure under the Abused and Neglected Child Reporting Act, 325 ILCS 5/1, et seq., which mandates disclosure whenever a mental health professional has "reasonable cause to believe [that a child may be abused or neglected]".

3. Disclosure of information needed to protect at-risk children is also encouraged by 405 ILCS 5/6-103, which immunizes from potential liability those mental health professionals who disclose such threats to law enforcement personnel.

4. Mental health records and communications may be disclosed to any agency with the written consent of the patient. Confidentiality Act, Section 5. Whenever DCFS believes that mental health services are necessary as part of the placement of a child in any setting or the return of a child to any setting, it should routinely obtain written consent from the parents or other custodians for the release of records concerning those services.

5. As part of its contracts with agencies providing mental health services to parents or other custodians, DCFS should require regular disclosure of mental health records and create a system for insuring that such records are routinely forwarded to the appropriate caseworker in a timely manner.

6. DCFS and DMHDD should enter into an interagency agreement pursuant to Section 7.1 of the Confidentiality Act to permit the sharing of relevant information concerning the treatment of persons having custody of minors whenever there is a reasonable suspicion of abuse or neglect.

7. DCFS and DMHDD workers and community providers should be trained concerning the provisions of the Confidentiality Act and the Mental Health and Developmental Disabilities Code described above and the use of consent forms.

8. DCFS and DMHDD should jointly develop materials to be provided to community mental health providers advising them of the requirements of the Confidentiality Act and their obligations under the Act.

9. DCFS and DMHDD should work to reduce the incidents of re-disclosure of mental health records by taking the following steps:

   a) Make certain that whenever records are disclosed to any entity, that entity is advised in writing that re-disclosure is prohibited under the Confidentiality Act.

   b. Provide a written warning to any entity that improperly re-discloses records provided to that entity by DCFS or

DMHDD. A copy of that warning should be provided to the recipient of services and his counsel, if any.

c. Where appropriate, refer claims of improper re-disclosure to the relevant state's attorney or the Attorney General for prosecution under Section 16 of the Confidentiality Act.

III. Assessment:

We propose a systematic, efficient, non-adversarial and methodologically sound system to assess the parenting capabilities of DCFS cases with mental illness and a history of hospitalization. This system consists of screening services associated with intensive parenting assessment teams. These assessment components may be integrated with intensive case management services or those services may be separately organized. The elements of the system are described below.

A. Screening Services:

We propose establishing screening services to rapidly evaluate complex cases in which a mentally ill parent might be at risk for harming a child. The services would be available to support DCFS workers who, based on their own risk assessment, cannot ascertain the likelihood that a mentally ill parent might abuse or neglect a child. The screening services would develop and employ a systematic protocol for functional assessment of risk and parenting competencies. The screening services would triage cases, determining whether or not further action or assessment is needed, and the extent or urgency of further action or assessment. The services would be skilled clinical facilities with a range of pediatric and mental health services. Ideally, their services would be available 24 hours a day, 7 days a week, and could be mobilized within the allowable 48 hour period of protective custody following an allegation of maltreatment. This would preclude the need to take temporary custody unless indicated based on screening results.

The screening would be designed to determine if the index case meets specific criteria at one of three levels of risk:

Threshold One: Cases deemed to be at low risk for abuse or neglect.

Threshold Two: Cases deemed to be at risk for future abuse or neglect but not in imminent danger, such that a more thorough evaluation could be conducted in an outpatient setting in the relatively near future.

Threshold Three: Cases deemed to pose immediate danger or in need of intensive inpatient evaluation.

If Threshold One is predicated on the provision of services (e.g. medication, food stamps), these services must be available, and specific recommendations for needed services will be indicated. For Threshold Two or Three cases, specific recommendations will be made for a service plan to be implemented while awaiting more comprehensive evaluation.

We recommend setting up such screening services on a regional basis, with at least four centers serving the four DCFS field office areas of Cook County. These centers might be set up via contractual relationship. We recommend that they be associated with either an established child abuse evaluation and treatment center or institutions which provide a broad spectrum of physical and mental health services.

We further recommend that at least one service be University-based, in order that appropriate studies be undertaken to better understand the population served, and to enhance assessment procedures (e.g., to develop brief screening instruments).

Access to the screening services would be through direct referral from DCFS. DCFS workers would identify appropriate cases based on completion of the risk assessment protocol and gathering of relevant criminal and mental health records. When a DCFS worker felt a case needed screening, the worker would contact the case supervisor, who would decide whether to initiate the referral and would monitor follow-up. In order to ensure that the screening services were not used excessively or inappropriately, an independent utilization review procedure should be established.

B. Intensive Parenting Assessment Teams:

The screening services help identify cases in which risk is minimal or where risk seems so great that an early decision for removal of the child seems necessary. In cases where continuing questions exist, and/or where decisions about placement or return to the parent are unclear, a more intensive assessment process is necessary.

We propose creating Parenting Assessment Teams. The teams should be co-located with screening services and these comprehensive assessment services must be organizationally independent of the Juvenile Court and DCFS. The evaluations they develop will be provided to DCFS staff and should be easily accessible to the court, the Guardian ad litem, and other appropriate parties.

To facilitate this more comprehensive assessment, we recommend that the screening services and parenting assessment teams be integrated. The teams would be composed of experts in mental illness, parent-child assessment, child development, and the sequelae of child abuse and neglect. The composition of the teams, the data

they would assess, and the nature of the reports they would generate are described in Appendix B. At least one team ought have the capacity to conduct inpatient assessments of parent(s) and children in special circumstances as may be needed.

The teams would conduct thorough evaluations according to established methods. They would prepare written reports with clear recommendations, and describe the basis for these recommendations. When necessary, they would also be available to testify in court. They would not be associated with one side or another of an adversarial process, but would advise the courts, DCFS staff, the Guardian ad litem and others involved in making decisions concerning the best interests of children. The public defender and/or the state's attorney would still be able to find experts to promote their cases, but the judge or mediator would have access to an independent opinion as well, and would have a better sense of what data are relevant in assessing the likelihood of abuse and neglect.

This system is likely to be an improvement in the following ways:

1. It should improve the accuracy, comprehensiveness, and relevance of parenting assessment and prevent tragic mistakes.

2. It should substantially decrease the time it takes to adjudicate these cases. Not only will this save money, but it will spare children from unnecessary separations, uncertainty and lack of a constant parental figure at a time in development when this is of the utmost importance. It will also speed the separation process when that is indicated. It may also spare parents from a worsening of their mental illness due to the prolonged stress of uncertain custody and multiple court dates.

3. It could prevent a "backlash" against mentally ill mothers who are nonetheless adequate parents.

4. It could markedly improve communication among clinicians, DCFS workers and judges.

5. Over time, judges would become better educated about the components of a valid assessment by repeated exposure to this team and its reports.

We believe that clear identification of the task is necessary for the function of the Parenting Assessment Team. The team is to advise the Court, DCFS staff, the Guardian ad litem and other appropriate parties. It is not engaged in treatment or in helping to foster enhanced parenting skills. Its purpose is to provide thorough, clinically relevant, evaluation of mentally ill parents and their children who have cases with DCFS. The team will assess psychiatric diagnoses, parenting skills, parenting risk behaviors, and child development. The team will generate reports for use by DCFS case workers, judges and arbitrators who must make decisions

about child custody, provision of services, mandated treatment, termination of parental rights, and other relevant matters.

We believe that this proposed program will serve the Court, the needs of DCFS and, most importantly, the needs of children. We, however, believe that the utility of such a program should be carefully assessed. We recommend that the courts permit such a program to be carefully studied.

C. Intensive Case Management:

Numbers of parents with mental illness can effectively care for children when they are well established within a treatment program which provides comprehensive psychosocial rehabilitation plus judicious use of psychoactive medications. The Thresholds Mothers' Project has provided a national model for such a program. The Thresholds program currently has the capacity for working with 30 families and functions in collaboration with the University of Illinois Pregnancy and Post Partum Treatment Program in order to provide more intensive treatment on an outpatient basis. Programs like the Thresholds program need to be more generally available. The major elements of such a program are:

1. Membership in a supportive peer group for mentally ill parents.

2. Case management services which coordinate a wide range of elements of care and entitlement programs, and which can provide or arrange for marital therapy, counseling, and/or psychotherapy.

3. Sophisticated psychopharmacologic services which provide effective medication management while seeking actively to limit side effects. Additionally, patients are taught about medications, their importance, side effects, dosage, etc.

4. A psychosocial program including educational activities and vocational activities. In addition, a range of social programs are available. At Thresholds social programming includes mothers' therapy group, child development class, infant group, parenting skills, life skills, family milieu group, stress management, and goals group.

5. Substance abuse treatment. The incidence of drug and alcohol abuse among the mentally ill has been increasing. Use of these addictive substances significantly impedes rehabilitation and impedes restoration of functioning. Programs to educate members about substance use and the impact on individual behavior and upon the capacity to effectively engage in child rearing are emphasized. Regular random testing for use of substances should be available.

6. Family support services. In order to support the mentally ill parent in her work in child rearing, it is necessary to involve others and to help construct a supportive system. Spouses and significant others of mentally ill patients are involved in care as are parents. A focus on psychoeducation and enlisting the support of family members is necessary.

7. A therapeutic nursery. Younger children may be affectively deprived because of their relationship to a depressed or withdrawn mother. Attention may be disturbed and coping capacity diminished. Other children may be overwhelmed by repeated separations and the need to make adaptation to a range of differing caring adults over relatively short periods of time. A therapeutic nursery provides a setting in which children can be helped to develop a more stable sense of the self and in which mothers can be taught to work with their children to enhance their comfort with one another, their skills and appropriate parenting behavior.

   A program such as this will provide early identification and intervention for the at-risk siblings. The availability of such programs is absolutely necessary if one intends to assist moderately disabled parents to provide adequate care to their children. As a committee, we believe that the Thresholds' model is highly useful and worthy of wider emulation.

Obviously such a program must remain up-to-date about behavior of their clients. Acute recurrence of illness may substantially impede parenting functions and require reassessment and energetic treatment.

As we have noted before, we believe that it would be useful to establish programs of screening, intensive outpatient assessment, and ongoing case management in at least four centers serving the DCFS field office areas in Cook County. We believe that programmatic elements should be tightly linked to each other whether or not they are part of the same organizational structure.

IV. Training: A State Academy for the Training of Child and Family Welfare Specialists.

A. *Introduction*

Two state agencies have significant responsibility for the care of children, DCFS and DMHDD. Our deliberations have led us to conclude that the model of training used by these agencies is one based upon an assumption that those who are involved in work with children and families are largely professionally trained and need only to be oriented and to attend some periodic in-service

education and limited ongoing continuing education in order to be able to deliver effective up-to-date services.

We believe that this assumption ignores the fact that large numbers of state employees working with children do not have that level of training which enables them to function as independent professional practitioners. These workers, who are often most directly involved in the care of children, require educational experiences which will orient them to the work they are doing; provide a knowledge base, skills, and techniques that may be lacking; and continually work to upgrade their knowledge base.

In general, limited attention has been paid to the development of comprehensive curricula which meet the needs of on-line workers. This lack of attention to comprehensiveness begins at day one at each agency. The initial training is designed mainly only to meet the short term administrative needs of the agencies. No attempt is made at the beginning to identify the service and treatment tasks to be performed by the workers and to create a curriculum that would provide instruction in those tasks.

As far as on-going education is concerned, there has been no planning by either agency to design an in-service training program that would continue over a period of years and that would be required of all employees.

In addition, both agencies support numbers of community programs which offer services to children. Employees of those programs may also have more or less adequate knowledge of the tasks that they will be asked to undertake, the knowledge background which enables them to undertake their work, and clinical skills and techniques necessary for that work. Inadequacies in current training activities of these two departments need to be understood in order to develop an effective plan for reform. (In regard to DMHDD, we currently are only addressing that part of their service mission which involves the treatment of children and adolescents. Similar arguments for training innovation and reform might be made in regard to the adult psychiatric area and the area of developmental disabilities.)

1. The agencies have not focused on the need for comprehensive training beyond a brief orientation experience.

2. Since training is not a high priority activity in these agencies, their direction and those involved in undertaking the activities have limited authority and status.

3. Training activities are seen as competitive with direct service and time devoted to training often is viewed as time that cannot be spared from service.

4. While opportunities are available for continuing education experiences and for professional training opportunities, they are underutilized. The morale to seek training is not present.

In a number of states, over periods of many years, it has been demonstrated that the provision of excellent training opportunities enhances morale. Training which directly relates to the work and which can lead to undergraduate and graduate degrees, maintains a work force committed to the goals and mission of the settings in which individuals work and of the department.

In order to address these problems, bold steps need to be taken. It will not be sufficient, if the object is to put in place a meaningful training program, merely to reorganize existing training programs by making cosmetic changes. Tinkering with a flawed training structure will not produce effective training. The Task Force, therefore, recommends that the structure and the content of training for personnel assigned to provide services to children and families in need of mental health services be radically changed. We set forth our proposal below.

B. Create a State Academy for the Training of Child and Family Welfare Specialists.

The State Police and, we believe, the Department of Transportation, have "academies" which train their personnel. While the jobs of state policemen and transportation specialists are very important to the welfare of the people of the State of Illinois, a strong argument can be made that the training of personnel who must address the needs of children and families is as important. It is, therefore, proposed that the training of DCFS and DMHDD workers who serve children and families occur in an academy setting in which training is rigorous and substantive and in which satisfactory completion of a reasonably lengthy course of training and study is required.

C. Organization of the Academy.

The academy should be organized and administered pursuant to a cooperative arrangement between the state agencies and public and private educational institutions. Existing training programs suffer from lack of independent initiative and perspectives. The leading educators and scholars dealing with issues involving children and families are working in public and private universities and research centers. There has been very little interchange between state agencies and universities regarding the training of on-line personnel. State agencies and educational institutions should cooperate to provide state-of-the-art training to state employees.

In order to create an academy for the training of child welfare workers, DMHDD and DCFS should identify those educational institu-

tions which are currently engaged in training and research in areas relevant to the work of those agencies. Existing training budgets which support training of those involved in child care and family service should be reallocated to support the creation of a centralized training facility near a school or schools which have an interest in seeing that child care and family service providers are well trained. A Dean and Faculty for this Academy should be recruited from educational institutions. The Dean and the Faculty should retain their University affiliations while participating in the programs of the Academy. Efforts should be made to determine whether the Academy might be eligible to receive additional public and private funding. A Board of Directors for the Academy should be composed of University teachers and scholars as well as representatives from the State agencies. This Board should be nominated immediately and should begin the negotiations for the creation of the Academy. The Academy's Dean, who would be paid a salary, should also be chosen immediately to take the lead in the Board's efforts to establish the Academy and to recruit and to organize its faculty and its educational program.

D. Tasks of the Academy

In addition to providing entry level training, the Academy should provide continuing education. This education should be required and may lead to undergraduate and graduate degrees. Employees should be required to complete a certain number of hours of training at the Academy each year in order to be eligible for pay increases and promotions.

The Academy should provide its trainees with instruction in child and adolescent development, recognizing the signs of mental illness, parenting skills, and substance abuse. The Academy should also train its students in how to interpret assessments of clients made by other health care professionals. Students should be made aware of how treatment decisions are made and the implications of those treatment decisions. Students at the Academy should be made aware of treatment alternatives within and outside of the state and should be given basic instruction in the treatment criteria for making placement decisions.

The Academy should consider centering its teaching around case studies and involving students as much as possible in simulated problem solving. The Academy should also foster and supervise effective clinical training programs in which students are placed under faculty supervision with agencies that serve children and families. The Academy might wish to consider setting up its own children and family clinic in which students would perform their clinical rotations or utilize the screening and intensive parenting assessment sites as clinical settings. A major part of the educational program should be student and faculty criticism of the programs in which the students are placed for their clinical experience.

E. The Academy Could be Utilized by Employees of Other State and Local Agencies Addressing the Needs of Children and Families.

A well organized and effective training Academy for DMHDD and DCFS workers should attract the attention of other service providers, including employees of the Department of Corrections, judges and employees of juvenile courts, lawyers in the offices of the public defender, state's attorney, and public guardian, and employees of various private service providers. It may be possible to raise some operating expenses for the Academy by charging tuition to persons not employed by DCFS or DMHDD. The Academy could also serve as a setting for the education of staff in community agencies serving children funded by DCFS and DMHDD. If the Academy is run well, it could be the only place in the State of Illinois in which service providers from all agencies interact with each other. If the Academy could become a center for cooperation and sharing of information between service providers, it will have made a major contribution to the improvement of the quality of services.

APPENDIX A

Sample Data Collection Format

for Uniform DMH/DCFS Use

Date _____
Source of Information _____
Reliability _____

I. DEMOGRAPHICS

1. Name: _____
2. Address: _____
   _____
3. Phone Number: _____
4. List of Person/s with whom you live:

	Name	Age	Relationship	Time living with you
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				

5. Marital Status: _____
   (single, married, divorced, widowed, separated)
6. Name of Caseworker: _____
7. Phone Number of Caseworker: _____
8. Length of Time Living at Present Residence: _____
9. Number of Moves in the Last 3 Years: _____
10. Persons to Contact in Case of an Emergency: _____

	Name	Relationship	Address	Phone Number
A.				
B.				
C.				

11. Are you a Public Aid Recipient?: _____
    If Yes, please give your Medical Card Identification Number: _____
    A. Medicaid Eligibility: _____
    B. Entitlement: _____
12. Do you have medical insurance? _____
    If Yes:
    A. Name of Insurance Company: _____
    B. Phone Number of Company: _____
    C. Policy Number: _____
    D. Expiration Date of Policy: _____
13. Employment History: (List most recent first)

	Job Title	Company	Starting Date	Ending Date	Reason for Leaving
A.					
B.					
C.					
D.					
E.					

14. Number of Pregnancies: _____
15. Number of Live Births: _____

II. **CHILDREN** (List Oldest to Youngest)

	Name	Date of Birth	School	Grade in School	Currently Living With You
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Method/s of discipline used with children: _____

Have any of your children ever been taken away from you (by the state)? ___ Yes ___ No
If Yes:

	Name	Date Taken	Reason for Child Being Taken	Date Returned
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Do any of your children suffer from disabilities? If so, please list child and their disability.

	Name	Disability
1.		
2.		
3.		

Do any of your children suffer from medical/health problems? If so, please list child and their current illness(es) and current treatment.

	Name	Illness/Treatment
1.		
2.		
3.		
4.		

III. **PAST HISTORY** (Please include source and reliability of informant)

A. Psychiatric Treatment Setting: (List most recent first)

Type Setting	Dates (IP, OP), (Start, Stop)	Who Initiated Treatment	Who Terminated Treatment and Why?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

B. Medication Treatment: (List current meds first)

Name Med.	Dosage	Date Begun and Ended	Reason for Ending	Was it Effective?

**Were there any side effects to the medications listed above?
_____If Yes, list medications and side effects to each one.

C. Psychiatric Diagnoses: (List most current diagnosis first)

Diagnosis	Date Examined	Diagnosis Made By	Treatment Recommendations

D. Medical History: (List most recent first)

Diagnosis	Date Diagnosed	Treatment	Follow-Up (Frequency/Setting/Doctor)

E. Substance Use:

	Current Use	Extent	Treatment	Past Use	Extent
1. Alcohol:					

2. Cocaine: _____
3. Marijuana: _____
4. Narcotic (type): _____
5. Other: _____

Date of last urine toxicology: _____
Results: _____
_____

F. Legal Involvement: (List most recent first)

Current Charges	Date Committed	Sentence	Time Served	Status

G. Assets/Liabilities:

The following assets were noted in the patient and/or the family system (i.e , socialization skills, support systems, awareness/utilization of available resources, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

The following liabilities/hindrances were noted in the patient and/or the family system (i.e., socialization skills, support systems, awareness/utilization of available resources, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

H. History of Sexual/Physical/or Emotional Abuse:

Has the parent(s) been exposed to abuse themselves (either as a child or as an adult):

_____
_____
_____
_____

IV. FAMILY HISTORY

A. Psychiatric

Relationship	Diagnosis/es	Treatment (IP, OP, Meds.)
1.		
2.		
3.		

B. Medical

	Relationship	Diagnosis/es	Treatment
1.			
2.			
3.			
4.			

C. Substance Use:

	Relationship	Substance/s Used
1.		
2.		
3.		
4.		
5.		

V. CURRENT ASSESSMENT

A. Parent's Psychiatric Assessment
Date: _____

	Current Symptom/s	Duration of Symptom/s	Effect on Functioning (Work, Interpersonal)
1.			
2.			
3.			
4.			

Mental Status Examination

_____
_____
_____
_____
_____
_____

Parent shows evidence of delusions regarding the child(ren) ___ Yes ___ No
If Yes, please elaborate _____
_____

Estimate of intellectual capacity (below average, average, etc.) _____

Formulation

_____
_____
_____
_____
_____

Diagnosis (Multiaxial)

_____
_____
_____
_____
_____

Child Psychiatric assessment (For each child involved)

Name of Child _____
Date of Assessment _____

	Current Symptom/s	Duration of Symptom/s	Effect on Functioning (School/Interpersonal)
1.			
2.			
3.			
4.			
5.			

Formulation

_____
_____

Diagnosis (Multiaxial)

_____
_____
_____
_____
_____

Collateral Interviews

1. Other Family Member/s
2. Neighbors
3. Foster Parents
4. Teacher/s
5. Counselor/s
6. Probation Officer/s

Observations– To involve child/parent in various settings: (May take place in different locations over several hours)

1. Feeding
2. Playing (Structured and Unstructured)
3. Soothing
4. Description
5. Separation

Standardized Instrument Administration

1. M.A.S.T.
2. Child Abuse Potential Inventory (CAPI)
3. Parent Opinion Questionnaire (POQ)
4. Home Observation for the Measurement of the Environment (HOME)
5. Stress Related Inventory (SRI)

VI. CASE FORMULATION/TREATMENT PLAN

A. Diagnosis

1. Parental
2. Child

B. Past Risk Behaviors (i.e., suicide attempts, violence, neglect)

_____
_____
_____

C. Current Risk Elements

_____
_____
_____

D. Treatment Plan Design/Risk Anticipated

1. If complaint--able to estimate risk to the child
2. If noncompliant--risk to the child
3. If undetermined--further evaluation needed

E. Institution of Treatment Plan

_____

F. Re-evaluation Process

1. Frequency -- based on risk anticipated and updated compliance records.

   a. Each week
   b. Each month
   c. Every 3 months
   d. Every 6 months
   e. Every 12 months

2. Extent of re-evaluation process

   a. Psychiatric evaluation
   b. Instrument administration
   c. Home visit/environment evaluation
   d. Subjective reporting from social support systems

3. Utilization of assessment in determining competence of parent

   a. Guidelines
   b. Cautions

APPENDIX B

PROPOSAL FOR A PSYCHIATRIC PARENTING ASSESSMENT TEAM

A recommendation of the
Mental Health Task Force
Special Wallace Case Investigation Team

PSYCHIATRIC PARENTING ASSESSMENT TEAM: PROPOSAL

Purpose of the team: To provide thorough, clinically relevant evaluations of mentally ill parents and their children who have cases with the Illinois Department of Children and Family Services (DCFS). The team will assess psychiatric diagnoses, parenting skills, parenting risk behaviors, and child development. The team will generate reports for use by DCFS case workers, judges and mediators who must make decisions about child custody, provision of services, mandated treatment, termination of parental rights, and other relevant matters.

Composition of the team: The team will consist of:

1. a social worker (full time)
2. a psychiatrist (10 hours per week)
3. a clinical child psychologist (15 hours per week)
4. a pediatrician (5 hours per week)

The DCFS case worker involved with an individual patient will become an ad hoc part of the team for that patient.

It is estimated that this team could conduct thorough evaluations and service linkage for approximately 100 patients per year.

Data base for the evaluation: Each evaluation will include the following:

1. Demographic information (obtained by social worker and DCFS worker)

2. Past records (obtained by social worker and DCFS worker; reviewed by psychiatrist)
   a. DCFS reports
   b. DMH charts
   c. Criminal records
   d. Other relevant records

3. Psychiatric interview of parent (modified SCID-P) (by psychiatrist)

4. Urine drug screen of parent

5. Physical examination of child(ren) (by pediatrician)

6. Psychological and developmental assessments of child(ren) (by psychologist):
   Bailey (for children under 24 months)
   McCarthy (for children 24 months or over who are verbal)
   Merrill-Palmer (for children 24 months or over who are not verbal)

7. Standardized, videotaped assessment of parent-child interactions including observations of play, separation/reunion, and mother-initiated interactions (by psychologist)

8. Social network assessment based on Arizona Social Support Interview Schedule (by social worker)

9. CAPI (Child Abuse Potential Inventory) (by psychologist)

10. POQ (Parent Opinion Questionnaire) (by psychologist)

11. HOME (Home Observation for the Measurement of the Environment) (by social worker)

Structure of the final report: The final report will be prepared by the psychiatrist as team leader, after a team meeting during which the data are reviewed and consensus is reached about recommendations. A sample of the form the final report will take is attached.

Procedure for distribution of the report: The report will be sent to the Juvenile Court judge or mediator assigned to the case, to the State's Attorney, to the Public Defender and/or parents' attorney, and to the Public Guardian. The social worker will call to verify receipt by the judge or mediator before the court date. The social worker will attend relevant court hearings and will bring a copy of the report, as well as the supporting data. The team's role is as advisor to the judge or mediator, rather than as on one side or another of the adversarial court process.

Follow-up: The team will facilitate referral to appropriate treatment facilities and services, will monitor compliance, and will re-evaluate as needed. The team will generate a follow-up report by the date suggested on the first report. The form the follow-up report will take is attached. The follow-up report will be distributed in the same manner as the first report.

Referral to the team: Whenever a new case is referred to DCFS, the DCFS worker will ask the parent to sign a written consent form for release of information about psychiatric hospitalizations and outpatient mental health treatment. The signed consent form will be faxed to the relevant hospitals and clinics. The worker will obtain a verbal report over the telephone while awaiting the written records.

The DCFS worker will also be responsible for checking criminal records for the parents referred to the evaluation team. This will be greatly facilitated by the Office of Inspector General's recommendation that DCFS install a LEADS (Law Enforcement Agency Data System) network computer at the State Central Registry.

PSYCHIATRIC PARENTING ASSESSMENT

Parent's Name:

Child(ren)'s name(s):

Evaluation team:
Psychiatrist:
Pediatrician:
Psychologist:
Social Worker:
DCFS Worker:

Date of first referral to DCFS:

Date of next scheduled court hearing:

Dates of assessment:

Locations of assessment:

Purpose of assessment:

Structure of assessment:

Identifying data:

Specific allegations of abuse, neglect, or inability to care for child(ren):

Evidence for above allegations, and level of certainty:

Summary of risk factors for abuse, neglect, and inability to care for child(ren):

Summary of protective factors against abuse and neglect, and evidence of parenting capabilities:

Summary of the child(ren)'s condition:

Psychiatric diagnoses:

Recommended treatment/intervention/services (include proposed providers):

Recommended date for follow-up report:

_____

Signature of Team Leader preparing report

PSYCHIATRIC PARENTING ASSESSMENT: FOLLOW-UP

Parent's name:

Child(ren)'s name(s):

Evaluation team:
Psychiatrist:
Pediatrician:
Psychologist:
Social worker:
DCFS worker:

Date of first referral to DCFS:

Date of initial assessment report:

Recommendations of initial assessment report:

Court date and outcome:

Date of next scheduled court hearing:

Treatment and services arranged, with providers:

Dates of follow-up evaluation:

Structure of follow-up evaluation:

Patient's compliance with treatment and services:

Changes in risk factors since last evaluation:

Recommendations:

Recommended date for next follow-up report: