OFFICE OF INSPECTOR GENERAL

Illinois Department of Children and Family Services

REPORT TO THE GENERAL ASSEMBLY

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Denise Kane
Inspector General

ILLINOIS DEPARTMENT

OF

CHILDREN AND FAMILY SERVICES

OFFICE OF THE INSPECTOR GENERAL

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For society to function adequately, social interactions must be based on an assumption of honesty, truth and keeping of promise on commitment. This is particularly true of the relationship between members of society and their powerful institutions.

Kathryn Genhardt

To the Governor and Members of the General Assembly:

When I first assumed the duties of Inspector General I was quickly educated to the devastating effect that the fear of abuse of power had over families' lives. The potential of abusive institutional power intimidated foster parents waiting years to adopt children who had lived with them since birth as well as biological families waiting to be reunited with their children. These families feared that their fate precariously depended on the goodwill of an individual worker who could use the strength of the bureaucracy to protect or harm their loved ones. Today, while the Office of the Inspector General continues to vigilantly investigate allegations of abuse of power, I fear more the procedural banality of institutional power. Sociologist C. Wright Mills once warned of the insidiousness of procedures that create men with rationality but without reason. Procedures should function as guideposts. They cannot replace knowledge, common sense, thoughtful deliberations, or professional decision-making.

Recently the OIG investigated a case involving a six year old foster child who was removed from his foster home and placed in an institution. During the course of the OIG investigation it became apparent that this little boy, who had been sexually abused before coming into state care, was removed from his foster home not because of any disruptive or dangerous behavior but because of a conflict among adults who were unable to reach an agreement regarding certain aspects of his care. The child, "Gus," had been improving in kindergarten, had been learning to ride a bike, and was anxiously awaiting the arrival of a new puppy in his foster home when he was unceremoniously moved to an institution (at a cost to the state of approximately $9,000 per month), where his days consisted of various types of the "latest" therapies and learning a new set of rules. Rather than continuing kindergarten, he was provided only one hour of schooling each day. Once institutionalized, the wheels of many self-serving bureaucracies were set in motion and, in spite of prior reports by his therapist, teachers and extra-curricular instructors that he had been progressing in his foster home, school and community, all professionals then appeared to agree that costly and traumatizing institutionalization was the only option for the little boy. Moreover, the Court, without hearing any evidence on the issue, had ordered that his prior foster mother, who had never harmed Gus in any manner, not be allowed to visit him. The institution, the child's private guardian ad litem, the DCFS worker, the DCFS supervisor and the Court all appeared to have lost sight of the child, his needs, and their common sense.

The OIG was forced to commit substantial resources to demonstrate that it was not in Gus's best

interest to be institutionalized. When the Director of DCFS learned of the situation, he was immediately supportive of the OIG position. One by one, the professionals agreed that Gus should be returned to his former foster parent who remained committed to his care. DCFS Legal Division worked tirelessly to present Gus's case in Court. The case was assigned to a different judge who conducted a full hearing on the facts and agreed that Fred should be returned. After a year of institutionalization Gus has returned to his foster home.

Procedurally, all institutional and bureaucratic players justified their positions. No one assumed responsibility for the irrationality that drove the case. Each claimed loyalty to the principle of the best interest of the child. Despite this rhetoric and close to $100,000 of wasted expenditures, a six year old lost the freedom of his community, the right to be in kindergarten, and the comfort of a loving foster mother. We cannot become so wed to "procedures" that we equate adherence to procedures with fulfilling our "commitment" and "promise." The only true "promise" of this powerful institution is true commitment to the children and families that it serves.

Denise Kane

Denise Kane, Inspector General

INTRODUCTION TO THE OIG

The Office of the Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS or Department) was created when Governor Jim Edgar signed Public Act 88-0007 into law on June 24, 1993. The mandate of the OIG is to investigate allegations of misconduct, misfeasance, malfeasance, or violations of rules, procedures, or laws by any employee of DCFS or any foster parent or private agency with which DCFS contracts.

In addition, the OIG investigates particular deaths of DCFS wards. The OIG also performs duties assigned by the DCFS Director. Investigations yield both recommendations regarding the particular subjects of the investigation and recommendations for systemic change within DCFS to prevent similar problems from happening in the future.

The Inspector General's principal office is located at **2240 West Ogden Avenue** in **Chicago**, directly across from the Cook County Juvenile Court building. The location, separate from other DCFS offices, serves to strengthen the OIG's independence and objectivity and increases the OIG's ability to efficiently monitor investigations that are related to Cook County Juvenile Court. The OIG also has a satellite office in Springfield.

The OIG Foster Parent Hotline

In the Springfield satellite office, the OIG operates a statewide toll-free telephone number **(1-800-722-9124)** for foster parent access. Foster parents call the hotline to request assistance with addressing the following concerns:

> Child Abuse Hotline information; compensation 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.

During FY95, of the 144 calls to the Foster Parent Hotline, 86 resulted in OIG investigations. Foster parents and others who have utilized the hotline see the service as a connection with DCFS to check the status of their case, and to receive additional information. In addition to foster parents, the OIG hotline has received calls from DCFS wards inquiring about a wide range of issues. The hotline is an

important tool to communicate with foster parents, foster children, and others to ensure the safety and quality of care of Illinois children.

OMBUDS OFFICE

Among the OIG's responsibilities is the supervision of the Ombuds Office. The Ombuds Office investigates and responds to complaints, concerns, inquiries, and suggestions that relate to child welfare issues. The Ombuds Office ensures that recurring complaints or problems, systemic issues or agency structural concerns are brought to the attention of the appropriate DCFS offices, bureaus, divisions, or staff. In addition, the Ombuds Office suggests improvements and changes in the functioning of the Department.

Unlike the OIG which investigates employee or private agency misconduct and addresses systemic issues, the primary purpose of the Ombuds Office is to maximize client and public accessibility to DCFS services and offices. The public and DCFS staff can contact the Office by utilizing a toll-free number (1-800-232-3798). The OIG monitors the Ombuds Office through monthly meetings and case reports. The offices share case information and refer appropriate cases to each other.

Quality, Efficiency, & Innovation

During an era in which public officials are looking to increase quality, efficiency, and innovation in public agencies, the OIG brings all three elements to the Illinois Department of Children and Family Services. Since its inception, the OIG has offered a number of recommendations for Department-wide change through case investigations, research studies, and program initiatives. The OIG promotes quality services and professionalism, increases accountability, and decreases service overlap. OIG initiatives are primarily private/public partnerships which draw on existing community and statewide resources.

The annual report highlights Fiscal Year 1995 (FY95) OIG operations.

DCFS/OIG FY95 Vital Statistics

➡ State Central Register Child Abuse Hotline call volume for FY95 was 377,467. **The public demand for child welfare services has increased.** The FY95 call volume represents an **over 30 percent increase** in call volume since 1991.

➡ The total number of children in substitute care was 47,862 in FY95. This was a dramatic **increase of nearly 50 percent** from just three years earlier when 23,777 children were in substitute care.

➡ The total family/child caseload in FY95 was 66,128, involving 51,873 children. This was a **16 percent increase** from FY94.

➡ During FY95, DCFS issued 33,227 licenses to private agencies and private homes.

➡ Over 1,200 phone calls were made to the OIG to request information, technical assistance, and investigations.

➡ Over 656 written Requests for Investigation were received by the OIG in FY95.

➡ To aid the OIG investigations, 225 case files were impounded and over 75 subpoenas were served to various agencies.

The growing demand and scope of child welfare services necessitates the presence of the OIG to foster accountability and quality of services.

Quality

One of the most important tasks of the OIG is to make recommendations following an investigation or study. Through the recommendation process and other reform efforts, the OIG seeks to improve the quality of DCFS and private child welfare agency operations.

Recommendation Process

Investigation and report recommendations are first sent to the DCFS Director. The Director distributes the report and recommendations to key personnel for comment. After review, the Department files a response with the OIG. If the recommendations are accepted, the response from the Department should include a plan for implementation. If Department personnel disagree with the recommendations, the written response explains the reasons for disagreement. The OIG will consider the Department response and determine whether to redraft the report or allow prior recommendations to stand.

The recommendation process has three aspects: the recommendation itself, its implementation, and monitoring of the results. Monitoring ensures maintenance of changes which improve child welfare practices, and ultimately improve the treatment of Illinois children and families.

The recommendations for FY95 are included in an easy-to-read table format. Not all of the OIG recommendations from FY95 are included. Only recommendations that address important systemic issues and employee discipline are listed. The recommendations are first divided into two major categories: Systemic (issues concerning operations and procedures) and Case Specific (issues concerning individual workers or agencies). Systemic recommendations are further subdivided by subject matter: Division of Child Protection, Licensing, Systems Coordination, Ethics, and Child Welfare Practice. Case Specific recommendations are subdivided into Private Agencies, Workers and Management. Column 1 identifies the precipitating problem, column 2 identifies the recommendation, and column 3 identifies the DCFS or private agency response. Several investigations led to multiple recommendations. In Column 1, a different symbolic notation (*, #, ^, ~) is assigned to each case with multiple recommendations.

SYSTEMIC RECOMMENDATIONS

Division of Child Protection (DCP)

The Division conducts abuse and neglect investigations

PROBLEM ISSUE	RECOMMENDATION	STATUS
Parents with a history of neglect and suspected child sexual abuse passed a lie detector test concerning alleged abuse against their children. Despite evidence that the children were abused, DCFS maintained a goal of return home. *see also recommendations in Case Specific section	DCP should no longer use lie detector tests in sexual abuse investigations since results are often misinterpreted as conclusive.	DCFS disagreed with the recommendation. The debate focuses specifically on the use of lie detector tests with alleged sex offenders. The OIG's position is based on current child welfare literature that concludes that "passing" results for sex offenders are often inconclusive. The Department's position is based on current law enforcement practice.
The Director requested that the OIG prepare recommendations to improve the efficiency of the child protection investigation division.	DCP should have a Community Risk Manager to review investigations for deflection to available community resources, coordinate a post-investigation staffing among the DCP worker, caseworker and family, and act as a liaison between DCP and deflection agencies.	The Department is combining investigative and follow-up offices to facilitate face-to-face transfer of cases and has implemented Extended Family Support Services to assist relatives who do not need DCFS guardianship but do require DCFS emergency assistance.

Licensing

PROBLEM ISSUE	RECOMMENDATION	STATUS
A fire at a day care home resulted in an injury to a 3-year-old child. Before the fire, the day care home was reported to be over its licensed capacity by more than ten children in three prior licensing reports.	DCFS Day Care Licensing should implement and enforce mandatory, reasonable time frames for licensees to achieve compliance. Site capacity should be posted in the home.	The Department agreed with the recommendation as it conforms with Departmental policy. Additionally, revising the licensing document to make site capacity more prominent will be explored.

A licensed foster home had a number of previous unfounded abuse allegations.	Licensing should review any home that is the subject of two or more unfounded hotline investigations.	The Department agreed and will implement the recommendation.

Systems Coordination

PROBLEM ISSUE	RECOMMENDATION	STATUS
Children in care had a different caseworker than their parents. The parental caseworker had little information about the children and did not obtain or share important information from the child worker. *see also recommendations in Case Specific section	When a family is receiving services through more than one DCFS office, case records and information subsequently learned must be consistently shared between caseworkers. Staffings should be utilized to enhance case planning and decision-making.	DCFS will develop policy in this area.
A placement goal of return home was maintained despite a parental history of abuse and neglect. *see also recommendations in Case Specific section	DCFS policy must be redrafted to require workers, supervisors, and administrators to reassess the permanency goal when necessary.	DCFS is developing policy in this area.
Child placement and permanency planning often does not include extended family members.	Six months after placement, caseworkers should convene an extended family conference to determine the best available placement for the child. Family mediation should be employed to engage extended families in developing and enforcing appropriate plans for the child.	The Department has funded two family mediation pilot projects.
DCFS Resources failed to prevent further placement of children in a home while investigating abuse/neglect allegations in the home. A child who was placed in a home under investigation died while in placement. #see also recommendations in Case Specific section	DCFS must devise a system for ensuring that children are not placed in foster homes in which there are prior indicated or pending abuse or neglect reports. DCP should follow policy requiring notification of Licensing and Resources of all cases under investigation.	DCFS has developed procedures requiring workers to perform abuse and neglect checks, and criminal background checks prior to placing children in licensed homes.

A single, 62-year- old foster mother cared for numerous children. She was not being adequately monitored or serviced. Ultimately, a child died while in the foster mother's care. #see also recommendations in Case Specific section	Prior to placement, workers should assess the demands placed on the foster parent by current foster and natural children and determine whether the parent is capable of handling another child.	DCFS has drafted policy to require workers to consider functional age of children already in placement, prior to placing a child.

Ethics

PROBLEM ISSUE	RECOMMENDATION	STATUS
DCFS operates without a code of ethics.	DCFS must adopt a code of ethics to professionalize the Department.	The OIG, in coordination with a multi-disciplinary ethics committee, has developed a code of ethics for DCFS. [see page 23]
A DCFS private agency monitor also served as a licensed foster parent of the agency she monitored. The worker referred foster parents to the private agency.	A list of DCFS workers that are licensed foster parents was submitted for Ethics Panel review.	The Ethics Panel sent a letter to all DCFS workers who are foster parents, notifying them of possible conflict of interest issues, offering help in resolution of ethical issues and suggesting boundaries.
A DCFS worker violated the Mental Health Code by releasing confidential mental health records to a professional for assessment purposes without consent.	A Mental Health Confidentiality Panel (MHC) should be convened to allow for sharing of information among professionals when appropriate; DCFS should reexamine and supplement confidentiality training to make confidentiality rules more accessible.	The MHC has been convened by the OIG and is preparing recommendations regarding changes in procedure and the Mental Health Confidentiality Act. The Department is examining redrafting the internal confidentiality rules to make them more user-friendly.

Child Welfare Practice Issues

PROBLEM ISSUE	RECOMMENDATION	STATUS
A family had multiple service issues: drug abuse, homelessness, and inadequate finances. The lack of outreach and service provision to the family had significant impact on the children in care. ^	Services should be built within the context of local community resources such as after school programs or parenting classes.	The Department is implementing the Local Area Network System (LANS), a network of community and clinical services, to address this issue.
Chronic substance abuse by the caretaker was identified by DCFS but no efforts were made to ensure that welfare payments were used for children's needs. As a result, the children's material needs were not met. ^	A protective payee must be utilized when issues of substance abuse are present.	The Department, agreeing that housing stability is important, is developing information on the Illinois Department of Public Aid's Representative Payee Program.
Children residing with a parent whose other children were in DCFS custody did not receive adequate intact-family case services. This placed the children at serious risk of harm. ^	The focus of case monitoring should be adjusted to include children at home as well as those in placement.	The Department agreed because the recommendation is consonant with DCFS procedures to respond to the needs of placed and non-placed children. The Department will actively inform staff, especially the ACR division, to plan for entire families.
After the death of a child receiving DCFS services, there was inadequate response to family crisis issues. The emotional needs of the remaining children were not addressed. ^	A crisis intervention team organized by the Clinical Division should be convened to coordinate with existing crisis teams in public agencies to facilitate investigations and defuse crisis situations that develop.	The DCFS Clinical Division will respond to ensure crisis intervention in cases referred by the OIG. The DCFS Deputy Director of Clinical Services is redrafting the Cook County crisis response policy to accommodate statewide protocol. The OIG recently received a draft protocol developed to identify and respond to cases needing crisis intervention. The OIG is reviewing the protocol to determine whether it will address the problem and whether it can be implemented.

Child Welfare Practice Issues

PROBLEM ISSUE	RECOMMENDATION	STATUS
DCFS rules convey conflicting procedures for prioritizing adoptive families.	DCFS should develop clear guidelines for prioritization of preferences in adoptive placements.	Recent federal legislation known as the Multi-Ethnic Placement Act affects the ability to consider race of adoptive parents in adoption decisions. New internal guidelines will be redrafted to explain the application of the new Act to daily operations.
A DCP investigator failed to review prior sequences that would have assisted in resolving an allegation of abuse. +see also recommendation in Case Specific section	DCFS training should focus on the necessity of attending to multiple sequence cases.	DCFS agreed to retrain investigators and follow-up workers on existing policy regarding reviewing all prior family investigations. The OIG will conduct a random sampling of cases to ensure that supervisors and administrators reinforce this practice.

CASE SPECIFIC RECOMMENDATIONS

Private Agencies

PROBLEM ISSUE	RECOMMENDATION	STATUS
Many complaints were made about a private child welfare agency's foster care services division and its residential division including: failing to report neglect and abuse; having foster parent training programs which allowed physical discipline; and employing a deficiently trained staff.	The private agency should be required within 30 days to: (1) determine which of its children have special needs as a result of having been abused; (2) segregate children in care by gender, developmental stage, and history of aggressiveness; (3) ensure that trained clinical personnel are responsible for developing and implementing individual treatment plans; and (4) ensure that employees working with children are appropriately trained on issues affecting sexually abused and sexually aggressive children.	The recommendation has been implemented, and the OIG continues to monitor the agency.

Worker Specific

PROBLEM ISSUE	RECOMMENDATION	STATUS
A worker did not adequately investigate allegations of neglect and failed to interview anyone with knowledge of the neglect aside from the alleged perpetrator. Additionally, the worker failed to document and report to supervisors additional allegations of abuse that were described during the investigation. +	The worker should be terminated for failure to investigate additional allegations.	A predisciplinary hearing was held and the worker was terminated.
A DCFS investigator violated DCFS procedure by taking pictures of child abuse victims in an insensitive manner. The worker's supervisor sanctioned the picture taking which did not comply with DCFS procedures.	The supervisor should be suspended for 2 days and transferred to another unit. The worker should no longer participate in child sexual abuse investigations.	The decision on disciplinary action is pending.

Worker Specific

PROBLEM ISSUE	RECOMMENDATION	STATUS
A child protection investigator made severely inappropriate and demeaning comments to parents who requested an investigation into the sexual abuse of their child. A therapist confirmed similar statements made by the worker.	The worker should be suspended for inappropriate professional behavior and the Department should conduct an administrative review of the investigation to ensure that the investigation was in compliance with Departmental procedures.	The worker received an oral reprimand for inappropriate comments made to OIG investigators. An administrative review was conducted.
A DCFS worker violated Departmental procedures by placing an additional child in a foster home that had reached its licensed capacity. #	The worker should receive a written reprimand for requesting a foster parent to breach her licensing contract.	The Department agreed with the recommendation. Discipline is in process.

Supervisors had documented that a veteran DCFS employee failed to perform case management tasks including home visits, and service plans but failed to discipline the worker. ~see recommendations in management section.	The supervisors should be disciplined. The worker should be terminated.	The worker's immediate supervisor was given a one day suspension. The worker was terminated.
A DCFS sexual abuse investigator disregarded a hospital finding that a child was sexually abused by his parents and failed to interview the child's foster parents to substantiate the allegations of abuse. *	The investigator should receive a one day suspension for mishandling the investigation.	The Department disagreed with the recommendation. Discipline is in process for a written reprimand.

Worker Specific

PROBLEM ISSUE	RECOMMENDATION	STATUS
An adoption worker failed to obtain completed files that were essential to preparing a case for adoption. *	The worker should receive a written reprimand for mishandling the case.	The Department disagreed with the recommendation, believing that the problem was due to systemic issues. Policy will be evaluated and possibly redrafted.
A child welfare specialist minimized reports of sexual abuse in a case involving children with a history of sexual abuse and maintained a permanency goal of return home. *	The worker should receive a five to ten day suspension for mishandling the case.	The Department agreed with the recommendation. Discipline is in process for a five day suspension.

A caseworker failed to conduct an adequate home study involving inspection of the home and interviewing children. A child died while in care at the foster home in which the home study was not completed. #	The worker's probation period should be extended.	Since the worker's probation period concluded before the OIG investigation was initiated, the Department could not implement this recommendation. The worker will receive additional training, and her next evaluation will consider the worker's performance in this case. Additionally, the Department will explore with Central Management Services and the Union the possibility of extending all new workers' probationary period from six months to one year.
An adoption worker failed to investigate a future adoptive home according to Department regulations. The worker also failed to assess the developmental needs of the adoptive children and the caretaking ability of a 62-year-old single foster parent caring for eight children. #	The adoption worker should receive a written reprimand for failing to appropriately investigate a future adoptive site, and failing to conduct an adequate home study.	The Department disagreed with the recommended level of discipline. The worker was counseled regarding decision-making in the case.

Management

PROBLEM ISSUE	RECOMMENDATION	STATUS
A DCFS administrator violated the Department's Employee Conflict of Interest Rules by using her position to obtain a contract for her husband. A DCFS Deputy Director approved hiring the administrator's husband, though he was not qualified.	The administrator should be terminated. A written reprimand should be given to the Deputy Director for failing to hire qualified employees.	The administrator was discharged. The Department informed the OIG that the Deputy Director "no longer works for the Department."
A child welfare supervisor ignored several indicators of abuse in three separate investigations of a family which included a convicted sexual abuser. *	The supervisor should receive a written reprimand due to failure to provide adequate supervision to DCP investigators.	The Department agreed with the recommendation. Discipline is in process.

A supervisor of an adoption worker failed to provide adequate supervision to a worker who failed to obtain information essential to preparing the children for adoption. *	The supervisor should receive a written reprimand for failing to provide adequate supervision.	The Department, noting that the supervisor operated within DCFS procedure, disagreed with the recommendation. The Department will address the problem as a training issue.
The DCFS Office of Legal Services was asked to review a case by the Director. The attorney assigned to review the case failed to conduct an independent review. The Director was provided an inaccurate portrayal of the case since the attorney relied on information provided by a supervisor and caseworker. *	The attorney should receive an oral reprimand due to failing to conduct an independent review of the case.	The Department conducted a counseling session with the attorney.

Management

PROBLEM ISSUE	RECOMMENDATION	STATUS
A child protection supervisor approved an investigation report which (1)disregarded a hospital finding that a child was sexually abused by his parents and (2) did not contain interviews with persons who could have substantiated the sexual abuse. As a result, an "unknown perpetrator" was indicated for sexual abuse and the sibling of the child, who was in parental care, was left at risk for harm. *	The supervisor should receive a written reprimand due to failure to provide adequate supervision to the DCP investigator.	The Department disagreed with the recommendation stating that since this case was handled primarily through a Child Advocacy Center, most of the supervisory oversight occurred there. The Department recommended that the supervisor receive formal counseling regarding the issue of indicating an unknown perpetrator. Although this course of action does not relieve the Department of responsibility of the final findings, it is also clear that other professionals contribute information in multi-faceted cases. The Department believes that formal counseling is adequate discipline for failure to indicate an identified perpetrator.

A Manager of Field Services whose responsibilities include case advising and supervising child welfare supervisors ignored evidence of sexual abuse of children by their parents, maintained a goal of return home, and failed to enforce Department rules and procedures entitling foster parents to information concerning children in their care. *	The manager should receive a written reprimand due to poor management of the case, and failure to provide adequate supervision.	The Department disagreed with the recommended level of discipline. Discipline is in process for an oral reprimand.
A DCP supervisor failed to ensure that a worker complete a case investigation within 60 days, failed to discipline, and failed to act on knowledge of this. A child died while the investigation was pending. #	The supervisor should be suspended for one day for failing to fulfill supervisory responsibilities.	The supervisor received an oral reprimand.
A DCP supervisor falsified her applications for employment and promotions on three occasions.	The supervisor should be demoted and suspended.	The supervisor retained her position, however a twenty day suspension was served. The supervisor was also determined to be ineligible for the Social Work Education Program.

Management

PROBLEM ISSUE	RECOMMENDATION	STATUS
A DCFS Resources Administrator received child abuse and neglect reports (CANTS) pertaining to foster homes and admitted disposing of them. A child who was subsequently placed in a licensed home that was the subject of a pending investigation died while in care at the home. #	The Resources Administrator should be suspended for failure to disseminate critical information.	The Department disagreed with the recommended level of discipline. The Resource Administrator was counseled regarding the problem.

A casework supervisor failed to enforce Departmental Rules and Procedures regarding providing foster parents information concerning children in their care. #	The supervisor should receive a written reprimand due to poor management and failure to provide adequate supervision.	The Department agreed with the recommendation. Discipline is in process.

Special Investigations

Following two incidents involving DCFS employees who were arrested for driving while their drivers licenses were suspended or revoked, the OIG began periodic reviews of employee drivers license status. The OIG looked at a sample of 200 DCFS employees and found that 15 of the 200 employees whose responsibilities include transporting children and families, were in violation of state law which prohibits driving while a drivers license, permit or privilege to operate a motor vehicle is suspended or revoked. Subsequently, drivers license review has become an ongoing project for the OIG. The DCFS Personnel Department notified all supervisors of the necessity for complying with state law and informed them of the OIG monitoring of employee licenses.

Administrative Case Review Reform

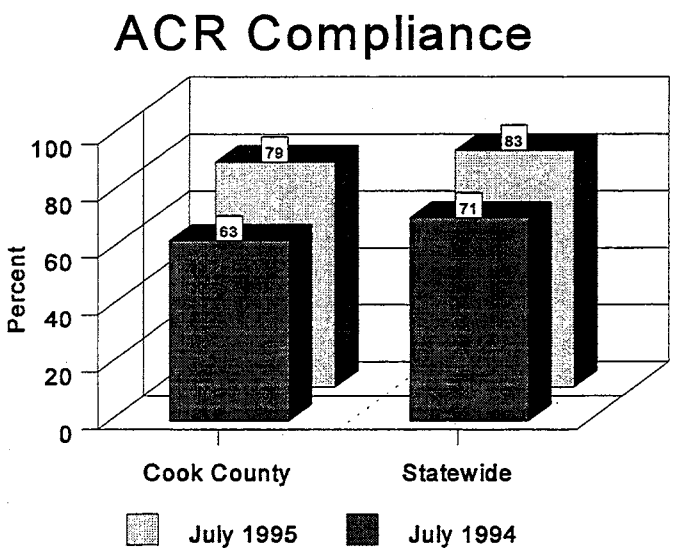
At the request of the DCFS Director in the fall of 1994, the OIG began identifying strengths and weaknesses within the administrative case review system (ACR). One of the first requests of the DCFS Director involved determining whether DCFS should continue to operate an administrative case review system. Following a period of observing reviews, working with ACR and Field Operations staff, and discussing their experiences with ACR participants, the OIG concluded that *despite problems with the ACR system, internal administrative case review serves a unique role that is important to the agency, and therefore should be continued.* One of its most important functions, and the one that is unique to internal review, is providing agency oversight to case planning and progress before the responsibility for case planning is assumed by the court. In addition, the Department's ACR system has developed a state-of-the-art computerized system to collect and generate data regarding the agency and the population it serves. The OIG did recommend, however, that lay advocates, within an independent advocacy organization, should be included in the review process.

The OIG has also made specific recommendations to the DCFS Director to improve the ACR process. A notable recommendation was that clinical staffings are needed

more than 45-day reviews (detailed below). These staffings should bring together an array of individuals involved with the family, should identify family strengths and weaknesses, and consider possible remedies to the problems that led to the abuse or neglect allegations. The OIG also recommends that the ACR should be a part of a Quality Assurance Unit of the agency in order to ensure that the range of information gathered is used to its fullest potential. Additionally, a method to screen out applicants who do not have the knowledge base or ability to serve in the reviewer's role should be developed. (The OIG is in the process of drafting a proposal for establishing the screening method).

Throughout the year, the OIG worked with ACR and Field Operations staff to improve compliance for six-month case reviews mandated by federal law and the B.H. Consent Decree (the B.H. Consent Decree mandates that every child entering the foster care system have a case review conducted within 45 days of entry). From July 1994 to July 1995 the proportion of six-month reviews on every child in the foster care system increased from 71 percent to 83 percent. Cook County compliance increased from 63 percent to 79 percent (see Table 1).

Table 1



Efficiency

OIG's internal operations and its administrative responsibilities foster DCFS organizational efficiency.

OPERATIONS MANUAL

As the OIG has evolved, it has grown in scope, responsibility, and staff. As a result, a need developed to establish structured, organizational procedures to identify appropriate OIG practices. The current manual is a 23-page document covering professional issues ranging from supervision and general investigative procedures to monitoring. The operations manual will continue to be updated as the OIG develops.

METHODOLOGY

Once a Request for Investigation has been reviewed and accepted by Intake, it is assigned to an investigator. The investigator carefully reviews all materials submitted by the complainant and contacts the complainant for any necessary clarification.

The investigator determines what files and documents are necessary for review. Relevant documents may include Child Protection Investigations, Follow-up casework files, court files, private agency files, hospital records, school records or police reports. The Inspector General issues administrative subpoenas to retrieve relevant records from sources outside the Department or private agencies with which the Department contracts. The investigator is also responsible for reviewing relevant Department Rules and Procedures and consulting with internal or external experts, as necessary. Persons with relevant information are interviewed and the subject of the investigation is given an opportunity to address negative allegations.

After collecting all relevant data, the investigator and the supervisor analyze the material and determine whether any misconduct was involved. The team also determines whether the facts disclose any systemic problems within the Department that need to be corrected. The investigator then prepares a report to the Director, outlining as well as analyzing the elements of the case. The report

also contains disciplinary and/or systemic recommendations. After reviewing the report, the Director circulates OIG recommendations for comment and submits a response to OIG. The OIG then monitors implementation of final OIG recommendations.

Child Death Review Team

In 1994, Governor Edgar signed the Child Death Review Team Act authorizing the creation of multidisciplinary review teams in various regions across the state to review child deaths in Illinois. The OIG supported this legislation and works together with the Review Teams to resolve difficult questions arising in OIG investigations. The Child Death Review Teams review cases of child fatalities in order to reduce child fatalities and serious injuries by gaining a better understanding of the causes and reasons for child deaths.

The Child Death Review Team, which meets monthly, is required to review every death that occurs in their region in which:

1) the child is a ward of DCFS
2) the child was the subject of an open DCFS case
3) the child was the subject of an abuse/neglect investigation during the preceding 12 months
4) the child was the victim of a sudden, unexplained death occurred.

The OIG conducts extensive investigation in death cases involving the wards of DCFS. The OIG has worked closely with the regional child death review teams in Cook County and in counties across the state. Recently, the OIG developed an intervention protocol to provide guidelines for DCFS and private agency workers to follow after a child death. This protocol was distributed to DCFS and will be distributed to private agency staff.

Innovation

Since its inception, the OIG has advanced a number of new projects, panels, and programs to ensure quality and efficiency in the Department.

Mental Health Task Force and the Parenting Assessment Team

The Mental Health Task Force has been operating for nearly two years. The Task Force arose from an OIG recommendation following the Wallace investigation - a child death case involving a mentally ill parent. The Task Force, a partnership between DCFS and the Department of Mental Health, identifies and addresses major mental health issues that may impact children and families. The Task Force focuses attention on those families served by DCFS in which there was an indicated finding of child abuse or neglect involving a parent who has been previously psychiatrically hospitalized. The Task Force assesses parenting capabilities to assist DCFS workers in making decisions in the best interest of the children involved.

The first project for the Mental Health Task Force involved making recommendations to the Department concerning mental health issues. The following have been implemented: (1) DCFS access to the Law Enforcement Agency Data System (LEADS) permitting rapid checking of criminal records of parents, foster parents, and relatives; (2) the development of an independent assessment team to conduct comprehensive, methodologically sound, non-adversarial assessments of parenting capabilities, and; (3) the replication of a model for intensive case management programs for mentally ill parents who could achieve adequate parenting skills.

The Mental Health Task Force continues to work on recommendations made in 1994 and examine issues of mental health and parenting. Presently, the Mental Health Task Force is examining issues of confidentiality and disclosure, and is developing a series of protocols for screening services and assessment of parents who are mentally ill and whose children are at risk. The Task Force is also reviewing ethical standards that can guide caseworkers and their supervisors in managing high-risk mental health cases.

An aspect of the Mental Health Task Force is the Parenting Assessment Team (PAT). PAT was created under the guidance of the Mental Health Task Force. PAT is a joint effort of the Thresholds Mothers Project and the University of Illinois at Chicago Department of Psychiatry and is funded by DCFS. The purpose of PAT is to assist DCFS and the Juvenile Court in evaluating parenting capabilities of mentally ill parents who are alleged perpetrators of child abuse and neglect.

By early Spring 1995 PAT established a toll free number for referrals (1-800-434-1923), developed an information packet and brochure and began accepting referrals. For DCFS staff, PAT is currently developing a training tool for assessing parenting skills and evaluating parent/child attachment.

Chicago Police Department Child Abuse and Neglect Training

The OIG, in conjunction with the Chicago Police Department (CPD), the Office of the Governor's Special Counsel for Child Welfare Services, and DCFS drafted a training program on child abuse and neglect for Chicago Police Officers.

The program expanded police officer knowledge of child abuse and neglect, educated police officers about how DCFS operates, and cultivated a better working relationship between the CPD and DCFS. Training sessions, attended by DCFS and OIG staff, informed officers of the crisis of child abuse and neglect, reviewed child welfare laws, and trained officers on how to recognize and respond to child abuse and neglect.

Ethics

Many of the OIG requests for investigations involve professional ethical issues. Additionally, the demand for ethics in public service has increased markedly over the past decade. The OIG staff along with an ad hoc committee composed of DCFS employees, private agency representatives, representatives from the National Association of Social Workers, and professors of social work and ethics have drafted an employee Code of Ethics. The committee has also framed an Ethics Panel to review professional issues, and has worked on establishing an ethics training component for all DCFS employees and contracting agencies. The Ethics Panel serves the crucial function of professionalizing DCFS. It also creates an outlet for workers to resolve difficult ethical dilemmas.

By spearheading this effort in child welfare, the OIG hopes to set an example for other public agencies to follow. A Code of Ethics defines the responsibilities of

employees in professional relationships with colleagues, agencies, clients, foster parents, the courts, and society. The Ethics Project attempts to foster accountability to clients and society.

Casework Best Practice

A major problem within the Department is the failure of many workers and supervisors to identify problems in cases and engage in appropriate problem-solving and decision-making strategies. As a result, and at the request of the Director, the OIG embarked on a project to incorporate principles of problem-solving and decision-making into casework practice.

The OIG, working with private agencies, has developed and begun implementation of an innovative training model based on principles of best practice for child welfare. There are three elements to the program:

Casework Principles	Training/Feedback	Recommendations for Implementation
The OIG has identified major areas of casework practice and has involved experts in each area to establish best practice principles, decision-making guidelines and service strategies.	The OIG has identified key supervisory personnel to participate in a training program based on best practice to include field testing the best practice principles. The key personnel are encouraged to use the best practice standards and to reconvene over a period of several months to discuss and modify practice ideas to assure they are workable and useful.	The OIG will make recommendations to the Department and the Legislature to further best practice principles, including recommendations for changes in law, policy and procedure, strategies for developing innovative service models, and suggested training curricula.

Practice principles have been developed for fast track termination of parental rights in appropriate cases, specialized parent assessment, behaviorally-based case management techniques, parent training, legal and court preparation, and ethics for child welfare. In addition, the OIG is developing a legislative proposal for fast track termination of parental rights in appropriate cases. When fully implemented, the best practice model is expected to enable workers to engage in more timely decision-making to better serve Illinois children and families.

Repair Assistance Program (RAP)

As a result of a series of cases concerning housing issues which involved the removal of children, the OIG initiated the Repair Assistance Program (RAP). Enlisting the help of DCFS Norman monitors (workers who address poverty related issues of neglect), the Special Counsel to the Governor, the City of Chicago Department of Housing, and the Chicago Coalition for the Homeless, the OIG developed RAP to respond to poverty-related neglect due to poor housing conditions.

Utilizing this unique private/public partnership mix, the program seeks to develop a more cohesive Departmental response to housing issues. Symbolizing a commitment to housing issues, DCFS has recently retained a housing specialist who has been working actively with the OIG in improving Departmental response to housing problems. The Department holds that children should not be removed from parental custody when correctable housing conditions can be repaired and abuse and neglect are absent.

RAP has three main components:

1) assist tenants with negotiating for needed utility services
2) assist tenants with using tenant ordinances or other related ordinances
3) repair conditions within residences that threaten child safety.

The partnership with the City was initiated with the help of then Special Counsel to the Governor, Anne Burke. The Office of Special Counsel continues to be involved in the RAP process. The partnerships represent one of the first times that the Department has worked closely with the City of Chicago Department of Housing on issues of deep and overlapping concern. The City has graciously agreed to train DCFS supervisors on the RAP program as well as City housing programs.

OIG Partnerships

Because the nature of the OIG necessitates the involvement of a variety of professionals and private agency personnel, the OIG has coordinated investigative and informational efforts with several organizations. Among the most frequently contacted agencies are the U.S. Attorney's office, the Attorney General's Office, the Department of Professional Regulations, the Federal Bureau of Investigation, the Cook County State's Attorney's Office-Division of Public Integrity, and the Illinois Secretary of State Drivers License Division. In addition, the OIG relies heavily on law enforcement personnel from municipal, state, and interstate offices.

Adoption Panel

Shortly after its inception, the OIG began responding to categories of complaints regarding DCFS adoption practices. An investigative study resulted (see 1994 OIG annual report for details). One of the recommendations stemming from that investigation was that nonbiased foster parent and adoption review panels be established to hear disputed issues relating to adoption.

The OIG has organized a panel in Cook County. The panel, chaired by Dr. Jeanne Robinson of the School of Social Services Administration of the University of Chicago, meets bi-monthly and reviews potential adoption cases involving complex issues. The panel also has a cost benefit. Costly multiple bonding assessments and evaluations are avoided and DCFS workers and attorneys do not spend numerous hours in contested court hearings.

Family Conference Model

Pro-active work with families at risk for entering the child welfare system decreases the number of cases in the system. Pro-active efforts also decrease the emotional costs to families and decrease the financial cost to the State. Recognizing this, the OIG sponsored utilization of the Family Conference Model. The Family Conference model is based on the premise that the Department will be better able to devise a permanent and safe plan for children with the help and input of extended family and community members. Family and community members who are involved in the child protection process are more invested in the success and enforcement of the case plan.

Originally developed in New Zealand, the community-based Family Conference Model enhances the extended family members' decision making functions by involving them in developing a protection and care plan for their children. The Family Conference Model operates to protect children, enhance social support and problem solving skills of families, and promote early permanency planning.

The OIG has introduced the model and has received support from DCFS to pilot the project in FY 96 in the Lawndale community of Chicago, and in the city of Champaign. Two case categories will be considered for the Family Conference: (1) first time cases of substance-exposed infants, and (2) cases when children have inadequate supervision or when a grandparent is concerned about the well-being of a grandchild.

Diligent Search Center

A major barrier to permanency planning and the adoption process in Illinois is the diligent search process. Diligent search refers to the State mandate that a diligent search be conducted to locate biological parents and inform them of the adoption process in order to ensure that parental rights are not being violated. The diligent search process is a time consuming, tedious process that is rendered even more difficult by an archaic, manual search system. Reflecting its commitment to improve efficiency, cut costs, and serve the children of Illinois, the OIG along with Peggy Slater - Legal Analyst with the Children and Family Justice Center at the Northwestern Legal Clinic promoted the idea of a Diligent Search Center to modernize and streamline the process.

As a result of the OIG submitting a grant application to the federal govenrment, DCFS has been awarded *federal grant money* to establish a Diligent Search Center in Cook County. The Diligent Search Center, to be operated by Illinois Action for Children and Court Appointed Special Advocates (CASA), will be located on the 8th Floor of Juvenile Court, thanks to the efforts of the distinguished Judge Nancy Sidote Salyers. The Diligent Search Center will be staffed by a Director working with volunteers and will be equipped with computer terminals with data base access to Public Aid and Juvenile Court information. The Center expects to cut the diligent search time in half, enabling social workers to concentrate on providing services to children. The Diligent Search Center concept has been met with widespread, enthusiastic support from caseworkers, the DCFS Director, the State's Attorney's Office, and Juvenile Court judges.

Kinship Permanency Planning

Kinship Permanency Planning addresses the needs of children who linger in relative foster care. These family cases use a significant amount of resources of both DCFS and the courts. The OIG recognized the need to address the issues of such families in order to fulfill the goal of ensuring the stable, permanent placement of Illinois children while decreasing the drain on DCFS and court resources.

The project provides families of wards an opportunity for a mediated agreement between care givers and birth parents that can lead to adoption, delegated relative authority or private guardianship, and allows the Department to remove itself from the lives of these families, while assuring continued safety of the child. Eligible cases for referral are those where the child has been with the caregiver over one year and the caregiver, birth parents, and child are interested in adoption.

There are many advantages to Kinship Permanency Planning:

1) giving children a sense of stability
2) moving families from dependence to interdependence, freeing the child welfare system to monitor cases requiring intensive services
3) providing case management services is less expensive
4) avoiding costly court processes
5) the adoption subsidy is financial need-based (unlike relativive or non-relative foster care) and does not have annual increases.

By conservative estimates based on research, the Kinship Permanency Planning Project is expected to annually **save well over one-quarter of a million dollars in DCFS and court resources** while ensuring the safety and support of children.

Early Identification of High Risk Families

Children's cases meeting the criteria for temporary custody move through the court system with little or no distinction between those involving serious harm to the child and little chance of parental rehabilitation and those in which the parents' prognoses for rehabilitation are good and their commitment level high. Failure to make a differential diagnosis results in most cases receiving unspecified services over an indefinite period of time while maintaining a placement goal of "return home." Young children who could be adopted are deprived of adoption opportunities. Their cases often remain in the juvenile court system as they drift through foster care.

After reviewing Illinois law and child welfare practices relating to termination of parental rights, the OIG concluded that a common misperception exists concerning the idea that federal and Illinois law require that efforts toward reunification be provided in each case, regardless of the parental conduct. The OIG is drafting legislation to clarify that requests for termination of parental rights can be filed along with the original petition seeking custody and jurisdictional findings of abuse or neglect. The OIG will also propose to legislators that two unfitness grounds be added to the Adoption Act: (1) relating to termination of parental rights when the parent will be incarcerated for a lengthy period of time and despite agency assistance is unable to make an alternative care plan and (2) relating to termination based on criminal court findings of "not guilty by reason of insanity" concerning the killing of another child.

It is anticipated that the proposed changes in law and practice will result in saving state dollars that are otherwise spent on families that cannot be rehabilitated.

Importantly, the changes will expedite adoptions for those children who cannot safely be returned home, but can find permanency in an adoptive home. The OIG is working closely on this project with Presiding Judge Nancy Sidote Salyers, Cook County Juvenile Court, Child Protection Division, and with other officers of the Cook County Juvenile Court.

Divorce-Custody Disputes

A number of requests for investigation received by the OIG involve allegations that the Department improperly investigated charges of abuse in the context of divorce custody proceedings. The cases consume an inordinate amount of the OIG staff time and resources. Recognizing the complexity of these cases since they involve two court systems (civil and juvenile) and often involve conflicting testimony, the OIG conducted research to determine the appropriate methodology for such cases. The OIG then convened a working group composed of representatives from private mental health care providers, the Department of Mental Health, Child Advocacy Centers and the Public Guardian's Office to develop recommendations based on previous research findings for the handling of such cases.

Children's Hotline

The OIG is initiating a Children's Hotline, patterned after the successful Foster Parents' Hotline, to provide a place where children in the system can call to have questions and concerns addressed.