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Testimony of the Cook County Public Guardian
Subject Matter Hearing
Documented Abuse at DCFS Residential Facilities

Before the following Committees:
Senate Appropriations I
Senate Human Services
House Adoption Reform
House Appropriations – Human Services
House Human Services
House Health Care Availability and Accessibility
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The Cook County Public Guardian is the court-appointed attorney and guardian *ad litem* for children with cases in Cook County's abuse and neglect courts. My office currently represents over 6,000 children in this capacity, ranging in age from newborn to 21. The vast majority of my clients are in the custody or guardianship of the Illinois Department of Children and Family Services (DCFS). The recent series of Chicago Tribune articles regarding DCFS residential facilities gives a voice to youth in DCFS care, allowing us to hear about their lives from their own perspective. I appreciate the time the committee members will devote to responding to the issues the youths raised and I look forward to developing solutions to ensure that Illinois' children, who rely on DCFS to take care of them, are safe. There are no simple solutions to this extraordinarily complex problem.

When I was hired as an entry level attorney at the Office of Cook County Public Guardian (OPG) in 1991, DCFS caseworkers were responsible for approximately 80% of cases, while the private agencies were responsible for the remaining 20%. Since then, the numbers have reversed, with private agencies currently responsible for approximately 80% of cases. The constant fact, however, is that DCFS is Illinois' statutorily-obligated child welfare agency responsible for the protection of children state-wide. When a court appoints DCFS as a child's guardian, DCFS is responsible for the safety and well-being of the child and for acting in the child's best interest. DCFS cannot abdicate its responsibility to private agencies to ensure the well-being of the children in its care.

The initial reaction to problem-laden residential placements is to close them. In 2003, the Governor announced that Maryville would be closed amidst reports of problems similar to those raised by the current Tribune series. When I was appointed as the Cook County Public Guardian in 2005, I filed a series of motions on behalf of my clients placed at the Mill, which operated in the same building as the residential facility known as Rock River and had many of the same issues we see today. As a result, the Mill was closed.

But the lingering question is when a facility is closed where do the youth go? In 2005, as is the case now, there were no new and improved residential facilities opening. My clients, who had suffered years of abuse, neglect, most of whom had been shuffled through multiple foster homes, shelters, hospitals and group home placements, were then placed on waiting lists. Eventually many of them were placed in other facilities equally ill-equipped to handle their particular needs. I am now convinced that while some facilities should close, the necessary focus should be on developing qualified, appropriate placements. Hiring an adequate number of well-trained staff (including direct care workers, therapists, psychologists, psychiatrists, administrators etc.) is imperative. And it will require the combined work of the legislature to fund and support a healthy DCFS; DCFS to ensure that its contracting agencies are providing safe, quality care to our children; committed private agencies and service providers; and a committed judicial system.

There are many tools my office uses to protect clients who do not feel safe. On the individual level, we file motions to request court findings that a client's placement is not necessary or appropriate for the child and ask the court to order DCFS to move the child; we file administrative appeals to request services for clients; and we request and participate in DCFS clinical staffings to discuss and locate appropriate placements for clients. The success of all of these efforts presumes the availability of alternate safe, nurturing, stable placements. Sadly, such alternative placements are often not immediately, if ever, available. In addition, we report issues raised by clients or observed by my staff to DCFS, the police, the DCFS hotline, and the Office of the Inspector General; and when children are harmed in placement, we may file civil actions against the wrong-doers.

On a more systemic level, we have written numerous letters to various DCFS Directors regarding quality of care issues for clients, including letters regarding some of programs described in the Tribune series; we interact almost daily with the DCFS monitoring division regarding quality of care issues both in residential facilities and foster homes; and we have presented testimony before various legislative committees since 2007, in which we have repeatedly expressed the opinion that the most pressing issue facing youth in state care is the insufficiency of safe, stable, and nurturing placements to meet youths' needs in a timely way.

There are many necessary components to ensure that safe, stable, nurturing placements are available for youth in care – including developing sufficient capacity in the system to respond to children's identified needs in a timely fashion, properly supporting and monitoring the critical private resources DCFS relies upon to provide care to children, and responding effectively to allegations of harm in placements chosen by DCFS. Moreover, while DCFS needs to be responsive to the concerns of the legislature, they also need to be insulated from political pressures not related to the quality of care provided to youth, misfeasance by their employees or malfeasance by their employees and agents.

Facilities that do not provide quality care should not remain open to in order to provide jobs in a certain area; facilities that provide quality care should not close because some communities do not want to live near children in DCFS' care.

Kia's Story

My client Kia's life illustrates the ills of the child welfare system and its inability to meet the needs of children. I take the time to tell her story because it illustrates so many of the critical issues facing youth in care, all of which contribute to the issues raised in the Chicago Tribune series on residential care. Some people who work in and around the system, who deal in statistics, may call the facts in Kia's case anecdotal. However, it is the lives of individual children that we should strive to improve, not statistics. Reliance upon statistics can be misleading and often fails to capture the real story. Developing solutions to improve residential care requires an understanding of the path the youth in residential care took to arrive there.

Kia entered DCFS care at the age of 7 after witnessing a long history of domestic violence between her mother and stepfather. For the next 5 years, DCFS moved Kia through four relative foster homes and two non-relative foster homes. At least two of these foster home placements disrupted because the foster parents could not handle Kia's behavior; four disrupted because of allegations of maltreatment. At one point, the assigned private agency identified 8 potential foster homes for Kia – all of whom were unwilling to take her in. As a result, DCFS placed Kia at the emergency shelter and recommended that Kia be considered for specialized foster care.

During Kia's two months at the emergency shelter she was psychiatrically hospitalized before being discharged to a temporary foster home. She was quickly re-hospitalized and discharged to yet another foster home, despite her obvious fragility. At this point, 12-year-old Kia fell victim to sex traffickers. The specialized foster parents asked DCFS to remove Kia from their home because they could not meet her needs. DCFS placed her in another foster home. Within a few weeks, Kia went on run and resurfaced about a month later. Kia – just 13 – reported that she had sex with multiple men and was treated well by her pimp while on run. DCFS again placed her at the shelter and she was again hospitalized. She remained in the hospital for three weeks after she was ready to be discharged, solely because DCFS did not have an available bed for her in a high-end residential treatment facility (RTC). Finally, DCFS placed Kia in a high-end RTC.

Kia ran away several times while at the high-end RTC. She reported that there was not enough staff in the facility to handle the clients during crisis. At one time, Kia had deep scratches on her arms, neck and face after an altercation with a peer. She made several suicide attempts, including one while she was supposed to be on "line of sight" precautions and facility staff lost track of her for a while. At 13, she was located by the police in an area known for prostitution. Eventually, she was gone from the RTC for so long that her bed was no longer held for her.

In November 2014, 14-year old Kia was officially placed at a shelter, but she was on run more than she actually stayed in the shelter. In early December, Kia presented at the shelter and was found to be in need of psychiatric hospitalization, but a hospital bed could not be located for her and she ran again. Two other times Kia returned to the shelter but was turned away because she was no longer on the

shelter's roster and, on one occasion, because the shelter thought she might be pregnant. At that time, a Child Protection Warrant was in effect for her and DCFS, the Cook County Sheriff, my office and the court were frantically looking for her. Last week, we filed a motion on Kia's behalf, seeking a court order to ensure that the shelter and DCFS would take appropriate steps in the event Kia returned to a shelter or was located. Cook County Sheriff Thomas Dart sent a letter to DCFS imploring DCFS to close the shelter. In reaction, DCFS moved all of the girls placed there and placed the facility on intake hold.

Because of the diligent efforts and collaboration of the Cook County Sheriff's Office and my investigators Kia was located on December 31, 2014. She has been placed at a residential treatment center. The facility where Kia was just placed will not have another opening for several weeks and already has a wait-list in the double digits.

Children in Care Must be Safe

When the State of Illinois removes a child from his or her parents it has the responsibility to place that child in a safe, stable and nurturing environment that is chosen to meet the child's needs, not because it's the first available place with an opening. Kia reported maltreatment in four foster homes; she reported that there was insufficient staff at her high-end residential treatment center to handle youth in crisis; she was able to attempt suicide at a high-end residential treatment center while she was supposed to be in the constant line of sight of staff; she was victimized by sex traffickers for months at a time, starting at age 12; and she was twice denied admittance to an emergency shelter when she attempted to return. DCFS' Guardianship Administrator is responsible to ensure that children in DCFS care are placed in permanent, secure and nurturing living arrangements. 89 ILAC 327.4(e). If we as a community remove them from their families, we have to offer them something better.

Increase the Effectiveness of DCFS Monitoring

The vast majority of children in DCFS care live in foster homes licensed through private agencies or in group care settings, including residential treatment facilities, run by private agencies. DCFS contracts with these agencies to provide services to the children in DCFS care. DCFS employs monitors to oversee the quality of services provided by the private agencies. DCFS monitors play a critical role to ensure the well-being of children in care. The monitoring division needs to be restructured and needs to have clear standards against which to measure programs. DCFS needs to actively and timely review the information it receives about programs from its monitoring division and other sources. Most importantly, the standards need to focus on the safety and well-being of the children in the program. And DCFS should review the facility's programming modules with measures for specific outcomes.

Last year, I expressed concerns about DCFS' shift towards a heavy reliance on data to monitor the private agency residential programs. I pointed out several programs where my staff observed significant concerns about the physical condition of facilities. **While data review is an essential component of monitoring, it cannot replace regular, frequent site visits. Data does not capture the actual quality of life experienced by the children. There are simply too many tangibles that directly impact the standard of care provided to children that cannot be seen in data. The safety and well-being of children while in a facility must be the primary focus, in addition to the current measures of how long the children are in the facility's program and how well they do upon discharge.**

Safety of children placed in foster homes is equally important. Negative experiences in foster care exacerbate the fragile emotional states of youth in care and contribute to youth needing higher levels of care – including residential care – in the future. The vast majority of children living in foster homes are placed in homes licensed by DCFS through private agencies. These agencies are responsible for assessing foster parents for licensure, monitoring the license, and investigating any complaints that licensing standards have been violated. If a licensing complaint is substantiated, the agency is responsible for developing a corrective plan to address the concerns. This can be a conflict of interest, much like if Exxon or BP Amoco was responsible for investigating themselves after an oil spill.

Although a child's case is assigned to a private agency and the child is placed in a foster home licensed through a private agency, DCFS remains the child's guardian and is legally responsible for the well-being of the child. DCFS has a procedure where they can place foster homes on "hold" when concerns arise about the foster parent's ability to properly care for or have harmed children. (See, DCFS Procedures 300, Appendix E, Part IV).[1] A "hold" prohibits the placement of additional foster children into the foster home. My office regularly requests that DCFS place a hold on a home to prohibit the placement of our clients in the home when we become aware of concerns regarding the care of our clients in the home. Foster children should not be placed in homes of foster parents who have proven to be unable to properly care for foster children, or where there is a known risk of potential harm.

Sometimes it appears that DCFS is reluctant to place homes on hold and DCFS has also lifted holds from homes when we believe there is a continued risk of harm. In many cases DCFS has not investigated the case, instead DCFS relies upon the private agency's internal investigation or the passage of time to determine whether to the lift the hold. It is essential that DCFS provide children removed from their parents' care with safe, nurturing homes free from known risks.

My office interacts almost daily with DCFS' monitoring division. We regularly share our observations and concerns regarding programs and the well-being of our clients in foster homes and residential facilities with the DCFS monitors, private agencies, and frequently with the Director, as they arise. Our information comes from interviewing clients, visiting them in their foster homes and at facilities, reviewing records, and speaking with others involved in my clients' lives. **It is imperative that DCFS' monitoring division look at this qualitative information, in addition to quantitative information, as they monitor quality of care children are receiving from private agencies. DCFS' monitors must play an active role in not only reviewing data and systemic information regarding a facility or foster home, but also in responding to situations where the expected standard of care has not been met – either systemically or in an individual case. First, DCFS must clearly define regulations and programming standards.**

Clarify Standards for Group and Residential Care

One essential element for monitoring a program successfully is knowing what the expected standard of care is. All DCFS-licensed facilities -- group homes and residential programs – are licensed as group homes under Department Rules. 89 ILAC 403. The Rules provide little detail regarding what is actually expected. The boiler-plate contracts DCFS uses to contract for services also provide little detail about what a program is actually expected to provide for children and youth. For example, we recently reviewed a contract for a residential facility that treats young children, up to the age of 13. Their boiler-

[1] DCFS' hold process was upheld in *Dupuy v. Samuels,* 397 F.3d 493 (7th Cir. 2005).

plate contract includes provisions for preparing the youth to live independently and for treating pregnant and parenting teens. Each agency's contract should specify what services and programs the facilities are expected to offer to the children they serve.

Critical Resources Must be Adequately Supported

Adequate funding for quality placements for youth in care is critically necessary to ensure their safety and well-being. Residential treatment facilities should be reimbursed at a rate that enables their programs to provide the high level of quality care, supervision and programming that these extremely vulnerable children require. Qualified and trained foster parents need to be reimbursed at a rate that covers the actual cost of care for children, including those with special needs.

In October of 2007, the University of Maryland School of Social Work published a report titled, "Hitting the M.A.R.C., Establishing Minimum Adequate Foster Care Rates for Children." The report compared the actual costs of caring for a foster child in each state with the rate of reimbursement the state provided to foster parents. Illinois needed to increase foster care reimbursement rates by 74% to 81% (depending upon the age of the child) to cover the actual cost of care. Adequate financial support to licensed qualified and trained foster parents, in addition to providing necessary services such as quality mental health treatment for children and adequate respite care, has been found to be one component of increasing placement stability and child well-being.

In 2009, the Illinois Legislature enacted PA 96-0247, which recognized the M.A.R.C. study and requires DCFS to report annually to the General Assembly regarding its efforts to meet the standards set forth in the study. Residential, group home and transitional living facilities face similar struggles when their programs are not adequately supported to meet the actual costs of providing quality care for the extremely traumatized and clinically complex children they serve. It is reported that residential programs have received only a 2% increase in the last 7 years. This is insufficient to provide quality high-end care.

Multiple youth in the Tribune series described opportunities to run away from high-end treatment facilities because the staff responsible for supervising them were pulled away to handle emergencies. Other youth reported that they felt unsafe because staffing levels were insufficient. Youth at high-end facilities will engage in problematic and sometimes dangerous behaviors and facilities need to be adequately staffed to respond with appropriate therapeutic interventions. Residential programs that treat our most emotionally traumatized youth must be funded at levels sufficient to ensure necessary levels of qualified staff and clinical programming at all times.

Develop Critical Resources to Respond to Children's Identified Needs in a Timely Fashion

Timely Placement of Children and Youth

DCFS is required by law to place children consistent with their health, safety and best interests. 20 ILCS 505/7(c); 89 ILAC 301.60(a). However, on any given day children in DCFS care are waiting for appropriate placements. These children and youth wait in psychiatric hospitals beyond when they are ready to be discharged, in shelters intended to provide short-term emergency care and in placements that DCFS itself has determined are inconsistent with the child's needs. Another small number of children wait for appropriate placements in detention centers or Illinois Youth Correctional Facilities. Treatment facilities frequently have long wait lists for admission into their programs.

The children who require residential treatment are moved up and down on waiting lists – vying for the coveted first place spot – depending upon their specific circumstances. Adolescents who need foster homes are frequently diverted to group home care. And, as the Director acknowledged in the Tribune series, some youth wait in residential care because foster homes are not available for them. Meanwhile, the children and youth deteriorate and become discouraged because they do not receive the services they require, including in many cases, necessary mental health treatment.

The lack of qualified placements and the resulting gridlock impacts children who are not safe or who are in otherwise inappropriate placements. Some judges in Cook County, aware of the wait lists for placements, are hesitant to order DCFS to remove children from inappropriate placements, knowing that that it is unlikely that an appropriate placement will be immediately available for the child or youth. Other judges order DCFS to immediately place children in facilities, thereby "bumping" the waitlist line.

Intervene Early / Invert the System's Response

Over the past two decades, Illinois has drastically reduced the number of children in state care. As of September 2014, there are 15,009 children in care. Illinois now ranks third in the nation for taking the fewest children into care because of abuse or neglect. The youth entering care now, however, come with extraordinary histories of lifelong trauma. In many cases, Illinois' failure to quickly provide services to a troubled family and delay in removing a child from an abusive or neglectful circumstance prolonged the child's exposure to trauma. This exposure to prolonged trauma may be the result of a policy shift by Illinois in responding to children who are abused or neglected or the widely known failures in DCFS' investigation division (DCP). Due to this prolonged trauma, many of the youth entering DCFS care have significant psychological and emotional needs. These needs can lead to failed placements because the foster parents, although well intentioned, can't meet the needs of these traumatized children. And with each failed placement, a child's risk for physical, psychological and emotional health problems increases.

Although the needs of some of today's children are different, the system is still shaped by the 50,000 children in care during the mid-1990's. Back then, many of those children did perfectly well cared for by concerned relatives or traditional foster parents. In the 1990's, a hierarchy of services was provided to children that required a particular type of placement to fail multiple times before increasing the child's level of care. It is time to re-examine the practice of requiring children to "fail up" to more intensive services over a prolonged period of time. Instead, intense services should be provided at the outset of each case where certain risk or trauma factors exist.

Develop and Support Foster Care Resources for Adolescents

According to DCFS, there are over one hundred children remaining in residential facilities solely because DCFS is unable to locate appropriate step-down placements for them – usually a specialized foster home. For these over 100 children, the discouragement of remaining in institutional care when a foster home is needed is debilitating. And for the children and youth who need the 100 residential treatment facility beds, waiting in hospitals and other inappropriate settings is also debilitating.

My client Demani is one of these youth. Demani[2] is 12 years old and has been ready to live in a foster home since January of 2013, after several years in residential care. His 10-year-old sister, also in residential care, has been ready for a foster home since June 2013. The court recently found that their placements in residential care are neither necessary nor appropriate because the children no longer require residential care; despite these findings, a home still has not been located for Demani.

Several jurisdictions outside of Illinois have implemented a multi-dimensional treatment foster care model. Multi-dimensional treatment foster care is a model that developed in the 1980's as an alternative to residential and group home placements for children and youth with severe emotional and behavioral disorders.[3] Key elements of the model include: (1) foster parent recruitment and screening, **(recruiting and training a professional group of foster parents)** (2) intensive pre-service training, (3) ongoing consultation from professional staff, (4) ongoing school consultation and monitoring of behavioral and academic progress, (5) individualized youth treatment that includes weekly therapy, (6) family therapy, and (7) aftercare services.[4] Four studies of the program were conducted in the 1990's and show that overall the model is feasible, cost-effective and leads to better outcomes for children and families when compared with residential treatment.[5]

Prevent the Sex Trafficking of Youth in Care

Over the past several years we repeatedly hear about clients, like Kia, for whom even the most structured residential treatment centers are insufficient to keep the children safe. These clients are typically young, mostly female, teenagers who suffer from the effects of repeated traumas. They typically have been sexually abused and suffer from mental illness or developmental delays. They repeatedly run from even the most high-end facilities in Illinois, and are frequently sexually exploited while on run. Due to the frequency and length of the runs, the youth never receive the treatment the facility attempts to offer.

The coordinated efforts made in Cook County between law enforcement, DCFS, the Court and my office to find youth on run are thwarted by the fact that the youth are returned to the same placements they ran from – or sometimes to even less secure shelter placements -- when they are located, and they run again.

In 1998 Governor Edgar signed into law Public Act 90-608, authorizing the establishment of secure, locked, or semi-locked therapeutic residential facilities, so that children can be kept safe long enough for them to benefit from treatment. The Act empowered the Juvenile Court to oversee such placements and hear objections from the youth. The Act also authorized DCFS to develop Rules regulating the licensure of secured facilities. Rule 411 was issued on June 30, 2000. 89 ILAC 411. No secure therapeutic facilities have been licensed in Illinois. We don't know clinically whether secure therapeutic facilities are the best answer for these extremely vulnerable youth who are exploited or place

[2] I was appointed to represent Demani and his sister in November of 2013, after their cases were transferred to Cook County from another county.
[3] *See e.g.*, www.mtfc.com.
[4] http://www.mtfc.com/1994_Moore_Chamberlain_JEBD.pdf
[5] http://www.mtfc.com/1998%20Treatment%20Foster%20Care%20OJJDP%20December.pdf

themselves at extraordinary risk, but we do know that an answer for these youth needs to be developed. These children are not safe, and with each adverse childhood experience their risk for physical and mental health problems increases, and their opportunity to become successful, healthy adults decreases.

Allegations of Maltreatment of Children and Youth in Care Must be Thoroughly Investigated

Quality of DCP Investigations

The child abuse and neglect Hotline is essential to protecting the well-being of Illinois children, including those in DCFS care. In early 2014 there were well-publicized examples of problems in DCP, DCFS' investigations division, due to large caseloads, poor investigations, and poor supervision. When a child care staff or a foster parent is accused of mistreating a youth, the impact of these problems is even more devastating. The Hotline is called to initiate an investigation, and when Hotline calls are not adequately investigated, children are at risk. If the quality of the investigation is poor, the investigation is likely to be unfounded by DCP, and generally the staff will continue to work in the facility or the foster parent will continue to care for children. In some cases, a facility's management will terminate a staff member (because they found credible evidence of an infraction) while DCFS has unfounded the report (because the infraction doesn't fit the standard used for parents). However, because the report is unfounded by DCFS the staff member has no "record" with DCFS, and may apply for a job in another facility that is unaware of their background. Similarly, one agency may stop placing children in a particular foster home, but the foster parent can switch to another agency.

Generally, unfounded investigations are subject to confidentiality rules. However, one negative result of the need for confidentiality is that there is no independent scrutiny of the quality of these investigations. Indicated reports – those where DCFS finds credible evidence to believe the child is abused or neglected -- can be administratively appealed by the person indicated for abuse and neglect. This appeal process provides a level of checks and balances for indicated reports that does not exist for unfounded reports.

We recently received an unfounded report where a teen client in a residential treatment facility for teens and young adults with intellectual disabilities and mental illness received a bloody nose after a female staff member beat her with a closed fist "at least fifty times" (according to another staff member/witness).[6] A video of the incident shows that the staff member had several opportunities to safely remove herself from the situation and allow other staff members to step in, as crisis response models would mandate, but she instead continued to escalate the situation. A video of part of the incident shows another client – instead of anyone from the staff – coming to the client's aid, offering an ice pack and comforting her peer while other staff members cleaned up the room.

We requested that DCFS review this investigation. PA 98-453, which went into effect on August 16, 2013, strengthened our right to request reviews of unfounded reports. It is my understanding that this report has now been indicated. Of course, our ability to read and request reviews of unfounded investigations is limited to the small number of cases where our clients are subjects of the report and where DCFS provides us with a copy of the report; the vast majority of unfounded reports are not

[6] Guardians ad litem appointed under the Juvenile Court Act are some of the only persons entitled to access unfounded reports. 705 ILCS 405/2-17; 325 ILCS 5/7.8; 7.14; 7.22.

reviewed for quality purposes by anyone outside of DCFS, unless a child dies or is seriously injured within a year after the report was unfounded.

Professionals Working in their Professional Capacity Who Abuse or Neglect Children

The Abused and Neglected Child Reporting Act (ANCRA) recognizes that children can be abused not only in their family home, but also in residential facilities, schools, day care centers, etc. 325 ILCS 5/2. So, for example, when a child is placed in a DCFS-licensed residential facility or foster home, or is hospitalized, or is at a school, and there is an allegation that child is abused, the DCFS must accept that report for investigation.

The majority of the definitions for abuse and neglect make sense when an allegation is considered in the context of a parent with respect to their child; the analysis should change, however, when a professional, in their professional capacity, mistreats a child. We suggest a closer look at whether it is appropriate to apply the same definitions to investigate allegations of abuse or neglect by a parent, who has a constitutionally-protected interest in raising their child, to allegations of abuse or neglect by a professional, who does not have a constitutionally-protected interest in the child.

For example, in response to our requests for review of unfounded reports regarding our clients, we've recently been successful in convincing DCFS to investigate allegations of sexual contact between youth in high-end treatment facilities as inadequate supervision allegations on the part of staff when staff was neglecting their responsibility to supervise the youth. Other times we have been successful in having a facility – as opposed to specific staff – indicated for inadequate supervision (for example, when the facility failed to provide detailed information to direct staff workers about specific supervision plans for a particular youth or failed to provide sufficient staff to supervise the youth). But many of the other staff behaviors that contribute to youth not feeling safe – bullying youth, mocking youth, instigating outbursts or fights, encouraging or under-reacting to violence – do not fit the current DCFS allegations for investigating abuse or neglect. Indicated reports prevent staff from moving from one facility to another without the new facility being aware of the staff member's history with children.

Hotline Reports not Accepted for Investigation

Hotline calls involving children in DCFS care are frequently rejected for investigation and taken as "information only" or are "referred to licensing." For example, we have seen calls rejected where a client alleged sexual abuse in a previous foster home, where a client in a residential facility alleged being placed in a "headlock" by staff, where a client alleged that her foster parent slapped her and pushed her down the stairs, where a 9-year-old client alleged that his foster mother's ex-husband punched him and slapped him in the chest such that he felt like he couldn't breathe, and where an 8-year-old client reported being anally penetrated by a 13-year-old when they were both residents at a DCFS-licensed residential treatment facility for emotionally disturbed children. These children should have been closely supervised and cared for by facility staff. All of these reports meet the criteria to be accepted for investigation.

Limited Release of Information in Unfounded Reports to Protect Children

Occasionally, there is information contained in unfounded reports regarding our clients which, while perhaps insufficient to support an indicated finding, is still sufficient to suggest that a child or children may be at risk of harm.

For example, in the past we reviewed an unfounded DCP report in which direct child care staff at a DCFS-licensed facility told the DCP investigator that their Unusual Incident Reports[7] "are not always truthful as the program manager will have them (staff) write up whatever she wants concerning incidents that have occurred or how the kids were interacted with." It was imperative that the agency administration be made aware of the allegation that UIRs were being falsified by their staff.

About two years ago, we reviewed an investigative file in which a licensed non-relative foster parent told the DCP investigator that he works nights and returns home at 3:30 a.m. The foster parent cared for several children at the time, one of whom was our client. While our client was 17 years old, she was extremely emotionally disturbed, and had only been placed in the foster home to wait for bed at a high-end residential treatment facility to become available. When asked by the DCP investigator who takes care of the children while he works, the foster parent explained that they watch themselves until he gets home. It is not appropriate to remove a child from a parent, and then place the child with a state-licensed foster parent who is not able to properly parent the child. It was imperative that the agency responsible for supervising the foster parent's license be aware of the foster parent's statements to the DCP investigator.

Similarly, we frequently see comments by direct child care staff to DCP investigators contained in reports, which, while they do not rise to the level of abuse or neglect, should be provided to the staff member's supervisor for follow-up.

The confidentiality of unfounded DCP reports and investigative files is statutorily protected. Often this protection makes sense. However, when information is contained in a DCP report or investigative file that could impact the safety and well-being of children in DCFS care, it is imperative there be a mechanism to release that information to those who need it.

* * *

Recommendations

A) Increase the Effectiveness of DCFS Monitoring

1) Require DCFS to revise its licensing rules and contracts regarding group home and residential care to provide for specific standards of care. Performance measures must include quality of care – i.e. the safety and well-being of the children while they are placed there – in addition to how long they stay and whether the discharge was successful. Licensing Rules and contracts should require agencies providing group home and residential care to immediately report certain risk factors to DCFS, such as when law enforcement is called to the unit and when staffing levels are insufficient to meet the needs of the youth and when staffing levels are met only by relying on staff accepting shifts that result in them working more than a 50-hour work week or relying on staff from temporary agencies. DCFS should be required to work with the agency to ensure the safety and well-being of the youth when issues arise.

[7] These reports are required regarding state wards by Department Rules, 89 ILAC 331, to notify the Department and others, including the child's attorney and guardian *ad litem,* that an unusual event has occurred involving the child.

2) Require DCFS to publish Rules specifying the expectations of its monitors. Monitors should be expected to regularly visit facilities on an unannounced basis with many of those visits occurring during evening and weekend hours. Reports from monitors regarding these visits must be considered, in addition to statistical information regarding a program, in evaluating the quality of care the program provides.
3) Create an independent monitor within the legislature for a period of no less than five years with the responsibility to:
    a) Review data regarding key performance indicators at residential and group home facilities;
    b) Review qualitative information regarding residential and group home performance;
    c) Review DCFS' current monitoring process, establish new standards for monitoring and ensure implementation of the new standards;
    d) Make recommendations to the legislature and DCFS regarding improving the quality of care in residential and group home facilities;
    e) Ensure implementation of recommendations to improve the quality to care in residential and group home facilities; and
    f) Randomly review DCFS' decisions to remove foster homes from involuntary hold status; make recommendations regarding the involuntary hold process and ensure implementation of the recommendations.
4) Amend the Children and Family Services Act and the Juvenile Court Act to require DCFS to notify the court, and all parties to the child's case pending under the Juvenile Court Act, when a child is residing in a DCFS-licensed child care facility that has fallen below the expected standard of care; including facilities on intake hold or under corrective plans due to child safety and well-being issues; with the notification, require DCFS to provide information to the court and parties regarding how it is ensuring the safety and well-being of the child in the placement.
5) DCFS should be required to amend Rule 331.40(k) to eliminate the current provision that allows DCFS to waive the reporting requirement for youth for whom a particular type of behavior is part of the behavior pattern for a particular youth. All unusual incidents regarding a youth should be reported.
6) DCFS should review foster home licensing and approval standards to ensure that they adequately protect children in care. In addition, administrative rules related to addressing concerns in foster homes should be reviewed to ensure that when a risk is known, DCFS has adequate tools to protect children.

B) **Adequately Support Critical Resources**

1) DCFS should be required to convene a task force, which should include treatment providers, to determine the actual cost of care for youth in high-end treatment facilities and provide a report to the General Assembly of the findings of the task force by no later than January 1, 2016. The report should address at a minimum:
    a) Cost of ensuring sufficient staffing levels at all times;
    b) Cost of recruiting qualified staff;
    c) Cost of retaining qualified staff;
    d) Cost of making physical plant improvements to ensure safety and well-being (for example, providing single bedrooms, improving line of sight, etc.); and

e) Cost of providing programming and therapeutic interventions.

C) **Develop New Critical Resources**

1) The Auditor General should conduct an audit of DCFS' ability to meet the placement needs of children in a timely fashion. Specifically, the audit should determine how long children wait for placements once they are identified by DCFS as needing a specific type of placement, where they wait, and what the barriers to timely placement are. The report should include recommendations on the steps necessary to ensure that appropriate, nurturing placements are available in a timely fashion to meet children's needs.
2) The Juvenile Court Act should be amended to require that DCFS file a report with the court and all the parties to the child's juvenile case that explains the steps it is taking to ensure the child is in an appropriate level of care, and how the child's needs are being met in the interim. The report shall detail what placements are being considered for the child, how those placements will be prepared to meet the child's needs, and when those placements will be available for the child. The Juvenile Court should be authorized, after reviewing the report, to determine whether the child's current placement is safe or appropriate for the child, and, if not, to order the removal of the child from the placement and order any services necessary to ensure the child's safety and well-being, including specific placements.
   The report should be filed at the following times:
   a) On the 30th day that after a child is placed in an emergency shelter;
   b) Within 3 days of a child who is psychiatrically hospitalized being clinically ready for discharge or beyond medical necessity, whichever is sooner;
   c) Whenever a decision is made by DCFS that a child needs a certain level of care and the child has not been placed in that level of care within 30 days; and
   d) Within 3 days when a child is in a detention center or Department of Juvenile Justice facility solely because a placement cannot be located for the child.
3) The Juvenile Court Act should be amended to permit a court to require DCFS to report the steps it is taking for a particular child sooner. Currently, the Act permits a court to order DCFS to report within 10 days. 705 ILCS 405/2-28(1). Language should be included to provide that the court can order DCFS to report sooner as necessary to protect the safety and well-being of the minor.
4) DCFS should be required to implement a pilot program of multi-dimensional treatment foster care, an evidenced- based program, for:
   a) children entering care with severe trauma histories or emotional disturbances, with the goal of maintaining them in foster homes and preventing them from requiring residential care;
   b) children who require step-down placements from residential care; and
   c) children who are identified for residential or group home care who could be placed in a foster home if higher level interventions are provided.
5) The General Assembly should convene a multi-disciplinary task force to review and recommend treatment options for the most vulnerable youth in care, particularly those who repeatedly elope from Illinois' most high-end treatment facilities and who are re-traumatized by human traffickers. DCFS should implement a pilot program based on the

recommendations of the task force. Secured therapeutic care facilities must be considered and developed in order to protect wards who are exploited and place themselves at risk.

D) <u>Investigations of Allegations of Maltreatment of Youth in Care</u>

1) The General Assembly should create a short-term multi-disciplinary work group, subject to strict confidentiality provisions, with the authority to review, for a limited period of time, a sample of unfounded investigations, including investigations regarding children and youth in foster homes, and group and residential care. The work group should have the responsibility of identifying areas for improvement in the quality of investigations and for identifying areas for improvement in the investigation of facility reports.
2) DCFS should be required to rewrite Part 300, to provide for allegations that can be applied to professionals working with youth in their professional capacity. Consideration should be given to whether direct child care staff should be licensed or certified, with some of these types of allegations addressed within licensing or certification standards.
3) DCFS should be required to amend Part 300 to clarify that allegations of sexual activity or physical harm among youth and adult residents of DCFS child care facilities must be investigated as allegations of inadequate supervision on the part of the particular staff (for example, if staff was sleeping as opposed to supervising children) or the agency (for example, if the agency failed to ensure a sufficient number of staff or supervision plan to properly supervise the youth).
4) DCFS should be required to track and review, for a specified period of time, hotline calls that are accepted for information only, and to report to the General Assembly regarding consistency and compliance with ANCRA.
5) ANCRA should be amended to permit the limited release of information from unfounded DCP reports involving children in state care so that the information can be considered to protect children from future harm.
6) DCP should be strengthened and supported to ensure that the resources needed are available to improve the quality of abuse and neglect investigations.

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We recognize that from a national perspective, in many areas, DCFS is considered to exceed typical standards of practice. And I would agree that Illinois' child welfare system is better than the child welfare systems of many other states. However, when viewed from the perspective of a child in substitute care, this national recognition has little value. These children depend upon DCFS, the Legislature, the private providers, and children's advocates such as our office, to work together to ensure that the "gold standard" is actually met in each individual case, and to continually strive to improve the standard of care for children in the custody of DCFS. We appreciate the complexity of developing solutions for these complex issues -- certainly no one person or entity has all of the answers and we are very willing to participate in the development of potential solutions.

Respectfully submitted,

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