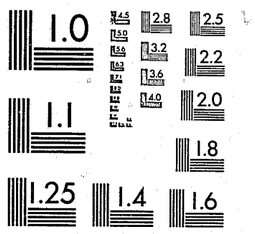

The Child Victim

Child Abuse in the Family and Society

A Report to the General Assembly

Illinois Legislative Investigating Commission

April, 1983

THIS REPORT IS RESPECTFULLY SUBMITTED PURSUANT TO HOUSE RESOLUTION 776 ADOPTED BY THE ILLINOIS HOUSE OF REPRESENTATIVES ON APRIL 26, 1978.

BY THE
ILLINOIS LEGISLATIVE INVESTIGATING COMMISSION
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HOUSE RESOLUTION 776

This resolution was sponsored by the following Representatives:

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Anne Willer
Harry "Bus" Yourell

The resolution was adopted by the Illinois House of Representatives on April 26, 1978, and is quoted below:

"WHEREAS, there is an alleged alarming increase in child abuse deaths; and

"WHEREAS, there are alleged discrepancies and differences in reporting and classification procedures of child deaths; and

"WHEREAS, these variances relate to coroner's offices, boards of health, police departments, and other interested agencies; and

"WHEREAS, there are questions about what actually constitutes child abuse in criminal proceedings; and

"WHEREAS, there are demands for stiff new penalties for parents who abuse or neglect their children; and

"WHEREAS, criticism has been leveled against the Department of Children and Family Services for allegedly mishandling cases of child abuse; therefore, be it

"RESOLVED, that the investigation include a thorough examination of the responsibilities, activities, and records of all agencies that deal with the child abuse problem; and be it further

"RESOLVED, that the Illinois Legislative Investigating Commission be directed to determine the administrative and legal requirements for developing a coordinated effort to detect, report, and reduce the incidence of child abuse in this State, and to submit their findings and recommendations to the Illinois General Assembly as soon as possible."

TO: HONORABLE MEMBERS OF THE GENERAL ASSEMBLY

This report presents our findings pursuant to House Resolution 776, adopted by the Illinois House of Representatives on April 26, 1978. The Child Victim: Child Abuse in the Family and Society is the final report in a trilogy issued by the Illinois Legislative Investigating Commission which deals with various forms of child abuse; the two previous reports are entitled Sexual Exploitation of Children and Child Molestation: The Criminal Justice System.

House Resolution 776 directed this Commission to examine the responsibilities, activities, and records of all agencies that deal with the child abuse problem and to determine how a coordinated effort could be developed to detect and reduce the incidence of child abuse in this State.

In fulfilling the mandate of this resolution, we conducted an investigation that was both lengthy and detailed. During its course, our investigative parameters evolved continually, for two major reasons.

First, the systems we examined were changing almost constantly. The Department of Children and Family Services, the agency legally responsible for the identification, investigation and treatment of child abuse and neglect, underwent changes in its directorship, changes in the laws shaping its powers and duties (for example, the major 1980 amendments to the Abused and Neglected Child Reporting Act), and changes in its internal rules and regulations.

Second, as our investigation progressed, we began to realize that the current focus of efforts directed toward the problem of child abuse and neglect must change drastically at some point. Efforts expended on treating abuse and neglect after the fact are not only a poor use of public funds, but also ultimately self-defeating. Primary prevention eventually must be given the same priority as treatment.

This realization led us to agree with many experts who believe that legislation will not solve the intractable problem of child abuse and neglect. Rather than being an answer in and of itself, legislation is a framework that should allow for the development of feasible solutions.

We believe that the existing framework is basically sound. While we propose numerous recommendations in the chapter concluding this report, only eight entail statutory revision. We feel that all eight legislative recommendations are worthy of approval and would be of valuable assistance in our State's continuing effort to combat child abuse and neglect, but one is of special importance and merits mention here.

We have concluded that the Department of Children and Family Services is the most appropriate agency to receive and investigate reports of suspected child abuse and neglect, contrary to the contentions of critics who advocate the use of other agencies, such as law enforcement departments. During our investigation, we have seen improvement in the Department's ability to perform these functions. Unfortunately, what we also have seen--and documented--is the Department's failure to develop essential cooperation with other agencies and professions. Lack of coordination has resulted in the duplication and fragmentation of efforts and services. The enactment of our major legislative recommendation, which would require the implementation of multidisciplinary child protection teams throughout Illinois, should help to remedy this inefficiency.

In addition to our chapters on the Department of Children and Family Services, agencies that contract with the Department for the provision of services, legal issues related to the problem of child abuse and neglect, and multidisciplinary child protection teams, we have devoted three separate chapters to case studies. These chapters deal, respectively, with actual cases of (1) child abuse and neglect not ending in death, (2) child abuse and neglect resulting in the child's death, and (3) intrafamilial child sexual abuse (incest). We chose these cases from among the many we examined because they most fairly reveal the strengths and weaknesses of Illinois' complex child protection system. These cases also illustrate many of the problems faced by child protection professionals.

As a legislative commission mandated by the General Assembly to investigate this area, we were able to gain access, although sometimes with difficulty, to otherwise confidential and privileged information. The reader should note that in the majority of case studies, the names of victims and others have been changed to protect their identities. Only when cases presented in this report have received wide coverage in the media, or when convictions for crimes described therein were obtained, are real names usually supplied.

Just as we have described only the most illustrative cases from the many on file, we have discussed only the most informative documents from the extensive body of child abuse literature. (The bibliography, however, lists all of the sources reviewed during this investigation.) The information and analysis finally chosen for inclusion in this voluminous report is that which we consider most valuable to the members of the General Assembly.

Respectfully submitted,

Co-Chairmen:
Rep. Dennis Hastert
Rep. Aaron Jaffe

Senate Members:
David N. Barkhausen
Adeline Geo-Karis
Emil Jones
Jeremiah E. Joyce
Bob Kustra
Frank D. Savickas

House Members:
Jane M. Barnes
Jeffrey D. Mays
John T. O'Connell
William C. Henry

Executive Director:
Ronald Ewert

[Discipline] can be exemplified by my recollections of being forced to kneel upright, with piles of books in our outstretched arms for hours, of being made to "shove out" (to maintain a posture as if we were sitting on a chair, without a chair to support us) and to "eat a square meal" (to face straight ahead, without looking down at your plates) while eating. For years we were lined up and spanked with a stick before school in the morning and again when our father returned home in the evening. Sometimes we were put in a cold shower in the middle of the night if our parents went out for the evening. If one of us was told to sweep the driveway, we would be spanked with a stick for each leaf our father discovered when he inspected the job.

The second type of abuse that I distinguish was that of unpredictable outbursts of rage. I recall incidents such as the time our father dumped over a fully-set kitchen table because our mother had served two starches with dinner. There was also the time he nailed me to the wall by my braid for laughing too loudly. Allowing a door to slam, dropping a utensil at dinner, being too slow, using the "wrong" tone of voice, failing to maintain eye contact, not standing up straight enough, and laughing too loudly were all likely to incur severe beatings. We were slapped and spanked with a stick daily and every few months received injuries that required medical attention.

Verbal abuse was incessant. We were constantly demeaned and insulted, told how stupid and unloveable we were and threatened with murder and torture. Sometimes our parents threatened to abandon us. Occasionally, our father threatened to commit suicide because we were such a burden. We just kept trying to be perfect and to minimize our demands so that they would love us.

Jessica Cameronchild
"An Autobiography of Violence,"
Child Abuse and Neglect: The International Journal (Volume 2, 1978, pp. 139-49).

Chapter 1

INTRODUCTION AND BACKGROUND TO THE PROBLEM

In April of 1978, the Chicago Police Department released information that there had been an alarming increase in child murder. The total number of child murders for both 1976 and 1977 combined was 13. By the end of March, 1978, ten such murders had been reported in Chicago alone.

In a Chicago Tribune story dated April 23, 1978, Representative Aaron Jaffe was quoted as saying, "I can't believe that only black people on the South Side murder their children. Suburban crime must also be there, but it is evidently not being reported." He also announced his intention to introduce a House Resolution to address the problem of child abuse and child abuse ending in death.

House Resolution (HR) 776 passed on April 26, 1978, with 43 co-sponsors listed on the resolution. We have already referred to specific clauses of the resolution. It was drafted with the intention that the Commission be able to investigate any facet of the child care system that could benefit from legislative or other recommendations.

In March of 1977, the Commission had been mandated by House Resolution 41 to investigate several allegations concerning child pornography operations in the Chicago area and the apparent rise in child prostitution.

We quickly discovered some overlap between these two investigations. Both required that we examine the child welfare and child protective services delivered by the Illinois Department of Children and Family Services (DCFS). Many victims of child pornographers and many child prostitutes were, or had been, wards of the state and in the guardianship of DCFS.

In April of 1979, House Resolution 138 passed, mandating the Commission to fully investigate the molestation of children by adults. Though this investigation was to prove more comparable to our investigation of child pornography and child prostitution, it too involved some facets of the entire child welfare system.

We have issued comprehensive reports to the General Assembly based on HR 138 and HR 41. As a result, and as we will mention later, changes in law have been enacted. We concluded our investigation into child abuse murder and related matters late in 1981. The investigation was lengthy because it involved necessary comparisons of data, interviews, statistics, and programs both across time and across space. We compared child abuse statistics and programs in Illinois between 1975 and 1981. We also sent investigators to several other states to examine their systems to prevent, detect, investigate, and treat child abuse.

In order to understand the problems facing the Illinois system, we conducted hundreds of interviews and reviewed hundreds of books and periodicals that discuss the various stages and types of child abuse. We also examined a number of individual case studies so that we could determine just where the state system had failed and where it had succeeded.

These case studies were not developed scientifically or randomly. In some cases, we solicited and used case studies furnished us by DCFS staff. In some cases, we took media accounts of abuse and examined the roles of all concerned parties in the investigation and disposition of the cases. And in still other cases, we asked to review DCFS case files from which we chose several interesting cases.

The reader should be aware that many abuse cases investigated by DCFS have happy endings. Many are handled exactly as they are supposed to be handled. It was not our intention to highlight DCFS successes, or to highlight DCFS failures, either. Rather, it was our mandate to determine what goes wrong with the system when it does fail. Our examination of individual cases and DCFS staff was designed to determine what systemic problems exist in the department and how they might be solved. We have compared "good" cases with those handled poorly, so we do have a sense of perspective. But our interviews with individuals of all components of the child protective system also have provided us with a sense of how a case may fail, or what a case might have needed for it to succeed.

Success or failure in child abuse cases is also difficult to measure. Many cases may seem to be "good" cases, that is, cases in which everyone does his job. But some of those cases still result in the death of children. Other cases that might be considered "bad" may present a tangled web of poorly conceived plans by child protective workers. Some of these cases turn out perfectly fine. A case can "go bad" at any of literally dozens of places. Assessing blame is a difficult job. We have limited our investigation of cases in such a way that we can present as many facts surrounding the cases as is possible. We have drawn conclusions about these cases, but the reader is invited to draw his own conclusions based on the information presented in this report.

During the course of our investigation, internal procedures in DCFS changed radically. We found that such change is common to DCFS. These changes necessitated our reinterviewing personnel from different divisions within DCFS. We also had to reinterview officials from other components of the child protective system. In some cases, we were unable to reinterview everyone whose role may have changed. This report by necessity reflects the changing nature of child protective services. We will share our conclusions, as well as our confusions, with the reader.

We have found that child abuse is a very difficult subject for people to deal with. We found in our interviews that many would prefer to pretend that child abuse is something that happens to

other people, or other types of people. Child abuse ending in death is almost incomprehensible to many citizens. And it is almost equally difficult for child abuse workers to handle. As we shall see, the Illinois child abuse "system" contains several unrelated, generally uncoordinated efforts on the part of many people. Many cases simply fall through the cracks between these efforts. Other cases are ignored. Some cases are mishandled. Clearly, the state needs a more organized response to child abuse, and we found that in some ways it is moving in the right direction.

The Abused and Neglected Child Reporting Act of 1980 requiring investigations of abuse and neglect cases to be initiated within 24 hours of a report has generated controversial opinions and results. Some claim that the law is too rigid and that its requirements can never be met. We will examine this Act in detail later.

The relationship between DCFS and many other agencies, individuals, and even the abusive parents themselves has been studied during our investigation. We will recount our conclusions about this subject in detail later.

We reported that this investigation was mandated by a tremendous increase in reports of child abuse deaths in the early months of 1978. Unfortunately, the incidence of child abuse death has remained high. An article published in the Chicago Sun-Times dated January 12, 1982, mentions that there had been three fatal beatings of children in an eight-day period.

Some say that child abuse appears to be on the rise because of an increase in reports. Others counter that reports have risen because of laws mandating such reports and because many citizens are aware that they can and should report. But the incidence of child abuse resulting in death is not a statistic that can be challenged. And, unlike many cases of abuse, one cannot hide the death of a child--at least not for long.

A. Defining Child Abuse

Upon first thought, child abuse seems to be an obvious category of injury. It is not as simple as it seems. Child abuse has even been defined differently in many state statutes. And there have developed subdivisions of child abuse that are considered together with it, including child neglect, emotional abuse, and even educational abuse. All of these terms, and others, are part of the everyday parlance of the child welfare and child protective worker. These terms are also commonplace in juvenile courts and among personnel of many agencies that must deal with child abuse almost every day.

This section of our report will present definitions as well as some sense of perspective concerning the place of child abuse in society and in the home.

One basic text is titled Defining Child Abuse. Its authors, Jeanne M. Giovannoni and Rosina M. Becerra, both teach in the School of Social Welfare at UCLA. One primary question they address is how law should define child abuse. They state that there is a great deal of disagreement concerning the specificity of child abuse terminology in statute. Broad language generally seems to have been written to allow judges wide discretion in determining if a case indeed is one of child abuse. They agree that usually only an obvious case of abuse would travel all the way to a judge in a courtroom. This poses the problem that some people may be hesitant to report a case that seems "marginal," and that prosecutors may be hesitant to bring such a case to court.

The authors state: "Yet all available evidence indicates that the more narrowly defined 'physical injury' constitutes only a small fraction of the kinds of situations that make up the bulk of public child protection efforts."

The authors also cite a study conducted in 1977 in which social workers, police, judges, and hospital personnel were asked if they agreed with the following statement: "It is difficult to say what is and what is not child maltreatment." Fifty-six percent of the social workers and 64% of the police agreed with the statement, and the percentages for the judges and hospital personnel were even higher.

One of the main considerations for all involved in determining the outcome of child abuse cases is the effects a charge of child abuse will have on the family. Sometimes, as we shall see, the decision to keep a family intact--a societal decision, not an interpersonal need--will determine the fate of an abused or sexually molested child. The authors address this problem: "At the heart of the controversies over what should and should not be considered mistreatment warranting state intrusion into family life is concern that such intrusion may simply constitute the imposition of the values of one segment of the community on other segments with different values." All parts of the child abuse system feel the need to keep the family intact if at all possible, for the sake of the child as well as the parent. But our society is so pluralistic that we fear judging one another's standards of discipline and conduct. The result is the hesitancy referred to above.

Two quotations from Defining Child Abuse are useful to further understand this phenomenon:

> Child abuse education programs would do well to emphasize not so much the bizarre, extreme situations but the borderline types of mistreatment, the bruises and welts that come from "normal" hitting, the threshold of child abuse.
>
> Clearly what is reflected in the data is a general acceptance of corporal punishment in this country. Since hitting children is acceptable, the demarcation of "normal punishment" and "child abuse" becomes a matter of the degree of physical injury inflicted.

The issue of corporal punishment will surface several times in this report. There is disagreement among experts about its effects on children in the home. Even its origin and purpose are disputed.

B. Family Violence

Another source our staff examined is "The Social Causes of Interpersonal Violence: The Example of Family Violence and Odyssey House Non-Violence" by Murray A. Straus of the University of New Hampshire. Straus presented the paper at a meeting of the American Psychological Association in August, 1978. Though the focus of the paper is on a specific program that treats violence in the home, we can extrapolate some of Straus' comments about corporal punishment and its role in American society.

Straus stresses that we learn violence in this country from infancy. These violent lessons remain with us throughout our lives, according to Straus. We apply the violence we learn in the home to our lives outside the home, though in "modified" form. He mentions that violence is much more prevalent in the home than outside of it because we learn to socialize ourselves among outsiders. Straus cites a study that shows a much higher incidence of fighting within the home than outside among high school seniors. Straus also says the following:

> The basic training in violence provided by the family fits a social learning theory model. It takes place through physical punishment, by observing violence, and by generalizing from the rules that are implicit in the way others react to acts of violence.
>
> In general, the rule in the family is that if someone is doing wrong, and "won't listen to reason," it is o.k. to hit. In the case of children, it is more than just o.k.
>
> The norms within the family are far more accepting of physical violence than are the rules governing behavior outside the family.

Straus' voice is not alone: many researchers and other experts in the child welfare field have studied the issue of violence in society in an attempt to understand violence within the home. Gerald A. Foster, D.S.W., presents his views in an article titled "The Politics of Juvenile Justice." Foster mentions the United States Supreme Court decision of Ingraham v. Wright, 430 U.S. 651 (1977). Foster states:

> We should quickly dispel the myth that we live in a child and youth oriented society.
>
> It can be said that society as a whole has failed today's youth and failed them in such a way as to alienate them and characterize them as scapegoats for the many shortcomings of a modern social order which finds its ethical and moral foundations rapidly eroding.

The relationship between the schools and society in general differs little from relationships in the different homes across this country. The social norm seems to be that children can and should be punished physically. That many parents go to extremes in their punishments at home is the issue that we are addressing in this report.

Richard J. Gelles, Ph.D., presented a paper titled "A Profile of Violence Towards Children in the United States" at the Annenberg School of Communications Conference on Child Abuse in Pennsylvania on November 21, 1979. The paper makes a number of points that add to our discussion.

The first is that violence in the home is a single issue, regardless whether the violence is wife abuse, child abuse, or simply children beating up their brothers and sisters. The research being conducted into family violence stresses the term "family" much more than it did in the past. In the past, child abuse was studied in isolation. Now, child abuse is studied with increasing frequency as a part of a larger picture of general violent tendencies. It is these tendencies to which Gelles refers.

Gelles agrees that the tendency has been to broaden the definition of child abuse, and that abuse statistics vary because of varying definitions. He states in his paper that estimates of child abuse nationwide ran from 30,000 a year to 1.5 million, and child abuse deaths estimates range from 365 a year to 5,000.

Gelles' research also indicates that younger children, ages 3-5, are most vulnerable to physical abuse and that older children, ages 15-17, are most likely to face "extreme forms" of violence.

He also found that the Midwest has the highest rate of violence towards children. Apparently this conclusion is based on a number of factors, not the least of which is most Midwesterners' favorable attitudes toward corporal punishment in the schools.

He also found that city-dwellers have a higher abuse rate than rural citizens and that abuse is unrelated to religion. The vast majority of abusers are 30 years old or younger; the older a parent, the lower the potential for abuse. There is no significant difference among the races regarding frequency of abuse. Parents with lower incomes have a high rate of abuse, but, strangely, parents with a mid-range of education have the highest rates of abuse. Gelles defines these people as high school graduates. College graduates and those who never finish eighth grade have significantly lower abuse rates. Blue collar workers have a much higher rate of abuse than white collar workers. Unemployed people have high rates of abuse, and the overall abuse statistics go up during periods of greater unemployment. Also, the more overall stress that a family undergoes, the greater the potential for abuse.

Gelles' work has led him to conclude that families in which decision making is shared between husband and wife have a lower incidence of abuse towards their children. The highest rates of

abuse occur among parents who are married less than ten years, have been abused as children themselves, do not participate in activities outside of the home, and have two or more children. There are other characteristics that can help identify the potentially abusive parent which we will mention throughout this report.

Vincent J. Fontana and Douglas J. Besharov's book The Maltreated Child: The Maltreatment Syndrome in Children--A Medical, Legal, and Social Guide also addresses the problem of defining abuse. The authors point out that neglect can be, and has been, as potentially dangerous as physical abuse and for that reason is often included in most states' statutes as a single crime or category.

C. Historical Overview of the Child Abuse Problem

Commission staff have attempted to trace the historical origins of child abuse. Such a task is not simple. Our conclusion is that child abuse has probably always existed. It has changed primarily in its societal sanctions. An article by Brian G. Fraser titled "The Child and His Parents: A Delicate Balance of Rights" addresses the issue of the origins of child abuse. Most early societies felt that children were not people but possessions and were treated as such. They were subjected to ritual sacrifice, exposure, mutilation, abandonment, and exploitation. Many of these latter practices ended in death. The primary reasons advanced for behavior of this sort were early forms of birth control, religious beliefs, and "treatment" of deformed children. Fraser cites the Hammurabi Code of 2150 B.C., in which a father had to "accept" a child into the family before that child received the status of being a person. Any reason the father had to reject a child resulted in infanticide. Once a child was accepted into the family, though, both child and parents had certain expectations of them. The child had certain duties and the parents had to provide minimum care and feeding.

In ancient Greece the father determined any newborn's fate. On the fifth day after birth, in a ceremony called the amphidromia, the father decided whether his child should be given a soul. If he decided negatively, the child was abandoned to die of exposure. Similarly, under early Roman law, the doctrine of patria potestas was upheld, under which a father had the power of life and death over his children until adulthood. The father could kill, mutilate, or sell his children. Roman law changed to prohibit infanticide until the child was three and then finally abolished infanticide altogether, but the child always could be sold into slavery.

Fraser cites the Visigothic Code (476-711 A.D.) as the beginning of attempts to protect children. Rights and duties of children became as one under the Code, thereby giving children status in society. Infanticide was a serious offense punishable by blinding

or execution. A child could be disinherited but not killed by his parents. "Reasonable" physical punishment was allowed; apparently this punishment was quite severe.

We also reviewed an article titled "Child Abuse and Neglect Part I: Historical Overview, Legal Matrix, and Social Perspectives" by Mason P. Thomas, Jr. According to Thomas, early treatment of children in this country was based on previous custom as well as English common law. Children could be severely disciplined as a matter of course by parents, teachers, and ministers. Most justification for punishment was rooted in passages of the Bible. In the 1600's and 1700's, few attempts were made to punish parents who may have been over-zealous in their harsh treatment of their children. Children from poor families or even from families that were simply too large were placed in apprenticeships and almshouses. They shared space in the latter facilities with adult paupers, the insane, and the severely retarded. Children often remained in these facilities until the age of eight, at which time they were placed in apprenticeship, an early form of foster care. This system lasted until 1875, according to Fraser.

The first reform movements for children occurred in New York City in the early 1800's. A number of organizations sprang up whose purposes were primarily to keep neglected and abused children from becoming criminals or threats to society. Their original aims were not directed toward prevention of abuse or protection of children.

Thomas refers to what has become a famous case of abuse, one that may have been pivotal in structuring child protective services in this country. Unfortunately, the case is misunderstood and almost always misrepresented. It is the 1874 case of Mary Ellen Wilson, often referred to simply as the case of Mary Ellen. The details of the case are interesting but will not be dealt with in detail here. Suffice it to say that Mary Ellen Wilson was a young child who had been badly abused by her mother in New York City. The case somehow came to the attention of Henry Bergh, who at that time happened to be the president of the American Society for the Prevention of Cruelty to Animals. Bergh asked the Society's counsel, Elbridge T. Gerry, to petition the court for the girl's relief. This petition was brought not by the Society, as is often maintained, but by its president acting as a private individual. As a result of media attention to the case, Gerry then organized the New York Society for the Prevention of Cruelty to Children that same year.

In his article, Thomas mentions that the Mary Ellen Wilson myth invariably is more interesting than the facts of the actual Mary Ellen Wilson case. Thomas says that the core of the myth is this: "Since there were no laws to protect children, the case was brought to court on the theory that the child was a member of the animal kingdom and thus entitled to protection from the same laws that were intended to protect animals." The point is meant to be shocking: how can it be that we provide better protections for our animals than we do for our children?

Thomas clarifies the myth thus: "Laws to protect children were not lacking but were not enforced systematically. The case was not brought into court by the Society for the Prevention of Cruelty to Animals on the theory that this child was entitled to the legal protection afforded animals; rather, it was initiated by the founder of this society acting as an individual, using the Society's attorney, by a petition for a writ de homine replegiando [an old English writ of law intended to remove a person from one person's custody to another's], on the basis of which the court issued a special warrant to bring the child before the court."

Ultimately, as a result of the court's hearing this case, criminal action was taken against Mary Ellen Wilson's mother, who was convicted of assault and battery and sentenced to a year at hard labor in the penitentiary.

The real significance of the case was the formation of the first of many societies for the prevention of cruelty to children. Soon after the original formed in New York City in 1874, it acquired police powers that it still maintains today. Thomas describes the original society thus:

> It was organized as a private group in 1874 and later incorporated under legislation that authorized cruelty societies to file complaints for the violation of any laws affecting children and that required law enforcement and court officials to aid agents of the societies in the enforcement of these laws.

The Society placed its agents into every courtroom dealing with destitute, neglected, or wayward children and offered judges their opinions concerning when children should be committed and to which institutions.

Further legislation in 1881 gave the power of arrest to agents of the societies and made it a misdemeanor for anyone to interfere with or obstruct the work of the societies. By 1890, the Society was present in all boroughs of New York and was responsible for 15,000 children, costing the city $1.5 million.

Thomas adds this remark to further fill in the picture of how the Society operated: "The Society's vigorous law enforcement methods greatly increased the number of children who received institutional care in orphan asylums and who became wards of public or private charities. However, their methods tended to discourage adoption or family foster placements."

After the formation of the Society in 1874, many other similar groups formed. Some had been organized to deal with cruelty to animals and simply added children to their protection lists. Some formed to protect both animals and children. Between 1875 and 1900 twenty "cruelty" societies confined their activities to protection for children. By 1900, 161 societies existed in this country designed to protect animals or children or both.

Thomas adds a long parenthetical comment to the Mary Ellen Wilson case and its impetus toward the formation of societies to protect children. Here he refers to the establishment of police powers for agents of these organizations:

> The NYSPCC [New York Society for the Prevention of Cruelty to Children], having been organized first, became the model for the law-enforcement approach to child rescue, with its agents exercising police powers under legislative authority. This approach seemed punitive to some reformers since it often separated children from their parents and emphasized the prosecution of parents, who were often punished by jail or prison sentences. Other child protection groups in Massachusetts and Philadelphia did not approve of the tendency of anti-cruelty societies to become arms of the police. They were concerned about preventive, remedial, and economic efforts that would strengthen the home so that a child might remain with his parents. These early disagreements provided the seeds for the growth and development of contemporary thinking on effective methods of child protection. The modern social-work approach to protection--protective services--tends to avoid this punitive approach, but these differences in concept and philosophy have continued into the twentieth century.

The rest of Thomas' article traces the changes in emphasis between the private and public sectors. Both slowly moved toward strengthening of the child's own home, and the overall responsibility for child protection became a public responsibility as federal and state legislation changed to mandate child protection measures. Private child humane societies continued to grow, however, peaking in 1922 with 414. By 1967, there were only ten such groups left in the country.

Thomas' article addresses the founding of Juvenile Court in Cook County, Illinois, in 1899. It was the first such specialized court in the country. Thomas notes that the court and the laws pertinent to it were drafted in 1898 by a "committee of social leaders and lawyers," and he goes on to describe the founding of the court and its early philosophy:

> The juvenile court was also that product of political compromise between private sectarian interests that operated the industrial schools and state welfare authorities who believed strongly in state-operated institutions for dependent and neglected children. The 1899 juvenile court law continued the blurring of distinctions between neglected, dependent, and delinquent children and the practice of mixing these children in the same institutions--sometimes under repressive and punitive conditions.
>
> The terms "dependent" and "neglected" were used interchangeably in the 1899 juvenile court law, and these terms were defined in words that described conditions that were believed to lead to crime in the early nineteenth century. The name of the court was new, but the simplistic philosophy linking poverty, neglect,

> and crime has remained unchanged. Moreover, it has continued as a major theme of juvenile corrections into the twentieth century.

According to Thomas, in effect this new law substituted the state for parents who could not control or provide for their children. Thomas argues that the law was disturbing because it was written by middle-class people to apply only to lower-class people.

As abuse became more recognized, the states adopted laws to deal with it. By 1967 all 50 states had a reporting provision. By 1972, 45 states had mandatory reporting; the other five had voluntary reporting procedures. In mandatory reporting, certain "classes" of people are required to report cases of suspected or confirmed abuse, depending on the wording of the law. The most obvious and common group of mandated reporters is that of doctors. Illinois law now includes teachers, coroners, police, private social workers, and many other classes of people, as do several of the other states' more progressive laws.

Thomas offers the following concluding remarks:

> This history of child protection in the United States indicates that public interest in children is cyclical, recurring between periods of relative indifference. The decade of the 1960's was the first time in a century that wide public interest was attracted by the complex and emotional problems related to protecting children from physical maltreatment by their own parents. The problem had been repressed from public consciousness.
>
> ...protective services to parents could usually provide child protection without the necessity of removing the child from his own home. The fact that reporting laws have been passed has served to assure the public--perhaps unrealistically--that children are being protected and that parents are being helped.

So much has been written about child abuse and its many components that it would be impossible to even refer to every article or book. Further research will be summarized as this report progresses when specific subjects become pertinent.

D. Companion Report Follow-up

We have referred to the two other investigations the Commission has completed that deal with maltreatment of children. Reports on both were issued in 1980 and were followed by Commission Public Hearings. Sexual Exploitation of Children: Child Pornography and Child Prostitution was published in August, 1980, and Child Molestation: The Criminal Justice System was published in October, 1980. On October 9 and 10, 1980, the Commission held public hearings in Chicago on matters pertinent to both investigations and both reports. Some of those matters directly relate to this report. In Child Molestation: The Criminal Justice System, we presented a brief section updating the reader on several specific case studies from our Sexual Exploitation report. Here, we will provide further updated information, discuss briefly the hearings, and offer other general remarks about the effects of our previous two reports.

At the public hearings, the Commissioners heard testimony from a variety of experts in the fields of corrections, law enforcement, probation, and others.

First to testify were two prostitutes who had been identified by Commission staff as having begun their illegal careers as juveniles or as young adults posing as juveniles. Through their testimony, we were able to receive the perspective of the girl on the street. Their experiences apply to this report only in that many girls run away to escape abusive homes or foster homes. We will examine cases in which just that did occur later.

We heard testimony from Dr. Frank Osanka, Professor of Sociology and Social Justice at Lewis University. He confirmed most of the impressions and conclusions reported in the two reports and has since adopted the reports as texts for his courses.

Dr. Stephen Hardy, Administrator of Menard Psychiatric Center of the Illinois Department of Corrections, testified about the Sexually Dangerous Persons Act and his program designed to rehabilitate sex offenders who volunteer to be admitted to the program. We had previously determined that the Menard program was the only correctional option for such an inmate wishing to be rehabilitated in Illinois.

Rudolph Nimocks and William F. Keating, both of the Chicago Police Department, addressed the issue of sex crime, training of officers assigned to sex crime involving juveniles, and the role of the courts and correctional facilities.

We heard similar testimony from William O'Sullivan and Thomas Schumpp, both of the Illinois Department of Law Enforcement. O'Sullivan also described in detail a new computerized program designed to track sex offenders and provide local jurisdictions with leads in sex crime cases.

Representing the court system on the first day of hearings were Lake County Assistant State's Attorney Henry E. Mueller and Richard J. Fitzgerald, Presiding Judge of the Criminal Division, Cook County Circuit Court. Mueller ran through the normal procedure of preparation of a case involving a sex crime against a child. Fitzgerald presented an eloquent argument for judicial discretion in sex crime sentencing, an argument our Child Molestation report endorsed strongly.

On the second day of hearings, the parents of two girls who had been the victims of sex crimes testified. They provided a realistic and moving account of the emotions victims and victims' parents go through when a sex crime is committed against a young child.

Susan Weaver testified as a representative of the Cook County Juvenile Probation Office. She has worked personally with one of the child prostitutes profiled in our Sexual Exploitation report and reiterated our conclusion that few child prostitute rings are operating anywhere in the city.

Susan Yellig and Barbara White testified as social workers from Children's Memorial Hospital. They offered an expert view of the trauma seen at the hospital level and methods parents, the police, prosecutors, and others could use to reduce the trauma suffered by a child victim of a sex crime.

Our final witness was William B. Kelley, Co-Chairperson of the Illinois Gay Rights Task Force. Kelley indicated his organization's concern that homosexuals not be portrayed as preying on young children, when such is so rarely the case. He applauded our presentation of cases, which made it clear that child molestation is not a homosexual problem at all, but a broad societal problem.

The hearings provided the public with information that bolstered the findings and conclusions presented in our two reports. They made clear the Commission's ongoing interest in the rights and treatment of children, particularly child victims. And they laid part of the groundwork for the continuation of our child abuse investigation.

Several specific sections of our previous two reports should be consulted by the interested reader for information on abused or neglected children. The Sexual Exploitation report makes it clear that some children involve themselves in child pornography schemes because of parental neglect. Such was the case with some of child pornographer John Spargo's victims. Spargo was able to convince many young boys to engage in sex with him and to pose for pornographic photos because their parents, who were almost all wealthy, had little time to spend with them. Other children involved with some of the men who are profiled in that report also appear to be neglected children. Many of the men--and women--arrested and convicted of child pornography schemes or taking indecent liberties with a child specialized in finding victims who came from foster homes, victims with low self-images, victims who were chronic runaways.

Both of our long case studies in Sexual Exploitation of two Chicago-area prostitutes--one male, one female--are of children who had been physically abused and who had extensive contact with the Cook County Juvenile Court. The girl that we studied, as far as we can determine, is still a prostitute in Milwaukee. The boy was murdered two years ago.

In Sexual Exploitation, we present the research findings of a study into male sex rings. Many of the victims enticed into such rings had been abused or neglected prior to their association with the people who formed the rings. Virtually our entire analysis of female prostitution centers around wards of the Illinois Department of Children and Family Services. We present an interview with one such ward and make it clear in a section on pimping that many of the girls (of age or below it) involved in prostitution are runaways from abuse or neglect.

Child Molestation presents fewer ties to this report on child abuse. Our previous investigations into child molestation and child prostitution and child pornography lead us to provide a distinction among the victims of these crimes. In some cases of child molestation, the victims are unknown to the offenders and are forcibly raped or otherwise molested in single incidents. However, a significant number of the victims of child molestation know their attackers and often are unwilling to report them because they may be friends of the family, because of fear, or for a variety of other reasons. They are not willing victims in spite of their seeming unwillingness to report their attackers. Further complicating these distinctions is the fact that some child molesters are also child pornographers. In fact, most child pornographers do engage in sexual activity with children. In sharp contrast to these types of victims are children who become prostitutes. Though it is true that certain factors may influence their decision to prostitute, generally they make a conscious decision to earn money through their activities. Only rarely are they coerced into lives of prostitution.

When Commission staff attended the Fifth National Conference on Child Abuse and Neglect in Milwaukee in April, 1981, there were numerous workshops that treated the subjects of child pornography and child prostitution. Only one of the presentations could even marginally be linked to child molestation. This seeming divergence can be problematic in one important regard: the effects of child molestation, child pornography, and child prostitution on their victims are often similar. Furthermore, these effects are similar to the effects that intrafamilial sexual abuse (incest) may have on children. In this regard, these four areas are integrally related. Because we treat the effects of intrafamilial sexual abuse in great detail later, we will not dwell on the effects that child molestations, child pornography, and child prostitution have on victims.

Instead, we refer the interested reader to sections of our Child Molestation report. While that report is issue-oriented, with chapters devoted to discrete areas of concern, all of the descriptions of the victims in chapters discussing specific crimes, as well as many interviews with experts in the field, mention the traumatic aftereffects that child molestation usually has on a young boy or girl.

Unlike the victims in Sexual Exploitation, the victims of Child Molestation do not come from broken homes. They are not runaways from abusive or neglectful parents. Most victims are involved without cause--at random. They are chosen by the molester simply because they are handy. The victims may suffer at the hands of a burdensome judicial system, at the hands of insensitive parents, and at the hands of a system that has less than complete regard for their emotional wellbeing following a molestation or molestation attempt. Victims may experience the same fear of men experienced by rape victims; they may withdraw, as do incest victims; they may "act out," as do victims of child pornography. Almost all of the

effects we later describe when we detail cases of incest also occur to victims of child molestation. For that reason alone, an examination of Child Molestation may be valuable.

There is another reason for the interested reader to do so, however. We discovered a high incidence of abused children growing up to be child molesters. Not all child molesters are psychotic or mentally deranged, though some are. Many have reacted badly to the trauma of abuse, particularly sexual abuse, while they were young. Some of the offenders profiled in our report are extremely young. Others have long histories of sexual abuse.

The title of this report is The Child Victim. After spending four years investigating different types and forms of victimization, it is clear to us that all child victims share some aftereffects in common. Of particular interest to readers involved in the field of incest should be our Appendix B to Child Molestation. It consists of the Chicago Hospital Council's "Guidelines for the Treatment of Suspected Rape Victims."

We now return briefly to our report on Sexual Exploitation. In that report we mention that during the course of our investigation, several individuals involved in sexual offenses against children were identified by a Commission undercover investigator. In several cases, the information was sufficient to persuade police to arrest the individuals. We presented data on seven such individuals and added additional information about several more. We will update the status of these individuals below.

Clarence Richard Barnett was arrested in Indiana on December 12, 1978. Barnett was convicted, and on March 12, 1979, Barnett was sentenced to one year imprisonment for Distribution of Obscene Matter. Barnett, a Baptist minister, had failed to provide bond and had spent several months in jail. The remainder of his sentence was suspended. Barnett now lives in Georgia.

John P. Mikalauskas was arrested on February 11, 1980, after he exhibited and offered to sell pornographic pictures to a Commission undercover agent. On February 14, 1980, the DuPage County Grand Jury indicted Mikalauskas on one count of exhibition of child pornography, one count of deviate sexual assault, and three counts of indecent liberties with a child. Mikalauskas entered into a plea agreement whereby all charges except the indecent liberties charges were dropped. On November 7, 1980, despite a sentencing recommendation by the State's Attorney's Office that Mikalauskas receive five years' imprisonment, Mikalauskas was sentenced to four years' probation. Terms of the probation included non-association with the victims of the indecent liberties charges as well as psychiatric and vocational counseling.

David I. Preston was arrested at his place of business in Belleville, Illinois, on January 17, 1980. Ultimately, Preston was charged with a violation of the "Harmful Material" statute, Ill. Rev. Stat. Ch. 38, ¶ 11-21. Unlike the child pornography

statute, the "Harmful Material" statute is only a misdemeanor offense. The prosecutor handling the case told us she would suggest one year's probation as a sentence. Preston was sentenced on June 20, 1980, to one year's probation.

Richard James Seeden was arrested on August 13, 1979. Seeden had met with a Commission undercover agent and had given him several pornographic Polaroid pictures. Seeden was charged with delivery and exhibition of child pornography. Seeden was convicted and sentenced on July 24, 1980 to one year's imprisonment.

On February 5, 1979, Robert C. Simmons was arrested and charged with a violation of the child pornography statute. Commission investigators had subpoenaed him to testify in our offices regarding his "business," the Media Exchange. Simmons admitted to us in a statement that he had mailed lists of child pornography he offered for sale. On August 30, 1979, Assistant State's Attorney Robert Zadek decided not to pursue the charges against Simmons. The charges were stricken on leave to reinstate but never were.

John R. Spargo communicated on several occasions with a Commission undercover investigator. Our investigator met with Spargo on August 17, 1979, at McHenry Dam State Park. Spargo brought with him a large photo album containing 76 Polaroid photographs of 12 boys engaging in various sexual activities. At that time, Spargo was arrested by plainclothes officers of the McHenry County Sheriff's Department and charged with a violation of the child pornography statute. On October 29, 1980, Spargo was sentenced to $1,000 fine and two years' probation following his conviction for exhibiting child pornography. After completing his sentence, Spargo was arrested on January 8, 1983 in Bettendorf, Iowa, on charges of lascivious acts with a child and indecent contact with a child.

The first person arrested as a direct result of our investigation into child pornography was Donald Warren Witt. Witt arranged a meeting with a Commission undercover agent for the purpose of displaying and selling samples of child pornography. During the meeting on December 2, 1977, Witt was arrested by agents of the Illinois Department of Law Enforcement. Because Witt was arrested prior to the effective date of the Illinois child pornography statute, he was charged with Exhibiting Obscene Material and Sale of Obscene Material. Witt agreed to plead guilty; in exchange for his guilty plea, Witt was placed on one year's court supervision and directed to furnish the Commission with any information he had regarding the manufacture or sale of child pornography. Witt was unable to furnish the Commission with much information except certain personal details, including his sexual involvement with young boys prior to his involvement with child pornography.

The fifth chapter of Sexual Exploitation reports on arrests of figures other than those with whom Commission investigators were directly involved. One case reported was that of the husband-wife team of Raymond and Lori Brown. The Browns were arrested on April 5, 1978, and charged with taking indecent liberties with a child after a 13-year-old ward of the state threatened suicide be-

cause of her despondence concerning her sexual involvement with the couple. This young girl, together with some of her classmates, had been involved sexually with both Browns. Raymond Brown had filmed some of the sexual activities between Lori and the girls. When the Browns were arrested, the Illinois Department of Children and Family Services assumed temporary custody of the Browns' one-year-old daughter.

On March 4, 1980, Raymond and Lori Brown were both convicted of taking indecent liberties with a child. Raymond Brown was sentenced to five years' imprisonment; Lori Brown received four years' probation. As we reported in Sexual Exploitation, "Pamela [the Brown's daughter] was returned to her mother's care after a spokesperson for the Department of Children and Family Services stated that the department was not concerned with what parents were 'into' but whether they treated their children well."

When we questioned Brown's probation officer, she told us that her office did not have a working relationship with DCFS, so she could not tell us anything about the status of the daughter. Brown's new probation officer told us that she was doing well.

We also learned that Raymond Brown was incarcerated on April 11, 1980, and ultimately was transferred to the Logan Correctional Facility. Brown was to have been eligible for parole 2½ years after the date of his original incarceration, with adjustments for "good" and "bad" time. In February of 1982, Commission investigators made a routine check on Raymond Brown and learned that he had been paroled on December 10, 1981. We also learned that counseling was not a condition of Raymond Brown's sentence while at Logan.

Next, we contacted John Frattinger of the Uptown Parole Office. Frattinger is Brown's parole agent. Frattinger outlined the conditions of Brown's parole: they are the normal conditions imposed on most parolees. There is no provision for counseling or psychiatric care. When we asked Frattinger why Brown had been released so early, he told us that Brown had served three months before being released on bail. He also served a brief period of time after his conviction. Brown was credited with six months of "good time" after he had been at Logan. Thus, Brown did in effect serve 2½ years of his original five-year sentence.

Finally, we determined that the DCFS case on Pamela Brown had been closed on November 12, 1979, and no further monitoring of the child is being done by DCFS.

Commission investigators initiated a case regarding a man thought to be involved in child pornography in 1979. A Commission undercover investigator wrote to David Kummer of Maple Park, Illinois, after reading an advertisement Kummer had placed in a maga-

zine titled The Compendium. A full description of this magazine is contained on pages 40-42 of Sexual Exploitation. In brief, the magazine was a preteen heterosexual journal that catered to child molesters and private child pornographers. Its editor stated in an issue that "The Compendium is a service designed to assist you in the biological phenomenon of puberty." Its owner was arrested in 1978 and the magazine's mailing list was confiscated by the Los Angeles Police Department.

Our undercover investigator wrote a letter of inquiry about services that Kummer's Studio 9 could provide. Kummer responded with a letter to one of our undercover postal boxes. A meeting was arranged between Kummer and our investigator. On October 23, 1979, Kummer and our investigator met in the American Room Cafeteria of the Sears Tower in Chicago. Kummer told our agent at that time that he was interested in young girls, particularly between the ages of 9 and 12. He told him that he had taken thousands of pictures of young girls, many of them at a supposed nudist camp near Marengo, Illinois. Kummer told him also that, whenever possible, he has the girl's parents sign what he called a "model release form." He said that other photographs had been taken at his home or at the home of one of the young girls.

At this meeting, Kummer told our investigator that he had engaged in sexual activities with many of the girls he had photographed.

Kummer told our investigator that he had conferred with his attorneys and planned to publish a photo album of his work. Kummer told our investigator that he saw nothing wrong with adult males engaging in sex with preteen females, and his artwork was to be an expression of his philosophy, though he never mentioned publishing photographs of sexual activity itself. (Prior to and immediately following the meeting, our investigator met with agents of the Illinois Department of Law Enforcement, who conducted surveillance of the meeting throughout.)

At this meeting, Kummer also referred to his family life. He stated that he and his wife often made love in front of his children and that one of his children even helped position Kummer and his wife for oral sex. Kummer said that "children are brought into this world for the entertainment of their parents," and admitted that both he and his wife performed oral sex on his daughters on numerous occasions.

Commission staff took the information we had developed to Kane County First Assistant State's Attorney Patricia P. Golden, who indicated her interest in pursuing the case. The decision was made among representatives of the State's Attorney's Office and the Department of Law Enforcement to try to develop a case for criminal prosecution. They proceeded with the case but were unable to develop sufficient information for criminal prosecution. The case was dropped.

I heard about you from a friend quiet some time ago. Perhaps we have similar interests? I have an interest in youth development. particularly the ages between 10 and 14. For a number of obvious reasons I have not pursued these interests as actively as I would like to.

Perhaps I should tell you a little about myself. I am a male, white 30 years old. I am into collecting photos as well as taking pictures. I also do some film developing. You may have seen my ad in several local publications.

I have a few young friends who I see on a fairly regular basis. I also have developed numerous contacts in Illinois as well as elsewhere.

I hesitate to write this letter, just as I'm sure you're curious as to why I'm contacting you now. I can assure that I am not a police officer, and my only hope is that if we do share similar interests perhaps we get together and discuss this further. I'm sure it will be beneficial to both of us.

I am a professional person, so discretion is a must!!!! You can expect the same from me!!!!!

If you're at all interested please call me at this number(312) 332-5789. Call during the day, please be discreet. Just ask for Ed, if I'm not in just leave a message, and I'll get back to you.

If not you can drop me a note at my P.O. Box.

Hope to hear from you soon,

Ed
P.O. Box _____
Chicago, Illinois
60611

[Letter from undercover Commission investigator to David Kummer.]

Studio 9

Creative Photography

MAPLE PARK, IL 60151

Dear Ed:

I have just received your letter. I would like to drop you a quick note to let you know something about myself. I believe that my unique feelings about young girls ages 9-12 are legitimate. I believe that because these feelings are not understood and they are repressed from expression through misunderstanding, I intend to promote my concept through legitimate legal means.

I am a very good photographer and have been working on a photographic portfolio for many years. I intend to publish my work as a means of expressing my feelings. I have of course worked with my lawers so that I understand and obey the laws.

I am professional person myself and discretion is a must, but I do intend to, and I have promoted my art work as a legitmate artistic expression.

I am 36 years old, married with three children(two girls). I am looking foreword to a legitimate discussion of this subject with you.

David Kummer

Subsequently, Postal Inspector John Ruberti had independently developed a number of advertisements that child molesters might be attracted to, and Kummer had responded to one of these ads. Ruberti met with Kummer at Kummer's studio in Batavia in October of 1981. At that time, Ruberti ordered six photographs of nude pre-pubescent girls and scheduled a tentative photo session with Kummer to photograph Kummer's seven-year-old daughter. Ruberti told our investigators that he asked Kummer if Kummer's daughter could "touch herself" for these photo sessions. Kummer allegedly replied that if a friend of his daughter touched her, that would be between the friend and his daughter. Kummer said that either he or his wife would be present at the photo sessions and that they would charge Ruberti $60. Finally, Ruberti asked Kummer if Kummer's wife could be photographed with their daughter. Kummer said he wasn't sure but thought that she would agree.

Commission investigators accompanied officers from various law enforcement agencies to the Kummer's Maple Park home on the evening of October 26, 1981, to observe the search and arrest of Kummer and his wife. Search warrants had been obtained for both Kummer's home and studio. Batavia Police Department officers arrested the Kummers at the time and DCFS worker Mary Hegen took the Kummers' three children to be temporarily placed in foster homes.

David Kummer was charged with the following offenses: two counts of taking indecent liberties with a child; two counts of obscenity; three counts of child pornography; two counts of indecent solicitation of a child; one count of contributing to the neglect of a child; one count of cruelty to a child; and one count of unlawful possession of marijuana. Gail Kummer was charged with one count of contributing to the neglect of a child, one count of cruelty to a child, and one count of unlawful possession of marijuana. These charges are a mixture of felonies and misdemeanors.

Bond for David Kummer was set at $25,000; bond for Gail Kummer was set at $10,000. An additional bond of $15,000 was levied on each of the Kummers for the marijuana charges.

Kane County prosecutors had been unable to proceed more quickly with this case. When the Kummers finally were arrested in October, 1981, the existing child pornography statute did not cover their actions. Public Act 82-0287, which amended the child pornography statute (Ill. Rev. Stat. Ch. 38, ¶ 11-20a) and which took effect January 1, 1982, filled what the Commission viewed as a loophole in the child pornography law. It had been our hope that situations such as the one presented by the Kummers could be resolved through such a law, which we feel would have covered the content of the photographs confiscated from the Kummers' home. The Act was co-sponsored by Representative Thaddeus S. Lechowicz and Senator Adeline J. Geo-Karis, now a Commission member.

Unfortunately, in spite of the work put into this case, most charges against the Kummers were dropped pursuant to a plea agreement. Circuit Judge Paul Schnake accepted a guilty plea from the Kummers to a misdemeanor charge of possession of marijuana. The

Kummers were sentenced to six months' probation. The judge also ordered through a stipulation of facts to the offense of contributing to the neglect of a child and ordered the Kummers to be placed on 12 months' court supervision. If the supervision period ends without incident, the Kummers' record with regard to child neglect may be expunged. Under the terms of the plea agreement, the Kummers will receive custody of their three children but the entire family must continue to receive psychological counseling. The Kummers are banned from making nude photos of children, including their own. All photographic equipment confiscated by the police was to be returned to them. The Kummers each paid court costs, as well, which were minimal.

Judge Schnake indicated that none of the confiscated photographs was even remotely obscene. An attorney representing the children argued that the Kummers are "very caring and loving parents," and a psychologist hired to assess the children said that they had suffered no trauma from any of the alleged activities of their parents. The attorney, William Bochte, criticized media attention to the case, saying that if the children have been affected adversely by the incident, it has been "due to media attention." The Kummers have also voiced their displeasure with their recent media exposure.

There seem to have been problems with the criminal case presented against the Kummers. We can only report what we know about the Kummers based on what we have seen and based on what David Kummer told our investigator. The Kummer Case reemphasizes what we found in our Sexual Exploitation report: that child molesters and child pornographers are usually respectable members of the community and often they are never convicted of any crime. Usually, though, these individuals are compulsive and will return to their activities, given enough time. It is unlikely the law enforcement community has heard the last of the Kummers.

Another case that Commission investigators identified during the course of our child abuse investigation but which properly belongs with these other cases of child molestation is that of John D. McCauley. His case came to our attention during the routine investigation of an abuse case ending in death. One of our investigators spoke with Villa Park policeman Andrew D. Subject regarding a case Subject had handled and was told in passing of the McCauley case. Subject made reference to the case in context of discussing his problems with DCFS. McCauley had been caught molesting a child in his care and had been charged with taking indecent liberties with a child. The bad thing was that McCauley was a licensed foster parent and day-care facility worker. Subject alleged that McCauley's license had expired but that DCFS continued to send children to his day-care center for supervision.

McCauley was arrested on February 27, 1981, and charged with performing a deviate sexual act with a six-year-old boy. The act allegedly had occurred in July, 1979. Villa Park Police Chief William Kohnke told reporters that his office had been investigat-

ing McCauley for about six months following a tip that irregular activities were occurring between McCauley and children for whom he "babysat." Bond was set for $10,000.

Leo Olsen, Director of Building and Zoning for Villa Park, said that McCauley had been licensed by DCFS since at least July 1, 1980, but McCauley refused to apply for a village license required by village ordinance. Olsen told reporters for the Chicago Tribune that his office had contacted McCauley several times but never was able to get inside his home to conduct an inspection. McCauley had even written a letter on June 13, 1980, to a state legislator in hopes of getting aid in finding a "loophole" in the Villa Park ordinance,

Police reports of the arrest of February 27, 1981, indicate that warrants had been obtained for a search of McCauley's home. The warrants specified that pornographic material was to be searched for. A warrant also was provided to allow the mother of one of the alleged victims to enter McCauley's home with a concealed transmitter. Police entered after the woman had engaged McCauley in conversation.

The police reports indicate that sexual abuse of children may have been occurring as early as October, 1977, and that some of the abusive incidents occurred with overnight child guests at the same time that McCauley had permanent foster children in the home.

McCauley met several of his victims at a Cub Scout activity at one of the Villa Park elementary schools.

Commission investigators who examined this case found out from DuPage County State's Attorney Criminal Division Chief Thomas L. Knight that McCauley had been accused of taking indecent liberties as early as 1976. McCauley had been arrested, according to Knight, but the charges were dropped.

McCauley pled guilty to one count of taking indecent liberties with a child for his actions in the latest case mentioned. McCauley was sentenced to four years' probation with special conditions that he serve 90 days in jail or 180 days on work release to begin April 11, 1983. He was fined $4,000 and $74 in court costs. Finally, he was required to undergo psychiatric counseling at the Isaac Ray Center, 1720 West Polk Street, Chicago.

Unfortunately, McCauley was not the only foster parent or day-care worker we discovered who had been involved in child molestation. Allegations about such workers surfaced on occasion during our investigation. Actually, these allegations are not surprising, given our findings in Sexual Exploitation. People like McCauley tend to involve themselves as closely as possible to children: that is undoubtedly why he was involved in a Cub Scout function even though he had no children of his own in the Cub Scouts. Many of the offenders profiled in our previous two reports managed to get themselves into situations in which they had close proximity to children. You can hardly get closer to children than by becoming

a foster parent--or a worker in any portion of the child welfare field. Furthermore, many children involved in the child welfare system are somewhat more susceptible to being approached for sexual purposes. Many feel that they have no one to whom they can turn for help--except, perhaps, their foster parent. Many are runaways. Many are relatively unstable in their own personal attitudes toward many things, sex included.

Though we only looked at the Kaleidoscope, Inc. group homes in passing, we learned that Karl Turner, a former Kaleidoscope staff member, pled guilty to engaging in sexual relations with a 16-year-old girl living in one of Kaleidoscope's homes in Bloomington, Illinois. As conditions of the plea agreement, Turner was fined $100 and ordered to serve 12 months' court supervision. Also as part of the agreement, a second charge of contributing to the sexual delinquency of a child was dropped.

We learned in late May of 1982 that another Kaleidoscope counselor had been arrested and charged wth contributing to the delinquency of a 14-year-old girl. A night-care counselor named Eric Tapley of Bloomington was charged with the offense after his supervisor learned about incidents involving Tapley and one of the Kaleidoscope clients. Tapley was terminated by Kaleidoscope, pled guilty to the offense on June 16, 1982, and was fined $100.

Following this incident, DCFS initiated a freeze on referrals to the Bloomington-Normal Kaleidoscope facility until a DCFS licensing review could be completed. A five-member special committee of the Illinois House of Representatives was charged with reviewing Kaleidoscope and recommending whether or not the state should continue funding.

At the same time, Kaleidoscope moved to replace male night staffers with women; increased the average age difference between staff and wards by hiring older people; and stepped up surprise spot checks at night.

The DCFS review led to a lifting of the placement freeze, and the House special committee recommended in a report released in November that no negative sanctions be taken against the child-care agency. The report described the criminal acts as "isolated" and took cognizance of Kaleidoscope's steps to minimize their occurrence in the future.

We will report on other improprieties as they occur within the purview of specific cases. It should be clear to the reader by this time that sexual exploitation, child molestation, and child abuse are related problems, not only because of the involvement of elements of the state child protective and welfare systems, but also because children who are victimized lay themselves open to further victimization. Any one of these three areas can lead to further victimization in a vicious circle that can be difficult to break.

As we mentioned, our previous two reports are being used by teachers, police departments, and courts as training materials and texts. Our Chief Investigator has participated in a number of workshops on the subjects of sexual exploitation of children and child molestation; he also has presented lectures to groups wishing to learn more about these problems. Both reports have been reprinted because of demand for their use.

Most recently, the Commission has been asked to furnish our reports and any additional information we may have to the newly-formed Committee on Sexual Offenses Against Children and Youths, a Canadian federally funded two-year investigatory project that will present its findings to the Canadian Parliament.

In addition, the directors of the Fourth International Congress on Child Abuse and Neglect have invited Commission representatives to come to the Congress in Paris in September, 1982, to give a paper on child prostitution. Commission staff have prepared an abstract that will be included in the Congress's Book of Abstracts for use by child abuse professionals throughout the country. Also, the Commission has been invited to display Commission reports in the Faculty Hall of the Congress.

E. Sexual Exploitation and Child Molestation: Update on Legal Issues

As a result of the two Commission reports issued during 1980, Sexual Exploitation of Children and Child Molestation: The Criminal Justice System, the Commission sponsored or supported the following legislation:

1. Sexual Exploitation of Children Legislation

a. Senate Bill 1, enacted into law as Public Act 82-341, amends the Criminal Code of 1961 (at Ill. Rev. Stat. Ch. 38, ¶¶ 11-15.1(c), 11-19.1(c), 11-19.2). This legislation increases the penalty from a Class 4 felony to a Class 1 felony for the following offenses: "Soliciting for a Juvenile Prostitute" and "Juvenile Pimping." It also adds a section on "Exploitation of a Child," for which the penalty for violation is a Class X felony. This legislation was approved August 26, 1981, and became effective as of that date.

b. House Bill 287, enacted into law as Public Act 82-287, amends the Criminal Code of 1961 (at Ill. Rev. Stat. Ch. 38, ¶ 11-20a (a)(2)(F)). This legislation amends the child pornography law to include as prohibited sexual conduct the exhibition of pre-pubertal as well as post-pubertal genitals or pubic area of any person. This legislation was approved August 19, 1981, and became effective January 1, 1982. This is the new legislation referred to in the Kummer case above.

2. Child Molestation Legislation

a. Senate Bill 618, enacted into law as Public Act 82-694, amends the Criminal Code of 1961 (at Ill. Rev. Stat. Ch. 38, ¶ 11-4.1). This legislation creates the offense of "Aggravated Indecent Liberties with a Child," which provides that a victimizer

of pre-adolescent children is guilty of a Class X felony. This legislation was certified November 12, 1981, and became effective July 1, 1982.

b. Senate Bill 1078, enacted into law as Public Act 82-180, amends the Criminal Code of 1961 (at Ill. Rev. Stat. Ch. 38, ¶ 11-11.1). This legislation creates the offense of "Sexual Abuse of a Child by a Family Member" and makes a violation a Class 3 felony. This legislation was approved August 13, 1981, and became effective January 1, 1982.

c. House Bill 288, enacted into law as Public Act 82-712, creates the Child Sexual Abuse and Exploitation Treatment Center Act (at Ill. Rev. Stat. Ch. 23, ¶¶ 2081-2087), which is discussed in Section C of Chapter 3. This legislation was certified November 12, 1981, and became effective July 1, 1982.

d. Senate Bill 1077, enacted into law as Public Act 82-782, adds a new section to the Code of Criminal Procedure of 1963 (at Ill. Rev. Stat. Ch. 38, ¶ 115.9). It provides that in a criminal prosecution for a sexual act perpetrated upon a child under the age of 18, the child can testify that he or she had complained of said sexual act and the person who heard the child's complaint can testify that it had been made, in order to corroborate the child's testimony. This legislation was approved July 10, 1982, and will become effective January 1, 1983.

Two other bills were sponsored by Commission members as a result of the Sexual Exploitation and Child Molestation reports. Senate Bill 741 would have created an exception to the hearsay rule in prosecutions for sexual acts perpetrated on a child under the age of 13, by allowing an adult to testify as to the details of the child's timely out-of-court statement about such act. House Bill 286 would have required film processors to report suspected child pornography. However, Senate Bill 741 failed in House subcommittee, and House Bill 286 was vetoed by the Governor.

3. John R. Spargo Conviction

The case of John R. Spargo was recounted in the Commission's Sexual Exploitation of Children report, as we have noted here. The Illinois Appellate Court, Second District, on January 19, 1982, affirmed the conviction of Spargo for the offense of child pornography (Ill. Rev. Stat. Ch. 38, ¶ 11-20a), and affirmed that the law was not overbroad. Spargo had shown child pornography photographs to a Commission investigator without offering to sell them and was arrested.

The appeals court decided that the word "exhibits" in the statute prohibited even private exhibition or dissemination of such material. Spargo had exhibited the photographs to the Commission investigator while in his car, where he was arrested.

In its decision, the court compared the offense of child pornography to obscenity, for which an affirmative defense that the dissemination was not for personal gain could be raised. However,

no such defense was allowed for child pornography prosecutions, the court said, because the child pornography statute was enacted to regulate against the sexual exploitation of children.

It was also held that the law was not so vague that it violated due process standards. The court disagreed with the defendant's argument that the statute's standards of obscenity were unconstitutionally vague, saying that the determinations were to be made with reference to the judgment of "ordinary adults." (See People v. Spargo, 103 Ill. App. 3d 280.)

4. Child Pornography: Recent U.S. Supreme Court Action

State legislative approaches to the problem of child pornography vary, but they, like Illinois, generally address both the production and distribution of pornographic materials which depict children. Most commonly, the states, again like Illinois, have followed the lead of the federal government (Protection of Children Against Sexual Exploitation Act, 18 U.S.C. §§ 2251-2253) and have created separate offenses within their criminal codes which specifically outlaw child sexual exploitation, rather than amend existing statutes such as obscenity laws.

Child pornography laws are similar to obscenity laws, but many omit the requirement that the material be obscene. Instead, they prohibit using or permitting children to be filmed or photographed in specifically defined sexual acts. Additionally, they generally prohibit the distribution and sale of such materials.

Obscenity was most recently defined by the U.S. Supreme Court in the 1973 case of Miller v. California (413 U.S. 15). In Miller, it was held that a work is obscene if: (a) the average person, applying contemporary community standards would find that the work, taken as a whole, appeals to the prurient interest; (b) the work depicts or describes, in a patently offensive way, sexual conduct specifically defined by applicable state law; and (c) the work, taken as a whole, lacks serious literary, artistic, political, or scientific value.

The federal child pornography law cited above outlaws the distribution of "obscene" materials which depict children involved in sexually explicit conduct. On the other hand, the ban on the production of the material has no such "obscenity" requirement.

Many states have followed the federal government and require that material which depicts children involved in sexual conduct be obscene according to the Miller standard, in prosecutions for distribution of child pornography. The Illinois statute (Ill. Rev. Stat. Ch. 38, ¶ 11-20a) goes further by incorporating the obscenity standard in prosecutions for both the production and distribution of child pornography.

Unlike those states following the federal law, twenty have attempted to combat the problem by barring both the production and the distribution of material depicting children engaged in set forth

types of sexual conduct, regardless of whether the material is obscene. New York is one of these states.

As it concluded its 1981-82 term, the U.S. Supreme Court on July 2, 1982 upheld the New York criminal statute banning the production as well as the distribution of child pornography regardless of whether it is legally obscene. In upholding the New York law that prohibits the production, direction or promotion of material portraying sexual conduct by children under 16, the Court in New York v. Ferber (455 U.S. 904) ruled that a state has greater leeway under the First Amendment to regulate pornographic material involving children than it has in enacting other content-based restrictions.

The result in this case was a major victory for New York prosecutors, who successfully persuaded the Court to reinstate the conviction of Paul Ira Ferber, a Manhattan adult bookstore owner, for selling two films depicting sexual acts by young boys.

Writing for the unanimous Court, Justice Byron White stated in the opinion that the legislative judgment that using children as subjects of pornographic material harms their physiological, mental and emotional health "easily passes muster under the First Amendment." The standard developed in the Miller case for determining what is legally obscene "does not reflect the state's particular and more compelling interest in prosecuting those who promote the sexual exploitation of children," and thus, according to the court, the Miller standard is not "a satisfactory solution to the child pornography problem."

In rejecting the argument that the New York statute is unconstitutionally overbroad because it could be applied to material that has serious literary, scientific or educational value, the Court stated: "We consider this the paradigmatic case of a state statute whose legitimate reach dwarfs its arguably impermissible applications."

This Commission's Sexual Exploitation of Children report was cited as a supportive reference in this U.S. Supreme Court case.

As stated above, Illinois law requires that child pornography be obscene in prosecutions for both its production and distribution. However, the production of child pornography constitutes conduct of a type rarely thought to implicate First Amendment protections; now, in light of New York v. Ferber, even the distribution of child pornography cannot be considered a protected First Amendment activity.

The distribution of child pornography, like its production, is a form of child abuse in and of itself, and Illinois law should not accord these activities First Amendment protections not required by the U.S. Constitution. Certainly, the abuse of a child which occurs during the production of pornography and, later, during its distribution is not mitigated by a court determination that the material is not obscene.

A proposal concerning amendment of the Illinois child pornography statute to effect more ease in prosecution is one of several legislative recommendations discussed in the final chapter of this report.

F. Addressing the Problem of Child Abuse

Child abuse is such an overwhelming subject that it can never be addressed exhaustively. This particular section of our report will both summarize some of the ideas presented thus far and introduce issues that we have not yet addressed. The most important issues toward which we are looking deal with state central registries and the whole method of identification and treatment of abuse and neglect.

Brian G. Fraser was Executive Director of the National Committee for Prevention of Child Abuse in Chicago at the time his article "A Glance at the Past, A Gaze at the Present, A Glimpse at the Future: A Critical Analysis of the Development of Child Abuse Reporting Statutes" was published in 1978. He is also a graduate of Colorado School of Law and has authored many important essays and articles on the issue of child abuse and neglect.

His article examines issues we have discussed, such as the definition of child abuse, and then moves into new areas, offering a brief view of the different processes in the child protective services method. Fraser also offers views toward both the history of child abuse and neglect functions and thoughts about the future of reporting statutes and services to victims that will result.

Fraser's first comments criticize the governmental response to child abuse. To Fraser, this criticism relates not only to child abuse but to any major problem that continues over time. Fraser's criticism is an open critique of American institutions. In the child abuse arena, this means that the federal government has spent time and money on demonstration projects that are proven neither effective nor ineffective. These projects, and related research efforts and programs within individual states, continue to be funded because "there is a belief that these diverse programs will magically coalesce at some future point in time." Fraser views this amalgam of services as ineffective if we wish to develop a coordinated, comprehensive national program to combat child abuse and neglect. In fact, Fraser sees this scattershot approach to the problem as a failure.

Fraser also addresses the definition of child abuse:

> ...the term child abuse has a much broader meaning. It is a generic term. In the simplest of terms, it is damage to a child for which there is no reasonable explanation. Child abuse is usually not a single physical attack or a single act of molestation or deprivation. It is typically a pattern of behavior. Its effects are cumulative. The longer it continues, the more serious the damage.

Fraser points out that there are different types of child abuse, which he defines at greater length later in his article. Neglect and emotional abuse cannot be defined absolutely, according to Fraser, because they reflect community standards of behavior. Cultural biases and community standards vary geographically and across time.

Fraser says that there are four variables which seem to be indigenous to the crime. The first is learned behavior. In most cases of child abuse, one or both of the parents was abused, neglected, or deprived as a child. The second factor is parental isolation. The parents may be physically or culturally isolated. They have no friends or relatives upon whom to call in times of crisis. Third, the parents usually have unrealistic expectations for their children. Fourth, there is usually a crisis of some sort which precedes and precipitates an abusive incident. When these four factors coalesce, child abuse is very likely to occur.

In light of the tremendous amount of child abuse that occurs every year in this country, Fraser suggests that legislation intended to prevent or treat the problem must take into account the sheer impossibility of anticipating every incident of child abuse. He calls legislation that requires treatment "for every abused child and his parents, when no resources exist, [as] shortsighted and self-defeating." Child abuse is such a complicated issue that only a multidisciplinary approach is likely to ameliorate the problem.

In terms of approaches to the problem, Fraser identifies three major areas of effort: identification of the child alleged to have been abused; investigation to determine if the allegations are indeed true; and delivery of services and treatment to both the child and his family. Fraser views the current child abuse system as remedial in the sense that it deals with the child only after he has been abused. All resources are allocated toward efforts to treat abuse that already has been inflicted, and Fraser sees that as a shortsighted approach to the problem.

In addressing identification, Fraser concentrates on reporting statutes. All states now have such statutes, as we have mentioned. The question is how well they are being utilized. Are mandated reporters really reporting? Are there sanctions against those mandated reporters who have been proven not to be reporting? Fraser notes that almost all reporting statutes concentrate on professionals who should report. But, Fraser mentions, most child abuse reports come from non-professionals, such as next-door neighbors. He argues that the general public must be made aware of their ability to report, if not their responsibility to do so. Many authorities agree that neighbors and relatives are the first to become aware of abuse, and therefore should be encouraged to bring this to the attention of the authorities.

Nonprofessionals are not among mandated reporters under Illinois law, but reports still have greatly increased. What we do not know is the proportion of reports from mandated versus nonmandated

reporters, because as the new reporting laws have gone into effect, a general awareness of child abuse reporting has occurred among members of the general public. So, though there has been an increase in reporting since the statute has been amended to include more professional mandated reporters, non-professionals may also be responding to the intent of the law.

Certainly recent efforts by DCFS to educate the public by placing advertising in public places and on television and radio will increase reporting among non-professionals. Also, efforts by DCFS to make professional reporting responsibilities clear in the past year should have effected an increase in reports among professionals.

Fraser devotes a small amount of space to a description of the investigation of a child abuse case. He mentions that normally, a local representative of a state department of social services is required to investigate any reported case of child abuse. We will see later that there are exceptions to this general rule. Nevertheless, a social worker is the person most likely to respond to a report. The type of investigation produced will almost invariably come from a social-work point of view, which usually is non-criminal in nature, even though in most states child abuse is a crime. This is an important issue that we will discuss in detail as the report progresses. Fraser makes the following interesting observation about the investigation phase of child abuse response: "The investigation which focuses on the reported injury creates a still life portrait of the child at the time the report was received. The proper investigation needs to focus on the child's life, not on a single event. The proper investigation should create a moving picture of the child's life."

Fraser says the best investigations occur as the result of coordinated efforts in which agencies complement one another. The pooling of expertise among professionals is presented as a key to a successful investigation.

The next category that Fraser addresses is titled "intervention" and refers, simply, to implementation of a treatment plan. Of course, in reality, several steps intervene between the child abuse investigation and the implementation of treatment. The most important of those steps involves the courts. We will describe these steps within the context of all of the case studies that follow.

Fraser refers to federal initiatives, most specifically the Child Abuse Prevention and Treatment Act, signed into law by the President on January 31, 1974 (42 U.S.C. ¶¶ 5101-5107). The Act allocates funds for distribution to the states for prevention and treatment of child abuse. Funds are distributed through a formula that has changed over the years.

Fraser includes a brief history of reporting statutes, a portion of which is worth quoting at length:

> The first generation of reporting statutes had a rather simple focus. Their purpose was to mandate certain professionals to report suspected cases of child abuse. It was an identification function. It was believed that if a case of suspected child abuse could be identified and funneled into the system, appropriate relief would be provided. It was an erroneous assumption. As a result, a second generation of reporting statutes began to emerge. The focus of these statutes was identification and investigation. It was believed that, if the needs were clearly established, existing agencies would provide the appropriate relief. That too proved to be an erroneous assumption. As a result, a third generation of reporting statutes began to emerge. In addition to identification and investigation, these statutes began to address the complex issues of intervention. These statutes began to address the issues of limited resources, limited expertise, lack of coordination, a need to involve the general public as well as professionals, and the need to establish a planning component.

Fraser then runs through the typical reporting statute item by item, starting with definitions--again. The definition section is important because it establishes parameters and because this section must be broad enough to cover several types of very dissimilar behaviors.

Most states refer to accidental vs. non-accidental injuries. Many statutes specifically refer to corporal punishment. Fraser states that corporal punishment is by definition inflicted non-accidental physical injury. No state, however, prohibits the use of corporal punishment by parents. The issue rests on what types and amounts of punishment are reasonable. Some states have been concerned with the distinction between non-accidental physical injury and corporal punishment and have attempted to distinguish between the two in their statutes. Four states specifically permit reasonable corporal punishment and state that it is not child abuse. On the other hand, four other states categorize excessive corporal punishment as child abuse.

Almost all reporting statutes also mention neglect in specific terms. Fraser states that there have arisen two schools of thought concerning standards for definitions of neglect. The first is that a child is entitled to "the care and support that a reasonably prudent parent might provide." The second is that a parent must only provide the minimum amount of care acceptable within the community. Obviously, this has to be viewed as a community-based issue. Fraser indicates that the "real standard" fluctuates from community to community.

Fraser mentions that some, but not all, states include sexual molestation within their definitions of child abuse. The problem is that there are many types of sexual molestation, as we detail in our Child Molestation report, and some are closely related to abuse, while others clearly are unrelated to what is normally construed as being child abuse.

Fraser also refers to a category that we encountered upon occasion during our investigation and which is receiving increasing interest from social workers and others. It is the area of emotional abuse or mental injury. Fraser's comments on this category are valuable:

> As early as 1958 it was suggested that mental injury should be included in any definition of child abuse. The same suggestion has been echoed by various commentators for the last twenty years.
>
> There is little doubt that physical trauma or a hostile psychological environment can cause mental injury. There is equally little doubt that the mental injury can be quite severe and the effects can have a pronounced effect in later years. It cannot, however, be said with any surety that a hostile or neglectful environment will result in mental injury. And this has prompted at least one commentator to suggest that mental injury and possible intervention should be "...premised solely on damage to a child" and not on a harmful environment which might result in psychological damage and mental injury.

In the remainder of this report, we will describe specific case studies of child abuse and neglect, abuse and neglect which ended in death, and intrafamilial child sexual abuse. The cases are intended to illustrate the child abuse system, including its strengths and weaknesses. They also provide insight into how the system is meant to function. Areas not covered within the context of specific cases will also be described in the report.

Family violence will not go away. It is our responsibility to develop recommendations for the development and implementation of the most efficient and effective instruments to limit violence within both the family and society.

Chapter 2

THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Illinois law names DCFS as the state agency solely responsible for protecting children. Besides child protection, the Department also provides services involving family maintenance, substitute care, adoption, child and family development, unmarried mothers, and youth development. As of June 30, 1982, DCFS had open cases representing approximately 23,000 children (see Figure 2-1). The Department served these children through its eight regional and 73 Services Offices (see Figure 2-2 for a map of the regions). For Fiscal Year 1982, the General Assembly appropriated $158.5 million to the Department, making its General Revenue Fund budget the 5th among comparative State code departments.

A. History

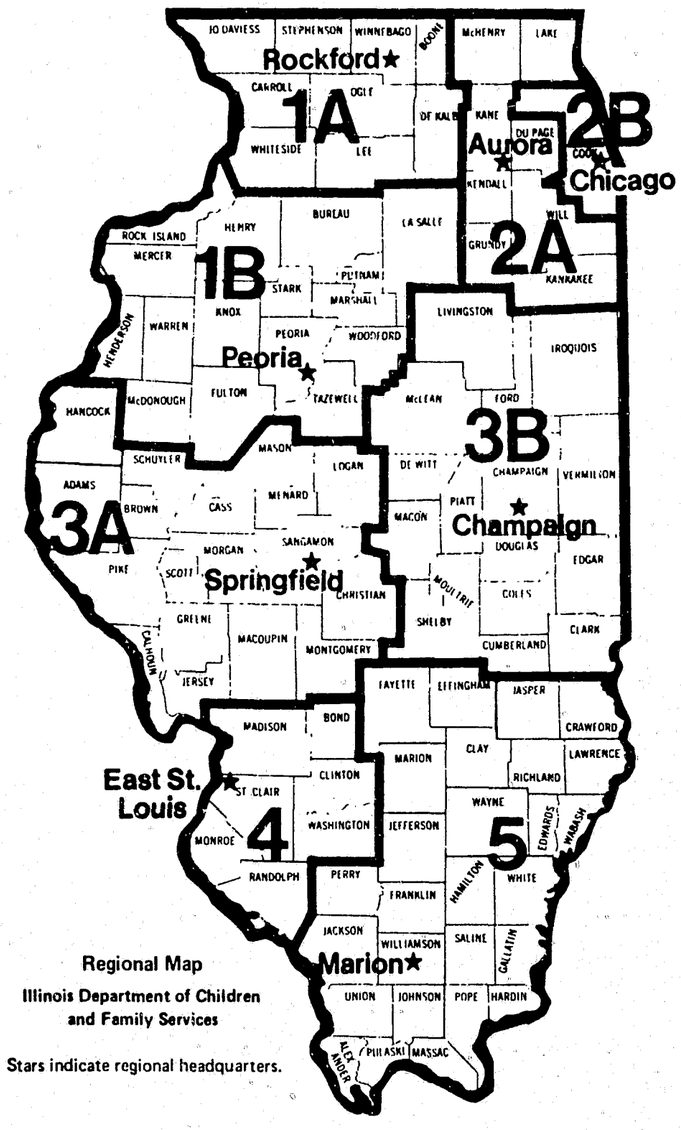
The earliest predecessor to the Department of Children and Family Services was created in 1905 by the Legislature under the Visitation of Children in Homes Act. The Department of Visitation of Children was charged with visiting all dependent and delinquent children placed in foster homes and institutions and with inspecting these institutions annually. The Department was a division of the State Board of Public Charities, and served a much narrower purpose than today's DCFS: to oversee the care of "that class of children who are subject to abuse and brutal treatment at the hands of foster parents, as is sometimes the case...."

The Department of Visitation became a division of the Department of Public Welfare when that Department was created in 1917. In 1929 a Governor's commission recommended that a Division of Child Welfare be established in the Department of Public Welfare to perform the visiting duties of the Division of Visitation of Children, and to license, set standards for, and supervise public and private agencies caring for children. The Commission also recommended that the new Division clearly separate its casework and supervisory responsibilities.

At about the same time, the philosophy behind the commission's recommendations was also expressed at the 1930 White House Conference on Children. (President Theodore Roosevelt held the first White House Conference on Children in 1909, which called for the nation to preserve and strengthen home life for children. The conferences are held every ten years.) The 1930 conference emphasized the need for state welfare departments to establish standards for all child care agencies. At the White House Conference, states were directed to provide "leadership, guidance, and direction to social work programs."

These sentiments led the Illinois Legislature to pass the Placement of Children in Homes Act (also known as the Child Welfare Act) on July 10, 1933. This act repealed the Visitation Act of

Figure 2-2



Regional Map

Illinois Department of Children and Family Services

Stars indicate regional headquarters.

Figure 2-1

Open Child Cases by Sub-State Regions
Fiscal Years 1981 - 1983

REGIONS	FISCAL YEAR 1981 As of June 30, 1981 Number	Percent	FISCAL YEAR 1982 (Estimated) As of June 30, 1982 Number	Percent	FISCAL YEAR 1983 (Projected) As of June 30, 1983 Number	Percent
Rockford	1,071	4.3	1,038	4.5	1,084	4.6
Peoria	1,448	5.9	1,377	6.0	1,366	5.8
Aurora	2,086	8.4	1,475	6.4	1,505	6.4
Chicago	14,053	56.9	14,014	60.6	14,111	60.2
Springfield	895	3.6	904	3.9	940	4.0
Champaign	1,742	7.0	1,694	7.3	1,779	7.7
East St. Louis	2,140	8.7	1,559	6.7	1,572	6.7
Marion	1,279	5.2	1,058	4.6	1,081	4.6
TOTAL	24,714	100.0	23,119	100.0	23,438	100.0

1905, as well as the Boarding Home Act of 1919, which had provided for the regulation of children's boarding homes. The new act was more specific, detailing the jurisdiction of the Department of Public Welfare in dealing with child care institutions. Day care centers and day nurseries were included in the list of institutions to be licensed.

On July 10, 1957, the Child Welfare Act was replaced by the Child Care Act. This new act expanded the state's authority and responsibility regarding child welfare. In 1961, the Division of Child Welfare was transferred from the Department of Public Welfare to the newly created Department of Mental Health. In that year, the Division of Child Welfare consisted of a central office in Springfield and seven regional offices. The central office handled policy, procedure, programs, planning, consultation, and personnel, while the regional offices were responsible for providing direct social services. At both levels, the Division licensed child care facilities and provided direct child welfare services to children of veterans. Services to non-veterans were provided if local resources weren't available. Child Welfare provided the following services:

1. Casework services to children in their homes or foster homes.
2. Licensing of child care facilities and the publication and development of minimum standards for the foster care of children.
3. Guidance and counseling to public and private child welfare agencies.
4. Local community planning for services to minors in need of supervision.
5. Counseling services and placement when necessary for handicapped children.
6. Services to unmarried mothers and their children.
7. Intercounty adoption and adoption studies.
8. Study and approval of interstate placement of children.
9. Intake studies for admission to state schools for the handicapped.
10. Consultation to State children's institutions.
11. Statistical research.
12. Assessment of child care institutions hoping to incorporate.

In 1963, the 73rd Illinois General Assembly passed legislation creating the Department of Children and Family Services. The legislation became effective January 1, 1964. The new department was to run most of the non-psychiatric programs and services to children formerly administered by the Department of Mental Health. The Division of Child Welfare's licensing duties were also transferred to DCFS. DCFS' current legal authority comes from the Child Care Act of 1969. For a discussion of this and other acts related to child protection, see Chapter 3.

B. The Department's Organization

Currently, DCFS has five divisions: Child Protection, Management and Budget, Policy and Plans, Program Operations, and Youth and Community Services. (See Figure 2-3.)

The Division of Child Protection, created last year, will be our main focus in this chapter. The division is responsible for the statewide toll-free child abuse and neglect hotline, the State Central Register of abuse and neglect reports, child abuse and neglect investigations, internal security investigations, and licensing. In this chapter's section on child protection, we will discuss all these functions except internal security investigations.

The Division of Management and Budget, as DCFS' 1983 Human Services Plan put it,

> supports the Department and its services areas by directing administrative management and fiscal activities of the Department. Included in this Division are the functional offices of Budgeting, Financial Management, Information Services, Financial Policy and Systems Design, Contracts/Grants, Affirmative Action, Employee/ Labor Relations, Children's Financial Benefits, and Central Support Services.

Of these functions, we will discuss only Contracts/Grants.

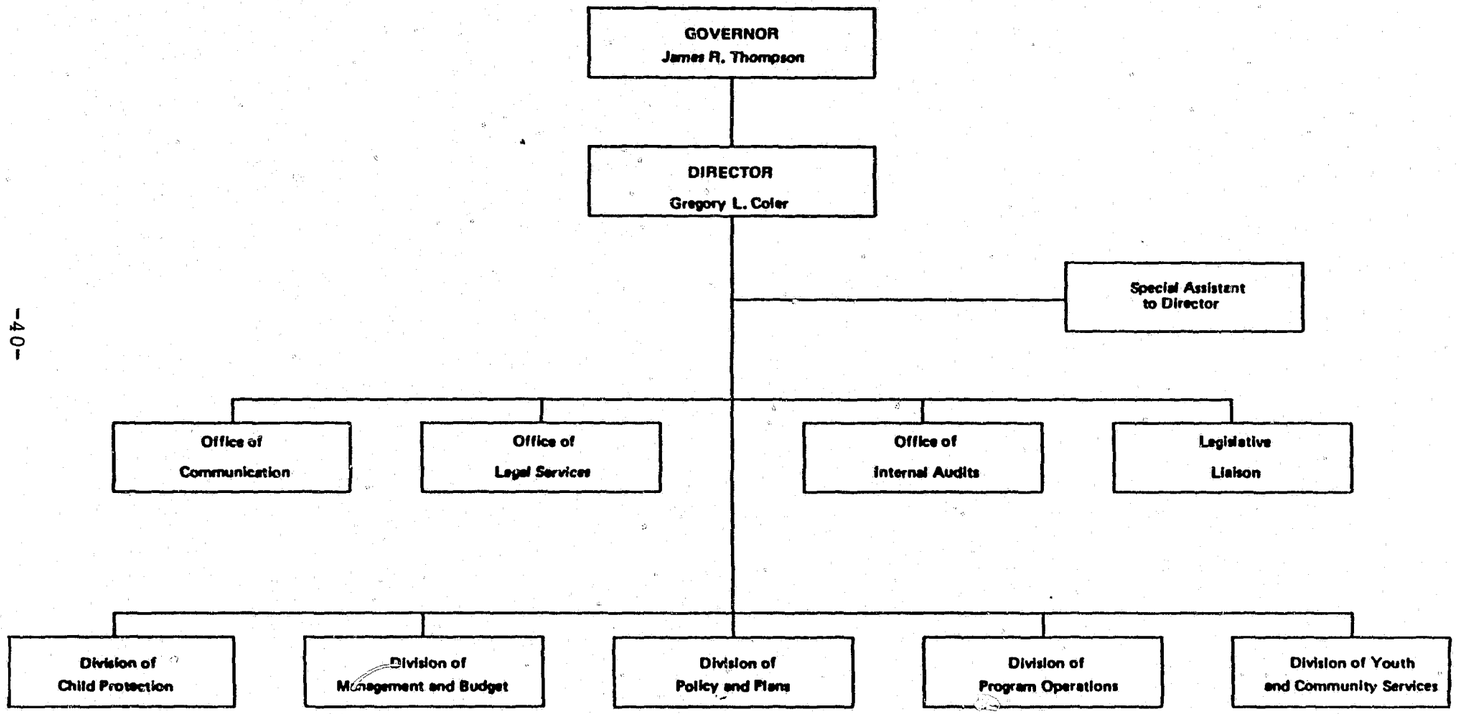
The Division of Policy and Plans is responsible for overall policy and program development, planning, staff training, and administrative case review. Administrative case review oversees DCFS' progress toward its permanency planning goals. One of DCFS' major initiatives for FY 1982 was to

> develop and implement permanency planning and case review systems in accordance with the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) to prevent unnecessary placement of children, reunify families or provide children who have been placed in substitute care with permanent, secure and nurturing living arrangements.

This is according to the Human Services Plan, which goes on to say that the case review system will "review cases of all children in substitute care every six months. The case reviews will be conducted by the Permanency Advocates [now called case review administrators] and will be open to the participation of parents."

Figure 2-3

Department of Children and Family Services



The Division of Program Operations "performs the vital function of direct management and supervision of the eight DCFS regions." The division also includes the management offices for Program Service Administration, Support Services, and Adoption Services. Later in this chapter, we will discuss the family maintenance and substitute care services provided by the eight regions, as well as the adoption services provided statewide. Included under the Adoption Services Unit's administration is the Adoption Information Center of Illinois, opened in March of 1981.

Organized in October of 1981, the Division of Youth and Community Services was created to serve Illinois' troubled adolescents by forging a coherent strategy from several fragmented programs. The Division is divided into four offices: Management Resources, Governor's Youth Services Initiative, Community Services Integration, and Field Services Management. Management Resources handles the Division's financial affairs. The Governor's Youth Services Initiative is explained in the 1983 Human Services Plan:

> This program, which began in 1979 as the Governor's Cook County Court Project, was designed expressly to serve youth with multiple problems. By combining and coordinating the resources and services of four state agencies, the Initiative develops individualized treatment plans for youth who formerly "fell between the cracks" of state agency mandates. Participating agencies are DCFS, the Illinois State Board of Education, the Department of Mental Health/Developmental Disabilities and the Department of Corrections. The Initiative operates in Cook County and three downstate regions: Champaign, E. St. Louis and Peoria.
>
> Currently youth in need of the Initiative's services are identified and referred by the Juvenile Court. The Initiative accepts referrals on a no-decline basis when they need one or more of the following criteria:
>
> - All regular channels to services have been exhausted.
> - There is a major disagreement between the court and a state agency as to that state agency's responsibility for a child or as to the type of service the child is to receive.
> - There is a major disagreement between state agencies as to which agency is responsible for service delivery or as to the type of service the child is to receive.
>
> The majority of referrals to the Initiative are multi-problem delinquents, but since most are non-violent offenders, judges are reluctant to incarcerate them. Most youth referred to the Initiative also are inappropriate for mental health hospitalization.
>
> ...After receipt of the referral, the Governor's Initiative Regional Coordinator convenes an interagency staffing. As the youth's holistic needs are identified, interim and long-term service

> recommendations are formulated. A comprehensive service plan then is developed that includes arrangements for residential placement, continuous project staffing, on-going direct contact with the youth and his/her family, guardian and service provider.

The project served 106 youths in FY 1981. The project is expected to serve approximately the same number in FY 1982 and FY 1983.

Community Services Integration is currently a one-person office responsible for division planning. Field Services Management absorbed the functions of the Commission on Delinquency Prevention, including administering such youth services as the Illinois Status Offender Service and the Office of Youth Training and Employment. Also, this office recently took over the operation of Unified Delinquent Intervention Services (UDIS) from the Department of Corrections.

We will now discuss in greater detail those functions of DCFS that most directly affect abused and neglected children. Though our discussion will center around the Division of Child Protection, it will touch on the divisions of Management and Budget, Policy and Plans, and Program Operations. This chapter should be read as general background to our case studies, which are rich in specific information about how DCFS operates.

C. Division of Child Protection

In August, 1981, DCFS announced that it had created a new Child Protection division, although implementation had begun in the Chicago Region early that Spring. The new division brought together Child Protective Services, the State Central Register, and licensing, all of which had previously been under Regional control within the Division of Program Operations. DCP would also be responsible for Internal Security Investigations, which had been performed by the Office of Investigations, independent of any division. The Internal Security Investigations section employs three investigators who investigate DCFS employee misconduct, often in cooperation with the Department of Law Enforcement. Internal Security Investigations is not relevant to our investigation. We will, however, discuss the State Central Register, Child Abuse/Neglect Investigations, and Licensing in detail.

1. The State Central Register: A Child Abuse/Neglect Tracking System

Before DCFS can help an abusive or neglectful family, the Department must be told about the problem. DCFS cannot see through the walls of Illinois homes, so it depends on reports from doctors, teachers, relatives, neighbors, and others to learn of abuse or neglect. Once an incident has been reported, DCFS must keep a record of the report and subsequent investigation. DCFS tries to reach two reporting goals: completeness and coordination. Completeness means receiving reports on as many of Illinois' child maltreatment incidents as possible, while coordination means

keeping track of proven abusers even if the family moves or years pass between incidents.

To improve DCFS' ability to meet these two goals, Public Act 81-1077 was passed and became effective July 1, 1980. The Act required the creation of a statewide reporting hotline:

> There shall be a single State-wide, toll-free telephone number established and maintained by the Department which all persons, whether or not mandated by law, may use to report known or suspected child abuse or neglect at any hour of the day or night, on any day of the week. Immediately upon receipt of such reports, the Department shall transmit the contents of the report, either orally or electronically, to the appropriate Child Protective Service Unit. Any other person may use the State-wide number to obtain assistance or information concerning the handling of abuse and neglect cases.

The Act also required an automated, computerized Child Abuse Register, which would be used to determine whether a reported victim had been abused before and to monitor the progress of protective services cases.

The new register and hotline, then, would perform the four functions identified in a 1978 Chicago Kent Law Review article by Douglas J. Besharov, at that time Director of the National Center on Child Abuse and Neglect. Besharov writes that an upgraded central register can:

1. Facilitate management planning by providing statistical data on the characteristics of reported cases and their handling;

2. Assist assessments of danger to children by providing or locating information on prior reports and prior treatment efforts;

3. Encourage reporting of known and suspected child abuse and neglect by providing a convenient hotline for reporting, by providing a focus for public and professional education campaigns, and by providing convenient consultation to caseworkers and potential reporters; and

4. Sharpen child protective accountability by monitoring follow-up reports.

Before we describe how the new system performs these four functions, we will see what led to the passage of Public Act 81-1077.

a. Background to the New System

In December, 1979, after Public Act 81-1077 had been passed, DiBernardo Management Consultants wrote a report for DCFS

discussing the implementation of a new child abuse tracking system. The report provides some background information on the State Central Register:

> Since the passage of the first child abuse and neglect legislation in Illinois in 1965, a State Central Register (SCR) has operated within the Department of Children and Family Services. Prior to the passage of P.A. 81-1077, the duties of the SCR were limited in scope and involved primarily recording reports of suspected abuse and neglect, providing information to Departmental staff related to prior reports of abuse and neglect, and preparing statistical summaries of child abuse and neglect reporting in Illinois.

The narrow statistical purpose of the register kept it from being of much use to the 18 area offices (DCFS reorganized its 18 areas into 8 regions in the summer of 1978). Thus, the area offices kept their own card files of cases.

Reports were received by over seventy field offices. This system, with each field office receiving its own reports, was in place when we began our investigation. We soon heard many complaints about the Information and Referral (I & R) workers who answered hotline calls. These I & R workers forwarded reports to Area multi-service workers, to CPS Intake, or directly to a CPS geographical team. Doctors, social workers, policemen, and school principals described DCFS' I & R staff as inexperienced workers who screened all but the most severe incidents. Several of the professionals also complained about DCFS' slow response to accepted reports.

One hospital's assistant director of social services told us he was never sure that the I & R workers were taking down his information, and felt as though DCFS did not want his input. The coordinator of another hospital's child abuse program said the I & R telephone workers were usually not skilled social workers experienced in working with child abuse, yet they determined whether or not DCFS accepted a case. The coordinator went on to say that I & R workers commonly refused failure-to-thrive and medical neglect cases because they were "not severe enough," even though the reporting act requires that these cases be referred to DCFS' Child Protective Services unit.

A social worker and two physicians at another hospital echoed these complaints, saying that not only were some serious cases refused, but an attitude of "why are you calling us?" came across the phone. They said that in one instance, the case of a child with gonorrhea was not accepted by DCFS because of lack of severity. Another time, one of the doctors tried to call DCFS for four hours before anyone answered. At another hospital, a medical social worker supervisor recommended that I & R staff be more qualified and experienced. A physician there told us that whenever he reported an abuse case, the DCFS worker would give him the impression that "it's a 'chore' that we've delegated to the State." He

also complained that when DCFS did act on a case, the caseworkers never told the hospital anything about what was done. Because hospital staff never heard anything about what DCFS did for maltreated children, they were unenthusiastic about reporting cases to the Department.

At two other hospitals, social workers told us they sometimes dissuaded doctors from reporting a case because if DCFS rejected it, the hospital would have hurt its relationship with the family for nothing. Another hospital's social worker supervisor said that in the past, DCFS caseworkers hadn't always come to the hospital, instead doing everything over the phone, but that having a DCFS liaison assigned to the hospital had helped.

A medical center's emergency department social worker described DCFS' reluctance to work on a case, saying it took a lot of prodding and urging to get DCFS to act. The social worker said the medical center's Suspected Child Abuse and Neglect (SCAN) team had helped push DCFS into action.

One hospital's director of social services bluntly stated, "Any call to DCFS is just a fiasco."

The director of community services coordination for Calumet City's Youth and Family Services made the same complaints we'd heard at the hospitals. He stated that DCFS hotline workers were not capable of answering or referring callers. He also said that the hotline workers restrict the cases DCFS will respond to, demanding expert witnesses' opinions before they act.

School personnel also complained about DCFS' reponse to child abuse and neglect reports. An elementary school principal and teacher told us the DCFS hotline did not live up to its name--that several follow-up calls were often necessary before a DCFS worker would visit the school. They also complained that the telephone interviews were too long; the I & R worker would ask about 25 questions. As hospital personnel did, these school personnel complained that they received no information once DCFS took over the case.

The director of pupil personnel services for East St. Louis' Board of Education told us DCFS was not as willing to act on neglect reports as on severe abuse reports. He said he had taken many cases of truancy to court himself in order to have the court force DCFS into some kind of action.

Although some hospitals and schools said they had no problems with DCFS' response to abuse reports, most complained of delays, unreasonably strict screening of calls, and lack of feedback once DCFS had taken the case. These problems led professionals to feel as though DCFS wasn't worth calling at all.

We also heard complaints from police officers. A Calumet city youth officer criticized the workers who took calls on the

local hotline, saying that getting them to accept a case became "a game of who can outdo the other with words." He explained that because the intake workers were not properly trained, or qualified in the first place, they either gave the caller a dose of doubletalk or transferred the call to an equally unqualified worker. The commander of the Peoria Police Department's Juvenile Bureau also complained that one of the bureau's biggest problems with DCFS was simply getting caseworkers to respond.

The complaints we heard in interviews were supported by findings we read in reports. Professionals told us I & R workers accepted neglect cases reluctantly, preferring clear-cut cases of severe abuse. The American Humane Association (AHA), in its 1976 evaluation of DCFS' Cook County protective services program, found that

> The Department emphasis on response to abuse reports has resulted in dilution of services to neglected children. The present organizational structure does not assure equal protection of children reported as neglected under the Abused and Neglected Child Reporting Act.

The AHA also criticized DCFS' system of coordinating and tracking cases:

> Fragmentation of the flow and processing of neglect and abuse cases arising from the present organizational framework results in built-in weaknesses and inefficiencies which seriously impair the ability of the Department to provide quality protective services.

In 1979, H. Frederick Brown and fellow researchers at the University of Illinois' Jane Addams College of Social Work submitted to the Illinois Law Enforcement Commission a report entitled, "Policies and Practices of the Child Protective Services System in Cook County." Brown and his associates found several problems with DCFS reports and records.

Data checks were not consistent or complete. Brown explains what a data check is for: "Following the telephone report of the abuse or neglect, CPS Intake will make a data check of any prior history with the family." In examining 882 child abuse and neglect case logs, Brown found that data checks were done for only 53.4% of the reports. The State Central Registry was consulted in only 22.3% of the cases, the EPS-1 file (a manual file of all Cook County Intake Forms for the past two or three years) in 18.5% of the cases, the computer printout and terminal of all active DCFS cases in 14.5% of the cases, and the Guardianship File in 30.1% of the cases. Brown writes,

> Clearly, the information sources available to workers are inadequate to meet the need for a quick accurate history of prior abuse/neglect reports and/or current involvement with the Department. The agency's computerized information system is especially cumbersome. First, it

> is not functional after hours, when over 40 percent of the CPS reports come in. Even more important, it is not accessible unless the worker already knows the number assigned the opened case; this is impossible when the call first comes in. If the system were based on retrieval of cases by names of children, parents, or their addresses, it would greatly enhance the possibility of obtaining what prior information exists. Since 46 percent of all reports occur after hours, the availability of the computerized case information at these times is critical.

The professionals we interviewed also claimed that inexperienced I & R workers screened reports too strictly. Brown found that approximately "one-fifth of the abuse/neglect reports received by CPS are closed at the Intake stage, usually without benefit of an in-person investigation." Brown lists eleven reasons workers give for closing a case at intake, and then observes, "some are clearly more appropriate than others." Two of the weakest reasons, in Brown's opinion, are denial of the allegation by the suspected perpetrator (usually over the phone) and questions raised about the reporter's credibility. In Brown's sample, 25.8% of the cases closed at intake were closed because the reporter's credibility was questioned. (These weak reasons may, however, have been given in combination with others.) Brown and his associates recommend that "Definite guidelines be established for closing cases at intake without further investigation."

Brown also mentions the intake workers' lack of experience, suggesting that the situation may be improving:

> Considerable effort has gone into improving intake procedures in Child Protective Services subsequent to the reorganization following the recommendations of the American Humane Association consultation. Until recently the Intake Unit was the only CPS unit which had Social Worker I positions where Social Worker II positions were required in all other units. Upgrading personnel in the Intake Unit may also be indicated.

Hospital and school personnel criticized DCFS' slow response to reports. Brown presents the following table in support of this criticism, pointing out that in 38.7% of these cases, in-person contact took place a week or more after the report. Illinois law required that in all cases, DCFS "shall initiate an investigation...within 24 hours." Because this deadline clearly was not being met in many cases, Brown and his associates recommended that "In-person contacts be required within 72 hours of receipt of initial report."

Timing of the First In-person Investigation

Number of Days after Report Received	Percent of Follow-up Cases	
One Day or Less	15.0%	(53)
Two Days	15.5%	(55)
Three Days	15.5%	(55)
Four Days to One Week	15.3%	(54)
Eight Days to Two Weeks	17.5%	(62)
Over Two Weeks	21.2%	(75)
	100.0%	(354)

(Timing unknown = 35)

Brown also discusses problems with DCFS' case records. In choosing his sample, Brown had to delete over a hundred cases out of a thousand because "they lacked essential identifying information and would be untraceable." He then writes,

> ...no record could be located or no follow-up recording had been done in 55 of the 148 cases in the sample that reached the follow-up stage, although all likely locations within CPS and the four DCFS Area offices were searched at least once.
>
> ...the case records themselves led to some problems of consistency since they contain several different data sources completed at various stages and by several different administrative units.

Besides these problems with the investigative records, Brown encountered problems with the service delivery records:

> Information about services was gathered from case records of open cases, supplemented by interviews with caseworkers when a record was not available or information was known to be missing. Due to extreme work load pressure and the emergency nature of much that must be done, it is probable that CPS workers do not consistently record all ongoing casework or case management services. Thus, our picture is incomplete.

In the final chapter of this 1979 report, Brown looks forward to the arrival of a new state-wide reporting system:

> Possibly the most encompassing piece of legislation to be passed and signed by the governor that will influence services to these children is Senate Bill 973 co-sponsored by Senators [Kenneth V.] Buzbee and [Richard M.] Daley. This legislation, with its required state-wide reporting and monitoring system, will require major reorganization. During this current year (1979) the state is

> placing the implementation of this legislation as their top priority. If this new system, as provided in that legislation, can be made to work, many of the problems pointed up in this research report will become more manageable.

However, he is cautiously optimistic about the new system:

> It is not clear that the new system will be able to develop a case monitoring system which can provide immediate information as to the status of any case that is being handled by IDCFS. Although the new system will comprise both manual and computer systems for monitoring CA/N reports, there will continue to be problems in the areas of handling the flow and use of case records by CPS workers. The present system of assigned case records being stored in desks of case workers or supervisors makes locating case records most difficult for researchers or intake workers who are responding to subsequent reports of abuse/neglect. The research project acknowledges the necessity of the case workers and the supervisors to have easy access to these records assigned to them, but a better control system needs to be devised.

b. The New System

In October of 1979, DCFS began a pilot hotline system downstate, and by July of 1980 had established the system statewide. Before the new system was installed, files took as long as three months to update and there was almost no way to establish links between cases. Families could "hospital shop"--take their abused children to different hospitals to avoid detection. And if families moved from one region to another, their abuse records didn't move with them. With the new statewide hotline and computerized central registry, coordination is greatly enhanced. Hotline social workers can receive a call in Springfield, type the family's name into the computer, and immediately learn if there have been previous incidents of abuse or neglect.

The worker takes down information about the present report on a Child Abuse/Neglect Tracking System (CANTS) form. The worker then phones this information to the appropriate regional office and enters it on the computer's files.

On December 29, 1980, one of our investigators visited the State Central Register in Springfield, where hotline calls are received. He interviewed William Ryan, Assistant Deputy Director of Program Operations, and Dennis Stuckey, Administrator of the State Central Register. Ryan and Stuckey told our investigator that they anticipated receiving 80 to 90 thousand calls per year, one-third of which would lead to investigations. Of the calls that were investigated, about 60% would prove unfounded. Thus, only about one-seventh of the calls would lead to founded abuse or neglect reports.

Ryan and Stuckey suspected, as we had, that before the implementation of the statewide hotline, regional personnel were screening less serious neglect allegations and focusing on abuse. Ryan told us that the workers taking calls now were all Social Worker IIs, and that 90% had field experience. But although the workers were more experienced, questions about definition and jurisdiction remained, according to Ryan. For example, should DCFS investigate cases of educational neglect? And is it medical neglect when parents fail to have their children innoculated?

Stuckey described the record-keeping prior to the automated registry as "unbelievably bad," with no way for Springfield to know how many child abuse reports were actually being received.

Ryan and Stuckey explained that the system was designed to be easily expanded as the number of calls increases over time. Shortly after the hotline was implemented statewide, fewer calls were being received than had been expected, which was fortunate because calls were taking longer to answer than had been predicted. DCFS had anticipated calls averaging eight minutes long, but eight-minute calls proved rare; they were only that short when a reporter had all the necessary information at his or her fingertips.

To handle busy periods, Ryan borrowed an idea from police departments: the "power shift." The hotline has five eight-hour shifts; overlaps cover the busy hours.

After a telephone worker receives a call and decides it should be investigated, she or he calls the regional office and gives it the information. The worker then submits the information to the Computer Entry unit where the workers keypunch in the report. On the following day, the hard copy is mailed to the regional office where the investigation is being conducted. DCFS initially planned to install CRT printers in the regional offices to avoid tying up caseworkers on the phone. However, the funds for this project were cut from the budget and a printer was not installed in Chicago until April of 1981. Presently 86% of the reports received by the SCR are transmitted to local offices over CRTs.

Monitoring case determinations is one of the duties performed by the Central Register's two midnight shift workers. If a case determination of "unfounded" seems inconsistent with the injuries described in the initial report, the case is sent back to the caseworker.

Besides receiving maltreatment reports and monitoring case determinations, Central Register workers counsel parents who call the hotline because they fear they are about to abuse their children. In a December 29, 1980 Chicago Tribune article, Gregory Coler is quoted on the hotline's contributions to child abuse prevention:

> Coler said the "most exciting thing" about the hot line is the fact that a growing number of adults are phoning when they feel they are

> about to hurt their children. "Sometimes we talk people out of hurting their kids right on the spot," he said.

We tried to discover how many calls the Central Register receives from potentially abusive parents. A DCFS pamphlet states that the hotline

> can and has prevented potential cases of abuse. This happens when a "self-referral" call comes in. For example, a distraught mother, under heavy stress, will call to warn that she fears she is about to abuse her child. "We get about 70 of these self-referral calls a month and can take immediate preventive action," says Mr. Ryan.

During the composition of this report, we spoke to the Register's Hector Caldera about self-referrals. He told us that in Fiscal Year 1981, 344 of the 20,908 reports to the hotline were from the victims themselves. In FY 1982, 353 victims reported. But Caldera could not tell us how many potentially abusive parents had called the hotline. Although the registry keeps track of how many mothers and fathers call the hotline, it doesn't keep track of how many of those parents called because they were about to hurt their children. Caldera told us he spoke with his supervisor after our inquiry, and they are considering tallying parents' self-referrals from now on.

While visiting the Central Register, one of our investigators spoke with three workers, each of whom seemed dedicated and enthusiastic about his or her work. They said that stress was not a problem, though Ryan had said it was.

In 1980, Ryan was also worried about the possibility of harassment calls: people reporting their neighbors out of spite. Ryan guessed that one or two percent of their present calls were harassment calls. Ryan also wondered if parents who were competing for custody of their children might call in to report each other.

The system has since expanded its line capacity from 10 to 13 lines. Stuckey said that in the past six months, callers have received busy signals only once or twice. There are times when callers are put on automatic hold because all the workers are busy, but they have been working on keeping this to a minimum by making return calls following peak periods when the situation permits it. He stated that they receive an average of 350 calls on weekdays and 150 to 200 a day on weekends.

The new hotline has received a fair amount of attention in the press. On June 29, 1980, the Chicago Tribune carried a two-page article that said the computerized reporting network was "considered the most advanced in the nation" and quoted an official in the U.S. Department of Health and Human Services as saying, "It's pointing in the direction we'd like all the states to go."

In February of 1982, articles appeared in both the Tribune and the Sun-Times describing DCFS' case backlog. The Sun-Times article

reported that the Cook County backlog reached 1,200 cases in July. In about 400 of the cases, investigation was not begun within 24 hours. In about 325 of the cases, the legal time limits were met. And in the remaining 475 cases were described by a DCFS deputy director, Michael Tristano, as "'lightweight', such as educational abuse, and 'logical to be put on the back burner.'" The article ties the backlog to the new hotline: "DCFS said the backlog developed when investigators were overwhelmed by calls with the implementation of July 1, 1980, of a toll-free telephone 'hot line' to report abuse and neglect."

In August of 1982, we spoke again with personnel from three hospitals we had contacted earlier in our investigation asking them to comment on current DCFS response. All three said DCFS response had improved under the new hotline.

To improve the flow and coordination of records, DCFS is working on merging its three management information system: CANTS, MARS, and CYCIS. DCFS describes this merger in its 1981 annual report, issued in the summer of 1982:

> This effort got underway when CANTS--the Child Abuse and Neglect Tracking System--went into effect July 1, 1980. Linked with the hotline and State Central Register, CANTS has exclusive use of an IBM 8100 computer. The computer records and stores all basic information on prior abuse or neglect reports, feeding it back to hotline workers and child abuse investigators responding to new reports. In addition, CANTS also tracks cases, prepares automatic reminders and reports, and generates statistics for use in analysis and research.
>
> ...The second system to be merged is the Management Accounting and Reporting System (MARS), which will computerize all aspects of DCFS financial management and payment processes. It will include all payments systems, appropriation accounting, budgeting, contracting, trust accounting, federal funds claiming, and rate setting. In the past, most of these procedures were done manually.
>
> The most innovative new system for which the Department is planning is CYCIS--Child and Youth Centered Information System. ...this system will track the progress of all children in public or private agency care or under juvenile justice jurisdiction. For DCFS workers, CYCIS will improve planning, goal setting, case reviews, and follow-up services. For managers and planners, it will identify trends and bottlenecks and provide a factual base for testimony to the executive branch and the General Assembly when the Department seeks new or different resources.
>
> Planning and programming for MARS and CYCIS proceeded through 1981. When completely linked with CANTS, the system will give DCFS a comprehensive management information system capable of monitoring all functions of the agency and tracking all children and facilities served. ...A pilot project is set to begin in the Springfield

Region July 1, 1982, with the rest of the state going on line in September.

DCFS' 1982 Human Services Plan identifies this merger as one of the Department's major initiatives, and lists several benefits of the new coordinated system:

- A more direct contact between the computer system and the worker by the use of terminals at larger field offices for data entry and correction.
- Faster response for turnaround of case documents by using field printers.
- Standardization of caseworker procedures and reporting.
- Automatic suspension of payments when licensing and contracting authorization does not match the payment request and faster notification of appropriate personnel when a payment is being suspended due to lack of proper authorization.
- A comprehensive review of caseworker decision through permanency goal and outcome goal achievement monitoring.
- Potential reduction in the number of eligibility forms since many can be computer generated.
- Creation of a single integrated file showing all purchased services. This file will assist budgeting, analysis of resources effectiveness and management decision making.
- Development of special management reports that highlight exceptions to the norm.

We will now discuss how Illinois' SCR fulfills the four functions described by Besharov.

Facilitate management planning

Before creating the SCR, DCFS had no way to accurately describe the distribution of child abuse incidents throughout the state. Since all reports now come to the central register the concentration of abuse incidents can be determined with absolute precision. For the first time, DCFS can accurately evaluate personnel needs for both investigation and follow up on child abuse cases and identify the target problems. For instance, the Department knows on a monthly basis which regions are experiencing problems commencing all of their investigations within 24 hours, what the investigator caseload is by region, etc. Management can now study these deviations to determine the reason for the deviation and initiate measures to change them when it is indicated.

Assist assessments of danger to children

Previously, the Central Register was so poorly thought of that the Cook County CPS Unit would only query the Register in 22% of the cases they received. The Register was only operating 40 hours a week and required a case number to access. The Department has gone from this part-time, impotent system to a 24-hour, computerized register which can be queried by a variety of mandated reporters with simply the phonetic spelling of a victim or perpetrator's name. Consequently, any past incident of abuse in the family can immediately be determined.

Encourages reporting

The department has advertised its 24-hour toll-free Hotline number encouraging the public to report information they may have regarding abuse or neglect of children. It was just more than two years ago that mandated reporters telephoning one of the 72 different DCFS offices which received reports, literally had to argue with the DCFS worker to get the worker to take down the information. One can imagine the treatment ordinary citizens received when trying to initiate a case. The Department has reversed from discouraging cases to actively encouraging reporting.

Sharpen child protection accountability

In the past, CPS workers were assigned to investigate reports of abuse by their supervisors who were supposed to insure that investigations were actually conducted. Frequently supervisors were not diligent in monitoring their subordinates' activity. The result was that many reports were never investigated and were eventually forgotten.

The SCR does not forget. Follow up referrals must be entered into the SCR at specified intervals. If proper follow up information is not received, the computer automatically notifies increasingly higher levels of supervision that proper action has not been taken.

Our investigators visited the SCR and Hotline on several occasions. We also interviewed other outside officials who had examined the operation, and inspected Central Registers in other states. It appears that DCFS has planned the hotline well, assigning the space and staff necessary to make it work. The staff seem well trained, efficient, and professional. By comparison to Central Registers we have seen in other states and certainly by comparison to the way reports previously were handled in Illinois, the Central Register and Hotline is an impressive operation.

c. Statistics Generated by the SCR

The follow table presents some statistics provided by the SCR.

	FY 81	FY 82
Telephone Calls to the Register	71,255	91,948
Child Abuse/Neglect Reports	28,852	32,852
Indicated Cases	12,442	14,652
Unfounded Cases	16,410	17,359
Pending Classification as Either Indicated or Unfounded	-0-	828

Rate of Children Reported Per 1,000 Children Under Age 18 Years by Region

Region	FY 1979	FY 1980	FY 1981	Estimated FY 1982
Rockford	14.7	20.5	18.8	19.8
Peoria	12.0	16.1	15.8	19.3
Aurora	3.9	6.0	9.9	13.1
Chicago	4.8	7.7	13.7	18.6
Springfield	13.5	20.2	23.9	27.4
Champaign	10.0	17.8	21.6	25.5
E. St. Louis	12.3	17.3	26.1	30.1
Marion	17.5	24.0	23.5	26.6
STATE	7.5	14.1	15.7	19.6

PERCENT OF TOTAL

2. Child Abuse/Neglect Investigations

The Investigations section of the Division of Child Protection serves as the division's front line. The investigators respond to reports of child abuse or neglect within 24 hours, determine whether or not the report is founded, take protective custody if necessary, and properly document all findings in order to support recommendations.

a. Background

When we began our investigation, there was no Division of Child Protection; Child Protection was under the Division of Program Operations. Many of the criticisms directed at DCFS over the years relate to practices that occurred under a system different from the one now in place. Many of the changes that have taken place in the Department attempt to solve the previous problems.

The cases presented in other chapters of this report all happened under the past system. In order for the reader to more fully understand the case studies and the changes that have taken place in the Department, we offer the following background.

In the early 1970's, Jerome Miller, Director of DCFS, divided the department into 18 Areas, leaving each Area office to administer and provide its own services. Some programs, however, remained centralized, covering the jurisdiction of more than one Area office. For example, the child abuse program for East St. Louis, set up by Jeanine Smith, coordinated CPS in the various East St. Louis Area offices. Smith was transferred to Cook County to set up a similar program, and in 1975, the emergency protective services for each of the four DCFS Area offices were consolidated into the Cook County Child Protective Services Unit. This unit supervised response to reports by Area CPS offices and provided follow-up services on a county-wide basis.

But this partial centralization did not solve all of Cook County's protective service problems. In 1976, DCFS asked the Children's Division of the American Humane Association to evaluate Cook County's Protective Services Program. The study team, headed by the Children's Division's Director, Vincent De Francis, issued its final report in November of 1976. Of its major findings, four concerned removal of children from their homes. The study team found that police and hospital personnel took children out of their homes without consulting the Department. Community agencies saw the Department "as a 'child snatching' service for use as a last resort." Placement in foster care occurred at an alarmingly high rate: 60-75% of the cases served by the Department. And of the child protective cases seen in court, approximately one-half resulted in no finding of neglect, implying that removal was not justified.

The team also found "an absence of synchronization between the various units because of basic differences in philosophy, orientation, training and skills." Finally, they found a lack of clear accountability, both to the community for protecting its children and to families already in the DCFS system.

Based on these findings, the study team made several recommendations for protective services in Cook County. It recommended that DCFS

--centralize its protective services;

--operate a 24-hour CPS intake unit;

--provide enough field units;

--emphasize accountability through selection and training of supervisors and administrators;

--increase interdisciplinary consultation available to the child protection staff;

--screen staff more carefully;

--continue in-service training;

--review purchase-of-service practices;

--provide emergency caretaker and homemaker services;

--review its information system;

--fully utilize a community advisory team; and

--continually evaluate the impact of CPS operations.

Apparently, DCFS listened to these recommendations. The report's acknowledgements section states,

> Based on the interim report of the study submitted to the Department in June 1976, the Department Director took action to implement the major recommendations. ...Task forces have been mobilized and those who initially helped in the study are now shouldering the task of implementing the findings.

The recommendation to centralize Cook County's protective services was implemented in 1978, when DCFS reorganized its 18 areas into 8 regions. Later, an office was established in the Division of Program Operations to coordinate Child Protective Services (CPS) statewide. Outside of Cook County, however, most regions used their multiservice workers to perform CPS duties.

Nevertheless, criticisms of the Department continued.

In 1979, the American Humane Association issued a 600-page survey of America's child protective services, including a section on Illinois. The survey describes both the state policy and the actual practice as reported by area offices. Several gaps in state policy appear: there is no state advisory committee specifically for child protective services, no policy regarding caseload size, no policy regarding worker to supervisor ratio, no statewide hotline, and no funding for consultative services (legal, medical, psychiatric, and psychological) outside the larger metropolitan areas.

By 1979, DCFS said it was providing 24-hour coverage, with specialized CPS staff on duty in Cook County's regional office specialized CPS staff on call in another regional office, and other staff on call in the six other regional offices.

DCFS also told the AHA that CPS workers receive higher salaries, and a special job classification "'is currently being studied by a Department committee.'" 20% of the workers had graduate degrees in social work; 2% had other graduate degrees. Only 10% of the workers had no bachelor degree. The service regions provided regular inservice training.

Finally, DCFS listed changes needed to improve child protective services:

--more adequate financing;

--more supervision;

--caseload controls (20-25 families);

--more inservice training;

--availability of multidisciplinary input;

--availability of auxiliary services; and

--more community cooperation and understanding.

Another analysis of Child Protection in Cook County around 1977 comes from the study by H. Frederick Brown that we mentioned earlier in this chapter, Policies and Practices of the Child Protective Services System in Cook County. The study examined 882 child abuse and neglect cases handled by DCFS during the last half of 1977. Brown identified the three major steps in processing CA/N reports as assessment of the report, case assignment and investigation, and follow-up actions in validated cases.

Assessment of the report occurred during the first 24 hours after the report was made: the intake stage. As we mentioned earlier, Brown found that full data checks on the involved family were completed only half of the time. And 18.7 percent of the cases were closed during intake, even though intake workers contacted the family in-person in only 6.5 percent of the reports.

88.1 percent of the cases not closed at intake were assigned to one of Cook County's nine CPS teams. The open cases were investigated by private agencies contracted by DCFS. Almost half of the cases sent to a CPS team remained there for over six months.

Brown found that investigation was initiated within 24 hours in only about 15 percent of the cases. The average time between receipt of report and investigation was 13 days; the median was five days. The more severe the case, the more quickly the investigation was begun.

Brown includes interesting information on the caseworkers' questioning of the abused or neglected children:

> Despite frequent physical contact with these children, workers noted the children's responses to the allegations in only 41 percent (176) of the cases in which recording on this point was clear. When asked, the children's comments ranged from support of the allegation in 42.5 percent of the cases, to minimizing it in 32.4 percent, to contradicting it in 25.0 percent of the cases.

The accused adults who were questioned contradicted or minimized the allegation in over 90% of the cases; only 6 percent agreed with the original allegations. The CPS worker is very likely to encounter both perpetrators and victims who deny or minimize the maltreatment.

Despite the adults' protests, the workers found that "about 70 percent (298) of the reports were valid in part. Twelve percent seemed clearly invalid; the rest (18 percent), were probably invalid."

In half of the cases, investigators found the maltreatment to be less severe than originally reported, and in another 42 percent, investigators found severity to be about as originally reported. In only 6.6 percent of the cases did the investigators find the cases to be more severe than originally reported. Brown points out that in cases of physical abuse, the reported abuse would probably appear less severe as time passed.

Brown also noted the difficulties CPS has faced:

> Despite a rapidly increasing number of child abuse/neglect reports, CPS has been required to operate under budget and personnel freezes, deteriorating staff morale, and major reorganization of the State Department. An indication of these problems is the reported fifty percent turnover rate of CPS personnel in Cook County during 1977 and 1978.

Brown's Cook County research convinced him that CPS workers needed to respond to reports much more quickly, rather than letting the police guide the case from the outset. Therefore, he wrote a grant proposal which was funded by the Department of Health and Human Service's National Center on Child Abuse and Neglect. The federal grant money made it possible to add caseworker response teams, which functioned after normal business hours, for each of three Chicago areas. The grant stated that the teams would

--develop on-the-scene response capability after hours, 7 days per week;

--provide crisis intervention after hours;

--develop culturally appropriate responses to different families;

--provide in-home emergency services to prevent inappropriate removal of children after hours; and

--use explicit criteria for emergency decisions.

The project employed 10 full-time workers, and reported five turnovers during the two-year grant period. During the last 18 months of operation, the project reported total expenditures of $239,000, including $11,000 in donated services. Among the seven CPS grant

receivers nationwide, the Cook County project reported the largest total expenditures. A report states, "If only client services are considered (that is, excluding costs attributed to overhead and community services), the actual direct cost averaged $411 per family and $481 per child, the largest direct costs per child among the seven CPS projects."

Despite these expenditures, the project failed, according to E.H. White and Company, with whom the National Center contracted to evaluate Brown's project:

> The Chicago project had great difficulty in achieving its goals. Their efforts were hampered by lack of upper administrative support, poor supervision, lack of adequate training, absence of procedures and difficult ongoing agency problems in service delivery. The project will not continue beyond the grant period.
>
> ...The project was never able to sufficiently break away from the agency's crisis orientation to thoughtfully conceive, plan, implement and review any of its proceedings.
>
> ...for supervisors, the project was an enigma. The grant proposal had been written by an academic theoretician with no experience in direct services. The project supervisor was not able to obtain a copy of the grant proposal to read until well past the midpoint of the grant period. The familiarity with goals at the administrative level dwindled at the supervisory level and became non-existent at the staff level.
>
> Most staff workers feel that there was nothing innovative or improved about the services provided. The immediacy of response was, according to some, already a departmental priority. There simply was not sufficient staff to carry it out....

We learned about the immediate response project's problems from DCFS personnel as well as from the report. One of the project's CPS workers told us that for the first six months, he received many calls and his responses were appreciated. There had been a constant feud with the police, who were highly critical of DCFS in general, but gradually the police began to understand the project workers' problems and goals.

However, the project's caseworker supervisor became ill, and regular CPS supervisors began to fill in for him. These substitute supervisors gave the project workers regular assignments that put them out of the office when the police called. The police were then told no immediate response workers were available. Soon the police stopped calling at all. By August, 1979, the whole project had fallen apart, according to the worker we interviewed. He felt that DCFS administration made success impossible and ultimately killed the project.

We learned more about the project's administrative problems from John Williams, who eventually served as Project Director.

Williams told us he was assigned to the project weeks after it began, and was given no direction. At the time, he was also serving as CPS' Intake Coordinator and Community Relations Administrator, but found himself supervising the caseworkers' daily activities. The original project director, Jeanine Smith, was transferred to Springfield almost immediately after the project began. The deputy director, Bernadette McCarthy, was also unable to devote the time needed to make the project work, according to Williams. Smith's replacement as CPS administrator, Marilyn Nelson, spent most of her time trying to handle the Intake Unit, and paid little attention to the immediate response project. Eventually, Nelson left to work for a private agency in Ohio.

In sum, Williams blamed DCFS' central administration in Springfield for the project's failure. DCFS named a project director and deputy director, transferred the director to Springfield, and then forgot about the project. Thus, a program which might have improved CPS' ability to help children was rendered ineffectual. DCFS' handling of the project is typical of DCFS mismanagement during the late 70's.

While the AHA survey, Brown study, and HEW project were going on, a 1978 reorganization was going into effect. This continued the centralization begun in Cook County in 1975. Gordon Johnson, then serving DCFS both as Deputy Director, responsible for the management of all eight regional offices, and as Regional Director for Chicago, discussed the 1978 reorganization in a February 28, 1980 interview with one of our investigators. The Cook County region absorbed four area offices now referred to as the North, South, East, and West offices. Johnson said the regional office had simply been serving as a buffer between the four areas and central administration in Springfield; the area offices still operated as separate units, without cooperating and coordinating the management of cases. Johnson was trying to unify management of the Chicago region.

Johnson described problems with DCFS' image. He said other agencies looked down on DCFS as non-responsive and uncooperative. Social workers appeared in court unprepared. Many workers were burned out. And DCFS was top-heavy in administrators, partly because the 18 area office administrators had to go somewhere when the areas were consolidated into eight regions. Johnson said attempts to fire personnel or abolish positions met insurmountable opposition.

Not only did the four Chicago area offices not cooperate, they hid resources from each other. Caseworkers would find private agencies in which to place children, keep them secret, and then take the secret with them when they left the department. At the time of the interview, Johnson was trying to establish a computerized file of placements.

After interviewing Johnson, we interviewed Jeanine Smith, who served as the Chicago region's administrator of CPS. Smith told

us that because DCFS had had four administrations in two years, there had been constant reorganization, and CPS staff morale was low. She said that when the newspapers reported a case of child abuse, the Department often was blamed. To appear as if they were doing something, the Department administrators would then punish the CPS worker.*

Smith stressed the importance, and difficulty, of hiring workers with master's degrees in social work. She said that former DCFS Director Jerome Miller (1973-74), had relaxed the department's educational requirements, and that since then, the union had defeated any efforts to raise those requirements. When CPS did manage to attract a good worker with a M.S.W., the worker often ended up being promoted too soon.

Smith added that Cook County had lost administrative support in the last couple of years. She said that the Department of Personnel did not seem to recognize the volume of work that had to be done in Cook County. As the staff was reduced, the remaining staff felt overwhelmed, and did not have time to properly train new employees.

Finally, Smith said that staff in other divisions of DCFS did not understand that CPS did more than investigate, that it also provided services to families in their homes.

On July 1, 1980, Public Act 81-1077, which had been approved September 27, 1979, went into effect, amending the "Abused and Neglected Child Reporting Act" that had been in effect since 1975.

*A book from which we have quoted elsewhere, Ruth S. and C. Henry Kempe's Child Abuse, seems to address this kind of problem in the following passage:

> Workers in child protection need to evaluate their performance constantly and routinely. Instead of seeking scapegoats for particular failures, everyone should ask "How could we have done better and how will we change because of our experience?" Since major decisions are jointly made, no one person is ever solely "responsible"; all are responsible, for good decisions and bad. Human conduct is hard to predict, and it makes sense to share life-and-death decisions across professional lines so that if a child is reinjured or killed after being prematurely returned to his parents, it is possible to say whether the wrong recommendation was avoidable or not. Similarly, when courts ignore the recommendations of a child-protection team and disaster follows, they should certainly know the outcome, though at present they are not routinely informed, at least in the United States. We learn from success and failure, and both should be out in the open. Instead of burying our mistakes, on the grounds for instance of "client confidentiality," we should be aware that we are too often concerned with professional confidentiality; far better to say, "We were wrong because....

We have already mentioned the statewide hotline and expanded central register required by the Act, but we have not discussed the Act's many references to Child Protective Services. Reports to the State Central Register, the Act states, will be immediately transmitted to the appropriate CPS unit. The CPS units shall be capable of responding to reports 24 hours a day, seven days a week. The Act also expands the 1975 law's discussion of how quickly investigation must begin. The 1975 law states, "The Department shall initiate an investigation of each report of child abuse and neglect under this Act, whether oral or written, within 24 hours after the receipt of such report." The 1980 law states, in part,

> If it appears that the immediate safety or well-being of a child is endangered, that the family may flee or the child disappear, or that the facts otherwise so warrant, the Child Protective Service Unit shall commence an investigation immediately, regardless of the time of day or night. In all other cases, investigation shall be commenced within 24 hours of receipt of the report. (Ill. Rev. Stat. Ch. 23, ¶ 2057.4)

The law goes on to list what an investigation shall include:

> ...an evaluation of the environment of the child named in the report and any other children in the same environment; a determination of the risk to such children if they continue to remain in the existing environments, as well as a determination of the nature, extent and cause of any condition enumerated in such report, the name, age, and condition of other children in the environment; and after seeing to the safety of the child or children, forthwith notify the subjects of the report in writing, of the existence of the report and their rights existing under this Act in regard to amendment or expungement. (Id.)

The law also sets out time limits for investigations:

> The Child Protective Service Unit shall determine, within 60 days, whether the report is "indicated" or "unfounded" and report it forthwith to the central register; where it is not possible to initiate or complete an investigation within 60 days the report may be deemed "undetermined" provided every effort has been made to undertake a complete investigation. The Department may extend the period in which such determinations must be made in individual cases for up to 30 days, but such extensions shall only be made once and only upon good cause shown. (Ill. Rev. Stat. Ch. 23, ¶ 2057.12)

If the CPS unit finds no credible evidence that the child has been abused or neglected, it shall close the case. It may, however, "suggest...services for the family's voluntary acceptance or refusal." But if the CPS unit finds credible evidence that the child has been abused or neglected, then

> based upon its determination of the protective, treatment, and ameliorative service needs of the child and family, the Child Protective Service Unit shall develop, with the family, an appropriate service plan for the family's voluntary acceptance or refusal. (Ill. Rev. Stat. Ch. 23, ¶ 2058.2)

When proposing this service plan, the CPS unit may explain its "authority to petition the Circuit Court under the 'Juvenile Court Act' or refer the case to the local law enforcement authority, State's attorney, or criminal court."

The 1980 Act also states that each CPS unit shall "maintain a local child abuse and neglect index of all cases reported under this Act which will enable it to determine the location of case records and to monitor the timely and proper investigation and disposition of cases." Finally, the Act requires DCFS and the Child Protective Service Unit both jointly and individually to conduct a continuing education and training program for DCFS staff, mandated reporters, and the general public on identifying, reporting, and understanding child abuse and neglect.

b. The Functions of CPS: 1980 to 1981

The new reporting law did not change CPS' functions; the CPS units continued to investigate reports and provide follow-up services. The law did, however, affect CPS by requiring around-the-clock response capability, increasing the number of reports through the new hotline, and changing the number and nature of forms through the expanded central register. One effect was to increase the number of CPS workers, especially in Cook County.

Cook County Organization. Prior to the establishment of the Hotline in Springfield on July 1, 1980, the majority of abuse and neglect allegations for Cook County came into the Information and Referral (I & R) section which took down the information and sent it over to the Intake Section of Cook County CPS. After July 1, 1980 some calls alleging abuse or neglect continued to be received locally, but the majority were received in Springfield at the new Hotline. After the Hotline workers obtained the necessary information, they transmitted it to the Intake Section of Cook County CPS. An intake worker would then conduct the initial investigation. If the case proved to be "founded," the case moved to a Geographic Team Worker (in another section of CPS) for the follow-up work. The Geographic Team Worker, a DCFS multi-service worker, or a contractual agency then provided services. In a case where the Hotline was notified that protective custody had already been taken, the case was not investigated by the Intake section, but was immediately transferred to the Geographic Team worker.

The Commission interviewed many Cook County CPS staff members after the Hotline was established in July of 1980. We also rode along with workers and sat with supervising caseworkers as they performed their duties. At this time Jeanine Smith was heading up the Cook County CPS office, with three geographic Team Coordinators and one Intake Coordinator. Under the geographical team coordinators were six or seven teams headed up by Supervising Social Workers. These Supervisors had roughly seven caseworkers reporting to them and doing the field work.

We learned that significant problems with CPS continued. The

establishment of the hotline strengthened only one link in the chain of child abuse investigation. The CPS intake and geographic teams continued to be overwhelmed by their tasks.

We spoke with one Geographic Team Coordinator who conceded that because of low manpower, there were many unassigned cases. She said that cases were put in order or priority, and less serious cases were temporarily handled through telephone calls. Eventually, a worker would go out and talk to the people involved. The Coordinator stated that the pressure to respond to every case led to worker burnout.

We observed the crisis atmosphere of the Cook County CPS office. One supervisor pleaded with one of her workers to go out and handle a case. The worker had already spent the morning in Chicago's Public Housing projects and did not want to go back out; the worker even asked if the supervisor could handle the case.

The supervisor told our investigator that because she had more cases than she could handle, she had to assign priorities to cases. The highest priority cases were hospital cases, severe abuse, critical neglect, and cases where the police have taken the child into protective custody. The child's age and the presence or absence of non-abusive caretakers in the home also affected prioritization. The supervisor confided that she had four or five priority cases for which she had not yet been able to send out a worker. The oldest had been received 11 days earlier.

Organization outside Cook County. The principal difference between CPS in Cook County and the other seven regions was the specialization of workers. Only Cook County had CPS workers divided into intake and geographic teams. In fact, in some parts of the state, prior to the implementation of the hotline, there was even overlap between CPS workers and multiservice workers.

The Commission interviewed DCFS workers and supervisors thoughout the state, concentrating on those assigned to CPS.

In April of 1981, we interviewed a CPS supervisor from Northern Illinois. She said that the office "used to be a good one" before the new hotline and CANTS system went into effect July 1, 1980. Now, she said, the office operates on a crisis basis because of the case overload. She compared the emergency-oriented office to a fire department.

The supervisor said that two workers handled the intake work on about 70 cases a week, while four other workers handled the follow-up work on about 200 open cases per month. One other worker did the intake and follow-up work for all Spanish-speaking families.

This heavy caseload, she said, made it impossible for her workers to always respond within 24 hours. She complained that the new law required in-person investigation by CPS workers, so

that even though Youth Officers and other law enforcement workers had offered to help investigate complaints, she could not accept their help. The supervisor recommended that CPS be allowed to delegate investigative authority to local police departments or social agencies, leaving the caseworkers time to serve families in which abuse or neglect has been established.

Cooperation with police and other agencies. In August of 1980, we spoke with two Youth Officers from the Chicago Police Department about their opinions of DCFS. One said he found the Department difficult to work with, and had developed his own methods of circumventing DCFS. In the past, he would see a clear case of child abandonment, call DCFS, and get a long runaround before the children were taken off his hands. At the time of our interview, the officer would directly call a caretaker service with a DCFS contract to come get the abandoned children. He would completely circumvent DCFS, leaving the Department and the contractual agency to complete the paperwork after the children were already placed.

The other Youth Officer thought that cooperation between DCFS and the Chicago Police Department had broken down because of the system at DCFS. He felt there were no guidelines to cooperation for the caseworkers. Both officers praised individual caseworkers, finding them quite capable, but stuck in a system that didn't allow them to fully perform.

Both officers also felt that DCFS is more concerned with keeping the family together than with protecting children. While the police are required to make arrests in flagrant cases of abuse, DCFS thinks arresting parents is not in the best interest of children. Because of this difference of opinion, DCFS does not share information with the police, and the police see DCFS as interfering. Thus, the police conduct their own investigations and take whatever action they feel is necessary without consulting DCFS.

Jeanine Smith told us she liked the idea of "guest desks." Local police departments and juvenile court offices can have guest desks for CPS workers to use one or two scheduled days per week. She added, however, that she would have to stabilize the Cook County CPS office before starting a guest desk program.

Downstate workers found cooperation with police to be good. Edward Wojnarowski said CPS' relationship with the State police is positive, and the State police are becoming more and more involved in child abuse and neglect cases, frequently accompanying workers on investigations. He said cooperation with local police varies. The three DCFS workers we spoke to in Murphysboro felt that their relationships with the police, state's attorney, courts, and other agencies were very good. One of the workers said this was because they had a very good supervisor and because they worked in a small town environment where everyone worked hard to solve problems.

The caseworker did say, however, that doctors varied in their cooperativeness. She said that most doctors in the area simply did not report middle class child abuse.

More recently, in January and March of 1982, we checked again with two other Chicago Police Department youth officers to see how the hotline was working. They described an immediate police response program, begun in January of 1981, as successful. When DCFS receives a hotline call about an abuse or neglect case in Chicago, the Department simultaneously notifies its Chicago Protective Services office and the Chicago Police Youth Division Headquarters. If the police get an emergency (911) call, they send a beat officer, who then notifies a youth officer. The youth officer notifies the hotline, and works with the DCFS workers in their investigation. Though the youth officer tries to coordinate his or her investigation with DCFS', he or she will not wait for the caseworker to arrive before conducting interviews. In all, there's been little friction between youth officers and DCFS caseworkers since the new immediate response program began.

The youth officers listed the advantages of immediate police responses:

--police are more mobile than DCFS workers and can thus respond to calls more quickly;

--abusers are interviewed before they have time to invent alibis;

--the evidence is fresher, so a more solid case can be built;

--some of the calls concern families with whom DCFS is already involved, and without the police response, might be handled routinely.

The youth officers told us their fellow officers had two main complaints about DCFS caseworkers: they take too long to pick children up and take them into temporary custody, and they do not exchange information freely.

Despite these problems, the sergeant we spoke to said the youth officers' complaints about DCFS have been steadily declining, and it appears that DCFS response time is improving.

During the composition of this report, in August of 1982, we called the Administrative Group Commander of the Chicago Police Department's Youth Division. The Commander said that the immediate notification program has "worked out very well." He said that the SCR workers in Springfield are required to notify the police regarding certain allegations of abuse. He said that although there used to be delays in notifying the police, the immediate notification program had been a success.

A July 26, 1982 DCFS memo to all SCR staff explains exactly what kinds of abuse require immediate notification of the Cook County police or State's Attorney's Office:

1. Case of death, brain damage, skull fracture, subdural hematoma, internal injuries, burns, scalding, poisoning, wounds, or bone fracture in which the child has been hospitalized.

2. All physical abuse allegations where the injury is serious (i.e., the child was scarred, extensively injured, extensively marked, or in danger of losing his or her life).

3. Allegations of sexual intercourse, attempted or completed, sexual exploitation, child pornography and/or child prostitution of which the parent is aware and/or involved, or sexual molestation of any sort.

4. All reports that are second reports on a family, regardless of the present allegation, the previous allegation, and the severity of the allegations.

In May of 1981, Kathryn N. Vedder, a Cook County Hospital pediatrician and a member of the Statewide Citizen's Committee on Child Abuse and Neglect, complained to us about the immediate notification policy. She opposed SCR going straight to the police instead of notifying them through the local DCP office because the police often arrive at about the same time as the injured child. First, according to Vedder, come the beat officers, then the supervising sergeant, then perhaps a detective, and finally a youth officer, until the emergency room is crowded with police. Vedder also said the Cook County Hospital Child Protection Coalition was quite upset about the immediate notification policy and the fact that hospital personnel were not consulted about it.

When we spoke with the Administrative Group Commander in August of 1982, he said that the beat officer no longer handles abuse cases first, unless the call comes into the 911 emergency number. He said that only the youth officer goes to handle the case. The exception is a death or very serious injury, in which case a violent crimes investigator would also be dispatched to the hospital.

Complaints: caseloads, paperwork, training resources. The CPS workers we spoke to often complained about heavy caseloads, heavy paperwork, inadequate training, and a lack of space and equipment.

In April of 1981, one of our investigators spoke to the supervisor of a Cook County CPS unit that oversees contractual in-home services. His in-home services unit monitors Purchase of Service contracts. Whenever it is decided that a child can best be served within its own home, the case is given to the in-home services unit.

The supervisor aired a by-now familiar complaint: overwork. With eight workers, his unit had 1200 open cases, with 900 to 1200 new cases coming into Intake every month. The supervisor said it was next to impossible to keep up with such a caseload. He said that DCFS never hires enough workers to handle all the cases the law requires them to handle. The problem, he said, was with DCFS' managers. He said a good manager need not be trained in social service, and it might even be to his or her advantage to be something besides a social worker.

The supervisor said it doesn't take long for a worker to figure out that when you are given an impossible task, no one really expects you to do it. So the worker does what she can until she realizes her actions are futile and looks for another job. The poorest workers can't find other jobs, so they are the ones who stay.

On January 9, 1981, we again met with Jeanine Smith, administrator of Cook County Child Protective Services, to ask her about problems faced by CPS. She told us that Cook County CPS lacks experienced workers, adequate training, telephones, dictaphones, and most all, office space. She also complained about the low salaries paid her workers. She pointed out that Chicago Police Youth Officers are given a year of training and probably $18,000 per year, while her CPS workers are given almost no training and $12,000 per year.

She also said that CPS' clerical workers are underpaid, so they use CPS as a training ground and then go on to a higher salary in private industry.

c. Ride-alongs

To better understand how CPS functions, our investigators rode along with CPS workers on case investigations. During one ride-along, we learned that the subject of the investigation had been involved in a child abuse court case back in 1975, and that the caseworker wanted to look at the file. Because the closed case dated back five years, she asked her team supervisor to help her find it down in the basement storage room. Our investigator went along, and saw files placed in cardboard boxes and stacked in the hallway. The supervisor pointed out that anyone could easily carry files out an open exit door at the end of the hallway without being seen. The supervisor then searched through the boxes in the hallway, many of which were completely unmarked. He then went into the lunchroom and searched through the filing cabinets--some broken, some unlocked, and some missing drawers. He couldn't find the file. The supervisor then said that adoption records were stored in the room, which anyone could get into. Finally, he called the filing system "disgusting" and said, "I hope you put this in your report."

Two weeks later, our investigator returned to the CPS office to discuss the filing system with the team supervisor who had searched for the 1975 file. The supervisor told him there was no

one at CPS with sufficient skills in filing and maintaining records; the clerks received no training in systematic filing. He said CPS needed a separate section for records, but that would be a major undertaking.

The supervisor stressed the importance of being able to find closed case files. Much of the information that might prove useful to the caseworker was not stored in the computer. But, he said, the caseworker's chances of finding a particular closed file in the basement were 50/50 at best. A lot of caseworkers no longer bothered to even look for closed files.

During the ride to the child's home, the intake worker discussed the stress of being a CPS worker. She said the stress was partly caused by inadequate staff, improper reports (which lead the workers to confront upset families who have not really abused their children), and the simple experience of seeing abused children. She also complained that schools wait until the last day of school to report abuse, so they will not have to face hostile parents themselves. Not only is it hard to deal with the large number of allegations that come in all at once, but it is hard to find the children once school is out.

The worker also discussed working with the police, saying she had never had any problem getting the police to accompany her when she needed them. However, she suggested that three or four officers be assigned to the DCFS office, always available to accompany workers on threatening cases. The accompanying officers would then be experienced with abuse, instead of beat officers who might not know what to do.

The caseworker commented that it takes almost a year to feel comfortable with being a CPS worker. She recalled three separate incidents in which babies arrived dead at hospitals, and the worker had to simultaneously console and interview the mother--not knowing if the mother was responsible for the death or not.

d. 1981 Reorganization

The CPS structure lasted less than a year before more changes were made. DCFS administrators' focus had moved from the hotline and central register to the next critical step in child protection--investigation. The major change was the creation of the Division of Child Protection and the use of investigative teams consisting of nurses, social workers, and experienced investigators.

The new use of investigators in CPS was publicly discussed at a May 27, 1981 meeting of the Statewide Advisory Committee on Child Abuse and Neglect. Gordon Johnson, Deputy Director, stated that one of DCFS' most glaring weaknesses was the initial investigation of an abuse allegation. He said that in recent cases which eventually ended in the child's death, a trained investigator would have seen danger signs that the social workers missed. Thus, DCFS was trying out a model CPS program in Cook County that employed an

11-member investigative team. (Michael Tristano later commented, "If it works in Cook County it will work anywhere," a comment that downstate CPS administrators might not agree with.) The eleven members would be a registered nurse, a trained investigator, and nine MSW social workers, all trained to conduct investigations. If the team finds that abuse is indicated in a reported case, the case is referred to a follow-up team. The teams were expected to cut the investigative reporting time from 60 days down to 10 days.

The investigative teams would report directly to Michael Tristano, head of the newly created Division of Child Protection since May 18, 1981.

In August of 1982, we spoke with James Winters, Administrator of the Cook County Division of Child Protection. He said that Cook County is served by ten DCP teams, eight day teams and two night teams. 64 investigative social workers and eight investigators make up the day teams. Four nurses act as consultants to Cook County DCP, handling DOA's, meeting with coroners, and acting as hospital liaisons. The nurses are not assigned to specific teams.

When we asked Winters why DCFS began the new system of child abuse investigation, he answered that the old Intake and Referral system was inefficient. The workers had been making the minimum number of phone calls to verify allegations, and had little face-to-face contact with the complainants or family members. Thus, cases were being referred to the geographical teams without a complete investigation by Intake and Referral. Also, the CANTS forms were not always filled out correctly and promptly.

Winters said that the Intake workers were constantly playing catch-up. As soon as they started to catch up on their current cases, their supervisors would give them even more. The Intake workers were overwhelmed and unable to complete thorough investigations. Winters said Intake was investigating only 50% of the cases coming in, and were closing only 30% of the cases. The rest went to the geographical teams.

Intake's inefficiency hurt DCFS' relationship with families. A caseworker cannot convince a family of the importance of being responsible and being on time for appointments when the worker himself cannot meet deadlines. Very often, according to Winters, an Intake worker would make an appointment with a family, get overwhelmed with additional priority cases, and not be able to cancel the appointment because the family had no telephone. The family would be left waiting for a caseworker who never showed up.

Winters also said that Intake workers would provide services to the family at the same time they were conducting the investigation. Sometimes services do have to be offered immediately, but when the child is not in serious danger, the caseworker should complete a thorough investigation, including an assessment of the family's needs, before offering services to the family.

Winters then told us that "thousands" of cases were mismanaged because of the old system's poor tracking. Intake and Referral sent cases to many different DCFS units, and no one knew where cases were going.

Winters contrasted Intake investigating 50% of the cases with DCP investigating 100% of the cases. Furthermore, unfounded cases under DCP have risen from 30% to 50%, and they are trying to push the percentage to 60%. Winters feels that DCP supervision is much better, and that the workers are making much more efficient use of their time. He added that when DCP was established, guidelines were tightened and goals were clarified. When the workers are operating under strict guidelines and procedures, they feel more comfortable because they know exactly what is expected of them. They also feel more confident that they will not automatically be blamed if something goes wrong.

Winters said one of the first things DCFS did when DCP was established was to cut down the caseload of every DCP worker. He added that under the old system, an inefficient worker could hide behind the excuse of an overwhelming caseload. He said that a caseworker should maintain a caseload of seven. Although Winters feels that seven is an acceptable figure, DCP is pushing its workers toward 12, having found that many workers can easily exceed 12 cases; many handle 15 to 25. The main incentive for the workers is competitiveness between the different teams.

Winters said that when DCP began, they had to deal with a backlog of cases and orders from Springfield to meet the 24-hour response mandate on new cases. In order to meet the deadline, Winters had to pull one member from each team to simply determine which cases needed immediate attention because children were at risk. These caseworkers did no investigating.

Winters then said they still have 60 days to complete an investigation, which can be extended to 90 days, but that DCP policy states that investigations should be completed within 10 days. Winters believed DCP met the 10-day deadline on the most serious cases.

The requirement to see everyone in the household is unnecessary, according to Winters. The requirement is not legal, but is part of DCFS policy. Winters felt that if the worker determines that an allegation is unfounded, the child is all right, and the home is a safe one, then there is no reason for the worker to see every member of the household. Winters went on to say that when DCFS has no credible evidence on a case, it should get out; he felt that in many cases, workers end up badgering the family for no reason. He estimated that DCP could save 30% of its time if workers were not always required to see everyone in the household.

Winters said that when DCP was first formed, administrators felt that DCP and follow-up workers should meet face-to-face to coordinate files. Winters had earlier given us a DCFS document

entitled, "Child Abuse and Neglect Investigations: An Overview," which states,

> If the finding is "Indicated," the investigative worker will contact the follow-up team supervisor responsible for that geographic area in order to schedule a case staffing. ...The staffing or meeting will have as participants the investigative worker and the follow-up worker assigned to the case. Jointly, they will review the investigative findings and the dynamics of the case. ...The investigative worker will also accompany the follow-up worker during their first contact with the family in order to introduce the worker and discuss future plans.

Winters said, however, that DCP and follow-up workers communicate only in the most unusual circumstances. He said that meetings between them would cause a backlog of 400 cases per month. He would also have to contend with the schedules of both DCP and the follow-up units. If the DCP worker has a very unusual or complicated case, the worker will put a note on the case report asking the follow-up worker to contact him or her. Winters felt that DCP's thorough investigations and case reports make meeting with follow-up workers unnecessary. Finally, he said that other DCFS units still distrust and are even hostile toward DCP.

In September of 1982, a Commission investigator spoke with one of the 10 team supervisors working in Cook County's DCP.

According to the supervisor, the main difference between the old system and the new system is that now those doing the investigations in DCP are taking the investigations from start to finish, whereas before, cases might be partially investigated by CPS Intake and completed by the Geographic Team. An advantage to this new system is that a caseworker going to court on a temporary custody hearing is not the same caseworker that is going to be treating the family later. There has always been a feeling that it is not feasible for one worker to perform both duties. The supervisor stated that the new system has brought tremendous improvement, commenting that the old system was a "patchwork mess."

The supervisor stated that under the old system some workers had to see as many as four to five cases per day. Under this system, they lost a lot of good people. He stated also that people left before the new system was implemented without ever giving it a chance.

Currently, caseworkers are seeing approximately four to five cases per week and at least 12 to 15 cases per month, besides the time that they spend in court. Cases are currently being assigned to workers as priority one, two, or three. Priority one denotes the worst type of cases or DOAs. Priority two includes cases of fractures, bruises, lacerations, etc. And priority three is the lowest priority: cases where there are allegations of inadequate clothing, mild neglect, dirty houses, etc.

During the Commission interviews at Cook County DCP we had an opportunity to view several case files. Most of the files we viewed were organized and neatly arranged. We believe these files could be easily reviewed by the follow-up caseworkers who are destined to receive the files of the founded cases. However, we still found many files that were disorganized and incomplete. Nevertheless, the condition of the files has improved over their condition in prior years.

Though the DCP has received a generally favorable response in the Department, there are some criticisms. One complaint was that with the new system caseworkers and supervisors have very little time to confer, as caseworkers are always busy working on investigations. One Department source complained to us that too many cases that should not be indicated, are being indicated. For example, a case where a six-year-old was playing in his front yard and ran out into the street, while playing, and was hit by a car. The case was "indicated" for lack of supervision. The source believed that the over-indicating came partly as a result of an incident in which a DCP Investigator resigned after failing to do an adequate investigation.

Assistant State's Attorney Diane Romza told us that the DCP investigators still need more training in asking the right questions and testifying in court. Romza said, for example, that when the DCP investigators interview doctors, they often fail to obtain a specific diagnosis explaining exactly how the victims were hurt. Or the investigators will say that an abuse incident has been "verified by various relatives" without giving the witnesses' names and addresses. Romza stressed the need for training DCP investigators how to testify in court, saying that many investigators are presently very defensive in court, and that many times she has seen DCP workers fall apart on the stand.

A CPS Follow-up Supervisor told us that many cases from DCP have to be re-investigated by CPS Follow-up Team workers. She said they receive disorganized files and confusing reports. Often, she said, she cannot figure out from a report who did what when. Sometimes the interviewee's relationship to the victim is not given. The supervisor said about half of the DCP cases that come across her desk are very tough to figure out.

She added that having two different units serving the families disrupts continuity. She said DCP very often makes promises to the clients that the CPS Follow-up teams cannot keep. The supervisor claimed that DCP workers have even promised families that their cases would be unfounded, and then ended up sending the case to CPS. In these cases, CPS becomes the "heavy."

DCP has the chief responsibility for the first contact with victims and the assessment of risk to the child. From here, the case moves to the Division of Program Operations for follow-up work. Though the follow-up work falls under a different division, we will discuss it here for the sake of continuity.

The case is transferred from DCP to follow-up by way of the Service Coordination Unit (SCU).

When an SCU worker gets cases from DCP, he breaks them down according to geographic area, and then looks to see if everyone in the family was seen. He also checks to see if there is a need for more recommendations on the case. The SCU worker also determines whether or not the DCP investigator looked at the allegations as compared to the story given. And, of primary importance, he determines if the child is still at risk.

Before assigning a case to the appropriate follow-up team, the Service Coordination worker considers two factors: the amount of services needed and the urgency. He then assigns a letter (A, B, or C) to the case according to its urgency:

(A) means contact within 24 hours;

(B) means contact within three days; and

(C) means contact within five days.

This assignment of letters is only a recommendation made by the Service Coordination Unit worker.

According to the CPS supervisor, they send back only about five percent of the cases that they receive from DCP. She also said that 85% of the cases that they get go on to Child Welfare Services.

There are currently 15 follow-up teams located at the area offices, at a Harvey, Illinois outpost, and at 1026 South Damen, Chicago. One of the follow-up teams at 1026 South Damen investigates all of the sexual abuse cases. Sexual abuse cases are routed directly to that follow-up team for investigation rather than being investigated by the DCP teams. Cases sent from SCU to the follow-up teams are sent by courier.

In September, 1982, we spoke to both a follow-up supervisor and follow-up caseworker. The supervisor stated that as a follow-up team supervisor, her role is to get indicated abuse and neglect cases from DCP via the Service Coordination Unit (SCU) and assign them to one of her workers for follow-up. Follow-up might include going to court as well as providing services to the family directly or through contractual agencies.

She stated that cases usually come to the follow-up teams 10 days after the report is made, but can come up to five months later. In cases where a child is already in protective custody, they receive them in about seven days.

The supervisor stated that they then keep cases for long as necessary to provide services. Though cases are only supposed to remain there for up to 18 months, they can actually remain longer. On an average, however, they keep cases where the children are at

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home between nine months and a year. She added that if they anticipate that a case will be long-term, they transfer it to Child Welfare Services. Masters stated that the bulk of the cases in CPS follow-up are cases where the child is in the home and "at risk."

According to the efficiency of the worker and the types of cases, each caseworker may have between 18-45 cases per month. Her whole team serves about 300 families per month. About 40 of these are serviced by contractual agencies.

The supervisor believed that the quality of investigations has improved under DCP. One problem that has developed is the differences of opinion between DCP decisions and CPS follow-up teams decisions. She said that the new system "sets up an automatic dichotomy with DCP and follow-up."

She said that she really preferred the other system because she saw the case almost all of the way through; now, she gets cases where maybe promises were made by a DCP worker that a follow-up worker can't keep. She added "It's difficult to pick up the pieces" after DCP. Clients are sometimes not in the best frame of mind by the time the investigation has been done and follow-up has to contend with them.

It appears that the next area for DCFS administration attention will be the follow-up teams. The Department has successfully brought about significant improvement at the hotline and registry function of the Department and indications are that DCP is accomplishing its child protection mandate better than CPS did in the past.

This, then, is how protective services are currently organized. Protective Services reports to the state, independent of regional operations. Investigative teams investigate all reports of child abuse and neglect within 24 hours. By law, the teams have 60 days to complete the investigation, and this can be extended to a total of 90 days. DCP's policy, however, is to complete investigations within 10 days. After the investigation is complete, founded cases are turned over to CPS follow-up workers (who are regionalized under Program Operations) in Cook County. Unfounded cases in which the parent is willing to accept recommended services are turned over to multiservice workers in Cook County. Outside of Cook County, both founded and unfounded cases are turned over to the general multiservice workers for follow-up.

DCP has 30 teams through the State now, with approximately ten members on each team. Cook County has 10 teams composed of a total of 64 investigative social workers, eight investigators, and four nurses.

3. Licensing

Licensing functions were turned over to DCP in August of 1982;

they were formerly handled at the Regional level. As DCP is organized at the state rather than regional level, licensing duties are now carried out at the state level, with regional licensing coordinators accountable to the state central office. The reorganization did not involve any change in the licensing requirements or functions.

The Department licenses Child Welfare agencies, Child Care institutions, Maternity Centers (for unwed pregnant girls under 18), Group homes, foster family homes, day care centers, day care homes, and night-time facilities. Such facilities must be licensed to do business with DCFS. Licenses are for two years. Child Welfare agencies that place children in foster homes can in turn license such homes for DCFS. Agencies or persons providing services but not care, such as Homemakers, advocates, or counsellors, are not licensed.

Before issuing a license, DCFS examines the prospective licensee for compliance with Department standards, such as amount of space, utilities, staff ratios and training, etc. Furthermore, a criminal background check is done on anyone applying for a license except for those wishing to open a day care home. One weakness we found in these criminal background checks is that DCFS does not check the background of, for instance, an uncle or son living with an applicant for a foster care home license. Thus, it would be possible that a child would be placed in a home where a relative of the foster parents had a history of violent or sexually criminal behavior.

Before granting a license, DCFS does not simply determine compliance with standards: workers help the applicant to meet the standards. This was said to be true also after the license had been granted. DCFS licensing workers make four basic types of visits: initial licensing, supervisory (to check compliance with standards); renewal, and consultation (when needed to work out difficulties in compliance with standards). At each step, licensing workers help the licensee to comply with standards, taking a "positive" approach. We learned that this was simply a way of saying that enforcement powers were weak. To illustrate this, in a May, 1980 interview, Willye A. Coleman, Day Care Licensing unit supervisor for Cook County, described the process of seeking compliance at an institution. If the center is in continual violation and "pleading" by licensing staff fails, then representatives of the center are called in to the DCFS office for an administrative conference. The center and DCFS licensing staff members try to work out whatever problems are occurring; usually more compliance time is granted. If this fails, the matter is turned over to the chief of Licensing Services in Springfield, who will either visit the facility to encourage compliance or will write to the center. The Licensing units have no disciplinary powers. If the center still will not comply, DCFS may hire a hearing officer and conduct a hearing. This happens infrequently.

Staff shortages were cited as the biggest cause of these

problems. Though licensing units are required to make monitoring visits yearly, these visits occur in reality only about every two years. One Foster Care Licensing Supervisor told us that workers were able to spend about 45 minutes per year with each foster family. Thus, the license renewal inspection is effectively the only inspection made. Because of staff shortages, DCFS would make supervisory visits (to check compliance with standards) only after receiving a complaint about a facility.

Finally, meeting the requirements for a license does not ensure good care, for example with a foster family. DCFS workers told us that when they feel a licensed family or facility is substandard, the Department would simply not make referrals rather than seeking license revocation. This is because of the lack of enforcement powers in the licensing units.

Though licensing is now under DCP, the investigations of technical violations and investigations of allegations of abuse or neglect of children in licensed facilities will remain discrete. If DCP investigates allegations of abuse or neglect, licensing representatives may at the same time conduct a compliance examination. This should give the licensing unit more authority in monitoring compliance.

D. Division of Management and Budget

At present, the Division of Management and Budget is a centralized agency, with no field staff. This division has several sections: Management Services, Information Services, Financial Policy and Systems Design, Affirmative Action, and Contracts and Grants. Only Contracts and Grants is of interest to us in this report. All of these sections develop policies and guidelines that must be followed by the sections' counterparts in the regions and in other divisions of DCFS, for instance, affirmative action.

Most direct care services provided to clients of DCFS -- such as residential care, foster care, counselling, legal and medical services, and psychological care -- are purchased by the Department from private agencies and persons. This necessitates a comprehensive system of developing and entering into contracts. As the child welfare system is continually changing, new, experimental programs must be tried out, so DCFS awards grants for the development of new approaches to the problems faced in child welfare. There are several ways to distinguish between contracts and grants. Contracts are for services to be provided on an ongoing basis. Contracts can be renewed year after year. Grants are for more experimental programs and are not generally renewed beyond the initial grant period. Should DCFS find that a service developed under a grant meets some of the Department's needs, it can negotiate a contract with the agency. Grant money is usually paid quarterly, in advance. Money for a contract is paid monthly; a contract is for one year. With a contract, DCFS reimburses the agency for units of service after they have been provided, with a maximum payment. Therefore,

the agency must have some initial operating capital. Both contracts and grants can be terminated for appropriate causes.

Agencies or institutions providing residential care, such as Child Care Institutions (e.g., for the physically and mentally handicapped), Group Homes, Community Living Facilities (for adults), etc., and other large facilities, such as Day Care Centers, must hold a license with DCFS before applying for a contract. Should an unlicensed agency approach DCFS to be considered for a contract, DCFS will refer the agency to the Licensing Division (discussed under DCP), which will then provide the applicant with appropriate regulations. Once the applicant is licensed, a contract can be negotiated.

Until July, 1978, all contracts for services were signed at the state level. Area offices would locate resources, work out the terms of a contract, and send the contract to Springfield for signature. After the move to regionalization in 1978, Regional Administrators had the authority to sign contracts. Each region would locate agencies that could provide needed services and negotiate contracts without involvement of a central office. Ideally, the regional system would have involved assessment of needs -- the regional office should know best what services it required. It was hoped that Regional Administrators would send out Requests for Proposals to local agencies, which would in turn propose to provide services to meet the regional needs. The regional office would then award a contract to the bidder whose program best met the needs at the lowest cost. However, in practice RFPs were rarely used. Generally, agencies with long-standing relationships with DCFS would retain contracts or be awarded contracts for new services. Agencies would often approach DCFS with proposals for new programs; if the regional office felt that the proposed program met certain Department needs, a contract would be drawn up. The Regional Administrator, if he thought a new program should be developed, would often approach an agency already under contract for other services and ask it to develop a program, instead of sending out RFPs.

This system has faults. Needs were not accurately assessed, so that purchased care would not necessarily fulfill the changing requirements of DCFS. Providers did not have much reason to improve services since contracts were generally awarded year after year unless gross non-compliance was detected. In our interviews with Contracts and Grants personnel, understaffing was often claimed as a reason for these problems.

In 1981, the signature authority for contracts was returned to the central office. Regional administrators can still sign routine, standardized service contracts, for example with day care centers. According to policy implemented in the Fall of 1981, contracts for new services will be sent out for bids. Needs are to be assessed at the regional level; RFPs will be developed by the regional offices, which will send them to the Division of Management and Budget for approval. The RFPs will be sent out for bid

by the central office, which will award the contract. The RFPs for demonstration grants (for developing new programs) will be handled by the Division of Policy and Plans, Office of Program Development. These also must be approved by the Division of Management and Budget. Furthermore, all contracts for non-residential care must be sent out for rebid every four years, so that renewal of these contracts will no longer be, in effect, automatic. It is still too early to tell whether these changes in the administration of contracts and grants will improve the quality of services purchased. Other than those prepared by the Office of Program Development, few RFPs have been sent out because DCFS is not developing many service initiatives during this tight budget period.

Evaluation

Until late 1977, DCFS had a monitoring and evaluation unit in Contracts and Grants that determined compliance on the part of agencies. After its abolition, there was never any clear procedure for monitoring: some interviewees said that the Contract Administrator was responsible for monitoring the facilities, others that the caseworker was to do so to determine if the individual child was receiving adequate services. Many reported that facilities were monitored by once-a-year inspections or even less. To make matters worse it was not until this year that a procedure for evaluating the effectiveness of types of services was established. Back in the spring of 1982 an evaluation was done to determine the effectiveness of specialized foster care.

DCFS Contracts and Grants Manager for the Cook County Region, Charles E. Johnson, told our investigators in April of 1980 that the Department made investigations only of residential facilities applying for contracts, not of agencies applying. Furthermore, he stated that DCFS did virtually no monitoring of existing contracts. Peter Lewis, Program Planner for Contracts and Grants of the Cook County Region, told us in July 1980 that such monitoring would not only establish compliance with contracts but would aid caseworkers in keeping track of available services and spaces. He told us that often a child would have to spend the night on the couch in a CPS office because the caseworker could not find a placement owing to inability to keep records of all available resources. Caseworkers spend hours seeking placement by a hit-and-miss method. And in September of that year, Manager of Service Operations for Cook County Region Sarah Trice told us that the system of monitoring a contract consisted of taking the agency's word for it that the terms of the contract were honored. Presently program monitoring is being carried out at the regional level by contract staff.

E. Division of Policy and Plans

A June 15, 1982 handbook for the Division of Policy and Plans explains that while three of DCFS' divisions provide services to children and their families (Child Protection, Program Operations, and Youth and Community Services), two divisions provide support to managers and field staff (Management and Budget and Policy and Plans).

The Division of Policy and Plans supports DCFS staff by

--preparing and distributing rules and procedures;

--coordinating and evaluating program development;

--acquiring and managing research funding;

--training staff; and

--reviewing case plans for progress toward permanency goals.

These five functions are performed by five offices within the division: Rules and Procedures; Planning, Monitoring and Evaluation; Program Development and Support; Staff Development and Training; and Administrative Case Review. We shall focus on the Offices of Program Development and Support and Administrative Case Review--the two offices within this division that most directly relate to our investigation of child abuse and neglect.

1. Program Development and Support

In September of 1982, we spoke with Linda Avery, Associate Chief of Program Development and Support. Avery told us that the office performs three major functions: writing grant proposals to obtain outside funding, administering the State Child Abuse Grant Program, and developing program models. Avery then explained the processes for gaining and administering grants.

For federal grants, Avery begins by reviewing the federal register for funding announcements. Avery looks for grants which might fit DCFS' priority needs as identified by the executive staff and the deputy directors of DCFS' divisions. Avery then describes any such grants to Director Coler in a memo which also recommends different ways of using the grant. Coler decides which, if any, recommendation will be pursued. The Office of Program and Development's grant writer then writes a proposal. The proposal is reviewed, in turn, by Avery, the Director of the Office of Program Development and Support, the Director of the Division of Policy and Plans, the Director of DCFS, the director of the division which will use the grant, and the Bureau of the Budget. Once all these administrators have approved the proposal, it is submitted to the federal funding source.

In fiscal 1982, DCFS received approximately $2,000,000 from external funding sources. Of this, approximately one-and-a-half million came from the Illinois Law Enforcement Commission. DCFS used the ILEC money to pick up functions previously performed by the Commission on Delinquency Prevention eliminated by Governor Thompson. Avery said that DCFS usually obtains four to six external grants a year.

Regarding the State Child Abuse Grant Program, Avery said that the program's funds are appropriated by the legislature under

the line item "Grant-in-Aid for Research and Treatment of Child Abuse and Neglect." The program was appropriated $1,225,400 in both FY 1982 and FY 1983. The program's final report for FY 1981 states,

> ...the Grant Program funded 63 projects with a total expenditure of $1,384,946. These projects can be broadly categorized by services offered as follows:
>
> Therapy and Counseling Projects
> Self-Help Groups
> Crisis and High Risk Intervention Projects
> Multi-Disciplinary Teams
> Outreach and Advocacy Projects
> Service Coordination and Networking Projects
> Community Awareness Projects
> Parenting Training

Avery explained that the process for awarding grants is similar to the process for awarding Purchase of Service contracts. In brief, Requests for Proposals are sent to agencies which DCFS feels could operate the new program. After regional personnel review the proposals, an agreement is negotiated, the grant is processed, and the program's expenditures are monitored. If the grant is for statewide services, the Office of Program Development and Support administers the grant; otherwise, the regional office of Contracts and Grants administers the grant.

Avery also explained the differences between grants and Purchase of Service contracts. Contracts have to be competitively bid; grants do not. Contractees bill DCFS on a per diem, per client basis; grant recipients are paid one lump sum, and can be paid at the outset. Contracts are usually entered for ongoing, maintenance services; grants are awarded for research and demonstration projects to develop model programs.

Finally, Avery told us that if grants under $10,000 are available, DCFS does not have to send out a request for proposal. Director Coler has the authority to approve and issue these small grants. Coler is able to award such grants for special needs and crises.

2. Administrative Case Review

The division handbook states the Office of Administrative Case Review's purpose:

> ...to: promote and assist the movement of children into permanent placement through on-going, periodic reviews of children in substitute care; identify and assess internal and external barriers to permanency planning; and advise all Department staff on the status of permanency planning for DCFS children as seen through the Administrative Case Review system.

DCFS began reviewing substitute care cases formally in July, 1981 to remain eligible for federal funds encouraging permanency planning. The office's staff of 49, including 25 regional case review administrators, is currently reviewing 1,300 cases per month.

On September 1, 1982, we interviewed John O'Donnell, Chief of the Office of Administrative Case Review. O'Donnell said that before administrative case reviews began, case reviews only occurred informally, and it was difficult to get the involved parties together. Private agencies complained that DCFS had no consistent procedure for reviewing the cases of their clients. Caseworker turnover further contributed to the lack of consistency.

With the new system, administrative case reviews are done every six months for DCFS wards who have been placed out of their homes for six months or longer. DCFS' computer provides a list of children up for review six weeks in advance, in order to give the reviewers time to set up a conference. DCFS then notifies the parents, sending a copy of the notification to the child's caseworker and any other involved parties, such as the private agency housing the child.

At the case review conference, the reviewer questions everyone concerning the goals described in the caseworker's plan. Those present discuss the progress that has been made toward those goals, and whether they continue to be appropriate. New goals may be discussed. O'Donnell told us that the case review administrators may heavily influence case planning, although they have no direct supervisory control over the caseworker. The caseworker certainly may object to the reviewer's suggestions. But the case review administrator may, in turn, go to the caseworker's supervisor and on up the administrative ladder, if necessary.

The children and parents themselves may also object to the case plan. If they are present, the parents and children are asked to sign the review, indicating their agreement with it goals. If they disagree, they tell the caseworker, and the appeal goes to the supervisor. If necessary, the appeal then goes to the administrative level, then the regional level, and finally the director of DCFS. Parents also may go back to court to complain.

Although he called the administrative case review process "absolutely vital," O'Donnell didn't think that it could be applied to all open DCFS cases. He felt that his office would need at least twice as many reviewers, and that it would take a great deal of time, because each case review takes at least 1½ to 2 hours.

We also interviewed a Cook County case review administrator, Susan Demaree, and sat in on two case reviews. Demaree said the purpose of a case review is to determine why DCFS was initially involved and why DCFS is still involved. The caseworker, the parents, the child if over thirteen years old, private agency representatives, and other service providers are all invited to

attend. The caseworker's supervisor is also allowed to attend, but typically doesn't.

In both reviews that we observed, Demaree clearly explained the ramifications of DCFS involvement in the case. She was very supportive in discussing difficult, sensitive topics. When we asked the caseworker how she liked the administrative case review process, she answered that she favored it because it provided an objective, formal review in which parents and children are brought together to discuss problems and further action. She also said that it is often difficult to solve a family's problem alone, and that a third opinion can be very helpful.

Although the current case review system simply looks at the problems of individual cases, Iris Slack, the Deputy Director of the Division of Policy and Plans, told us that the case reviewers had noted some patterns of problems that suggested needs for systematic change. The Division is considering formalizing this process, using administrative case reviews to systematically improve DCFS' contractual substitute care.

F. Division of Program Operations

The vast majority of DCFS' service delivery responsibilities are carried out by the Division of Program Operations. Prior to July, 1978 services to children and families were delivered through 18 Area Offices. These offices were then consolidated into 8 Regions, each of which is supervised by a Regional Administrator. The Deputy Director of Program Operations, Gordon Johnson, oversees the activities of each Region. Johnson has also served as Acting Regional Administrator of Region 2B, Cook County, for the past two years.

In addition to each region, Offices of Program Service, Support Services and Adoption Services are currently separate units within Program Operations. For our purposes here we will highlight only activities of Adoption Services and the general functions of the Regions.

1. Adoption Services

Although each region performs adoption services functions under the direction of the Regional Administrators, adoption activities are also carefully supervised at the state level by the Adoption Services office within Program Operations. Until last year, the office of Support Services performed this function, but the recent emphasis on permanency planning as well as the adoption initiative led to the creation of a separate unit. Anthony Veronico, Associate Director and Guardianship Administrator, is responsible for this new unit.

According to the Department's 1982 Human Services Plan, the "goal of the adoption program is to increase the use of adoption as a means of providing permanent care when it is impossible for

families to provide a permanent, secure, and nurturing living situation for their own children..."

The Plan summarizes the magnitude of the problem:

> The number of children in substitute care on December 31, 1980, was 11, 188, of whom 6,073 have been in substitute care over two years. Just over 50 percent of those in substitute care are 12 and under. National studies have indicated that adoption may be an appropriate goal for as many as one-third of the children who are in substitute care.

In May of 1982, Commission staff interviewed Anthony Veronico about DCFS' efforts in adoption. Veronico told us that in the early 1970s, Illinois was a leader in adoptions in the country, with around 1,000 adoptions per year. In the early years of the decade, this situation deteriorated, perhaps because other areas became higher priorities, so that adoptions suffered as a result. In 1979, Director Coler came to DCFS and stated that two of his highest goals for the Department were abuse and permanency planning for children in need. In the spring of 1980, DCFS began an assessment of its adoption programs, in East St. Louis, Chicago, and Marion. Other regions had caseworkers who handled adoptions along with other duties. Some regions may have been purchasing services from private agencies instead.

There were about 40 adoption workers statewide. Their priorities included the need for more staff who had specialized training to do work with "special needs" children. However, more staff was not enough: better management and training were also needed.

DCFS' adoption initiative was thoroughly described in a letter to the Commission dated April 23, 1982, from Dwight Lambert, Chief of the Office of Permanency Services. The bulk of the letter follows:

> Early in 1980, Director Coler identified adoption as one of the major priority components of the Department's permanency planning initiatives for FY 81 and FY 82. Goals directed toward the Department's adoption revitalization efforts were established resulting in the following major accomplishments in the adoption initiative.
>
> ° In June, 1980 a survey of the Department's regional adoption programs, focusing on barriers to adoption and initiatives to reduce/eliminate the barriers was completed. The survey identified two major barriers to a successful adoption program:
>
> 1. Fully operational adoption units were found in only three regions (the remaining five regions were providing adoption services but did not have specialized adoption units);

2. Legal expertise to assist with court issues relating to adoption was lacking in all regions.

- In November, 1980 a program entitled "One Church - One Child" was initiated in Chicago by Father George Clements and the Department of Children and Family Services. Father Clements appealed to his parishioners and later to other churches in Cook County, to respond to Chicago's lack of adoptive resources for black children. Through the cooperative efforts of the Department and Father George Clements, over twenty presentations (featuring slides of children available for adoption) have been made in Cook and several downstate counties.

- In January, 1981 the Illinois General Assembly passed a supplemental appropriation which provided additional funding to the Department. This funding facilitated the hiring of 68 adoption staff (11 of which were attorney positions). This supplemental has led to the creation of specialized adoption units in every DCFS region.

- In February, 1981 the Adoption Information Center of Illinois (AICI) was opened. AICI features a statewide telephone hotline, a photo listing book of adoptable children and potential adoptive families, and a public education and recruitment program. The goal of AICI is to make permanency through adoption a reality for more special needs children - especially black children.

- In September, 1981 a Regional Adoption Program Model was developed. The model was designated as the official document to structure the development of/enhance existing specialized adoption units in each region. The model established service standards designed to produce high quality services with statewide consistency. By November 15, 1981 each of the Department's eight regions had implemented the regional adoption program model and were functioning within the framework of specialized adoption units.

- In October, 1981 the Department embarked on a major adoption recruitment effort. A campaign entitled "I Want to be a Son - I Want to be a Daughter" was produced for the Department of Children and Family Services and the Adoption Information Center of Illinois by McCann-Erickson, a Chicago advertising agency. Staff from the Department of Children and Family Services' Office of Communication/Community Relations made personal contacts with at least 50 newspapers around the state asking publishers to run adoption ads as a public service. Over 100 radio and television stations were also contacted to participate. Response/participation by the media exceeded the Department's expectations. This particular effort also focused on special needs children.

- Legislation in the form of House Bill 985, 488 and 486 provided major reform of the adoption laws of Illinois in the past session of the General Assembly. This legislation was geared toward removing certain bureaucratic barriers from the adoption process. (It is not expected that the recent Supreme Court decision, Santosky vs. Kramer, which ruled on the standard of evidence required in termination cases will adversely effect the Department's adoption initiative as adoption staff have continued to be advised to prepare the strongest case possible for termination cases.)

These efforts resulted in better adoption statistics in fiscal years 1981 and 1982:

	FY 81 (7/1/80-6/30/81)	FY 82 (7/1/81-6/30/82)
Number of children freed	595	731
Number of children placed for adoption	592	847
Number of adoptions finalized	555	798
Number of subsidized adoptions finalized	293	493

DCFS has several ways in which it assures improved adoption services, some of which are mentioned in the foregoing letter. The Adoption Screening Committee comprises representatives from the State's Attorney's Office, from the Guardian Ad Litem's Office, and from DCFS. The Committee in Cook County presently meets three times a week for two-hour sessions. At first the Committee had fewer meetings until they realized the pressing need. At these meetings, members decide whether a case is "court ready" for termination of parental rights.

Calendars 7 and 8 of the Cook County Juvenile Court have a four to five month backlog for hearings on contested parental rights termination cases. In his interview with our Commission staff, Veronico said that he felt another juvenile court calendar to handle these cases is necessary because after such a long delay evidence becomes stale. In his opinion, the problem in terminating parental rights is affected more by the backlog in the courts and not so much by the "clear and convincing" standard, with which he saw little problem. Also, there is reportedly a nationwide problem with poor case records.

As of August 1, 1982, Calendar 12 has been added to hear child abuse and neglect cases at Juvenile Court. Judge Saul A. Perdomo presides. This new court room has cut the case backlog down to two months. Of course, this backlog does not apply to temporary custody hearings, etc., which must be heard much sooner.

All new cases opened in August and September, 1982 were assigned to Calendar 12; Calendars 7 and 8 received no new cases. However, as of October 1, 1982, new cases are assigned to the three by rotation, when petitions are approved by the State's Attorney's Office.

Termination of parental rights cases make up a relatively small percentage of the cases heard in Calendar 7, 8, and 12.

Veronico stated that DCFS is committed to reunification of the natural family if at all possible, so the Department is careful not to track children into adoption from the point of intake. Cook County Juvenile Court judges appear to be very firm that this tracking not take place.

Another problem in bringing cases to court is that DCFS caseworkers do not necessarily know what is needed to present a successful parental rights termination case.

In the winter of 1981, DCFS received a supplemental money appropriation. Through this, the Department was able to place at least one attorney in each region to work with DCFS caseworkers on termination of parental rights in adoption cases.

The actual parental rights termination case is presented by the Assistant State's Attorneys, not by DCFS attorneys. If the Assistant State's Attorney will not prosecute a case because he or she feels there is a lack of adequate evidence or lack of need for termination, then DCFS has no recourse. The Director of DCFS might intervene in such cases and try to negotiate with the State's Attorney's Office, but the State's Attorney's Office has the final say in these cases. DCFS has also been working with the State's Attorney Association to try to resolve any differences they may have on how particular cases should be handled.

Veronico pointed out one possible reason for pursuing termination of parental rights even when no adoptive home has been identified. He said a child whose natural parents' rights had been terminated would be more attractive to potential adoptive parents because the problems associated with termination would have already been resolved. There would be less trauma and less time involved for the adoptive family.

He also mentioned some problem areas in adoptions. Certain children are difficult to place in adoptive homes, termed "Special Needs" children. They include minority children, white and hispanic children over the age of ten, any physically or mentally handicapped children, and sibling groups. The age requirements for adoptive parents who want "Special Needs" children apparently are more liberal.

Veronico outlined what DCFS is doing about the problem of adoption of black children. DCFS respects race and culture but will leave a child in its placement (even if not of the same race) if the placement has been long-term. DCFS will look for a black family to adopt a minority child for six months, though the six-month period can be waived. The preference is to place children with families of the same racial and ethnic background.

On Chicago's South Side, there is an adoption unit called

Adoption Family Development Unit, which focuses on recruiting black families. This unit has increased staffing, use of publicity and news media, and local training programs for staff regarding recruitment strategies and the like. The staff have reviewed their criteria regarding the adoptive family. They have also been working on ways to break down the myth that black families don't adopt. Furthermore, there is a church campaign to increase adoptions. There have been appearances by DCFS staff and children on the Phil Donahue Show and the Lee Phillip Show, as well as articles on adoptable "Special Needs" children in the Chicago Defender Newspaper and in the National Enquirer.

Of the 200 black children who were placed last year in Cook County, eight were placed transracially. Because of DCFS' initiative and the Adoption Family Development Unit, there are currently no healthy black babies waiting to be adopted.

Veronico pointed out a potential problem in the new law that gives foster parents who have had children in their care for a year preferance as possible adoptive parents. The problem would arise when DCFS feels that the foster family is not the best possible adoptive family. It might be argued that if DCFS was displeased with the family, it shouldn't have left the child in the placement for a year. Potentially, this new law would push DCFS to find suitable placements more quickly and to seek permanent placements as early as possible.

Veronico also spoke about contacts with other states. Illinois participates in the Interstate Compact on the Placement of Children, Ill. Rev. Stat. Ch. 23, ¶¶ 2601-2609, which involves 44 states. Participating states share a photo listing book of available children. For example, a California couple could go to a private adoptions agency in their state, or to the state's equivalent of DCFS, seeking to adopt a child. Should they express interest in an Illinois child listed in the book, a home study of the couple done in California would be sent to Illinois for review; if there are no problems to this point, a pre-placement visit to California by the Illinois child might be made.

Illinois was one of the first states to institute "subsidized adoptions." Eligibility depends on the child, not on the parents. The subsidy can cover the following:

a. medical expense of the child; the subsidy would pay the part of a medical bill not covered by insurance;

b. a monthly maintenance payment for the child; by law the monthly payment must be (at least) one dollar less than the comparable foster care payment; this payment may continue until the child is 18 years old; it is renewable each year, unless, for example, the child has left home;

c. legal costs (a one time payment only);

d. special services, such as transportation (this is also a one-time payment only).

The death of one or both adoptive parents (depending on the circumstances) can result in the subsidy being cut off. The subsidy can apparently only go to the original adoptive parents, not to any step-parent. According to Veronico, under state law the child must be a ward of the state to be eligible for the adoption subsidy.

Yet another way in which DCFS is trying to improve adoptions services was developed in December, 1979. Under the Case Review system, administered by John O'Donnell, cases of children in care are reviewed administratively every six months, with an eye toward permanence (whether in an adoptive home, a long-term foster home, or an institution). Case goals and objectives, which are very specific, are reviewed at that time. Good documentation is needed for these reviews. Veronico told us that he believes the Case Review system will lessen the length of foster care stay.

Once a child is placed in an adoptive home, there is a six-month probationary period. Only after this trial period can an adoption be finalized.

DCFS offers certain services, such as counseling, to adoptive families during the initial six months of placement. However, DCFS is more likely to refer the family to a local organization or suggest that the family join an adoptive family support group. Should the family request it, DCFS will continue such services past the six-month trial period.

2. Regional Functions: Purchase of Care

As we mentioned, adoptions are supervised at the state level, though each region provides adoption services. All other family maintenance and substitute care services are provided at the regional level. These services, along with adoptions, are used in permanency planning. In its 1982 Human Services Plan, DCFS describes the concept of permanency planning:

> The mission of the DCFS child welfare system is to assure that each child in its care is able to obtain a permanent, secure, and nurturing living arrangement. The department's commitment to permanence is based on the conviction that children must have a consistent nurturing environment to achieve optimal growth and development. Continuity of care by sensitive and caring adults whom the child views as his own "parents" establishes the basis from which a child can develop a stable adult personality. This consistency of care also enables the child to internalize the values and behavior which will promote his/her parenting ability.

Permanency planning involves all aspects of direct provision of services. The 1982 Plan outlines six permanency goals:

Family Preservation

Family Reunification

Adoption

Long-term Placement (for older adolescents or children for whom the court will not terminate parental rights)

Independence (for mature, older adolescents)

Continuous Care (for the severely handicapped child).

These goals can basically be broken into three broad categories, as they are in the 1982 Plan: Family Maintenance, Substitute Care, and Adoption Services. In general terms, each case is handled at the least "radical" stage possible, first through Family Maintenance, then Substitute Care, and finally Adoptions, depending on the severity of the case. Some cases are from the outset handled through substitute care or adoption; some begin with substitute care and end with reunification of the family; others might begin with family maintenance services and end in adoption. In any case, preservation of the family is the primary goal if it can be achieved without jeopardizing the child's safety.

Once DCFS becomes involved after the initial investigation and after protective custody issues have been decided, caseworkers gather information, assess needs, develop a treatment plan, arrange for services, and monitor progress. Most services for children and families are provided by persons or agencies through purchase of services by contract with the Department. A more complete discussion of DCFS' contractual activities is found in our section on Management and Budget.

a. Family Maintenance

DCFS Director Jerome Miller (1973-1974) emphasized bringing back to Illinois those children who had been placed in substitute care out of state, for the most part returning them to their natural families if possible. He instituted the current policy of providing services designed to keep families intact by, for example, relieving the stress on parents that often results in abuse and neglect. Such services fall under the category of Family Maintenance.

Family Maintenance services are meant to relieve stress and to preserve and strengthen the family so that out of home placement is not necessary. These services include the following:

> Homemakers - To strengthen and support the parents' capacity to care for their children, Homemakers teach and provide home management, consisting of meal planning and preparation, budgeting, shopping, child care, light house-keeping, personal care and hygiene, and related activities; supervise medication, therapeutic diet

management, and care of medical equipment; and provide other home-management assistance. This service provides a stabilizing force in the family.

Caretakers - Trained caretakers are placed in the home when the child lacks supervision or care. This service maintains continuity of care in the home so that the child need not be placed out of the home.

Child Welfare Day Care - This service helps to reduce the stress that might contribute to neglect or abuse, allowing parents some time away from their children and ensuring that the child's basic needs are met. Services might include recreation, education, meals and snacks, physical examinations and immunizations, and transportation. The service also might help parents maintain a desired work schedule to better provide economically for the children.

Advocates - Advocates are adults who provide intense (5-15 hours per week) supportive relationships with a child. They also help children and families gain access to needed resources and services.

Counseling - Counseling is aimed at helping children and their families cope with or solve personal, interpersonal, marital, familial, and social problems that result in abuse, neglect, dependency or behavior problems. These may also include counseling for alcohol or other drug dependency. Counseling services are often combined with other family maintenance services, such as homemakers.

Similar to counseling and homemakers are programs of parent education. Finally, DCFS provides emergency caretaker services on a short-term basis.

b. Substitute Care

When family maintenance services will not help to stabilize a home, a child will be removed from the home, either temporarily until the home can be normalized, or permanently so that the child may be put in a stable substitute home. In its 1981 Plan, DCFS summarizes substitue care:

> Effective protection or treatment of children sometimes requires removing a child from the home. In these cases, substitute care is necessary. Substitute care involves placing a child in a foster family home, group home or institution. Substitute care does not have the legal status of a permanent living situation. It is considered only a means to an end, not an end in itself. Consequently, priority attention must be paid to planning for permanency for each child in substitute care.
>
> The ultimate goal for each child in substitute care is the establishment of a permanent, secure, and nurturing living situation. Whenever possible, families are rehabilitated and children are returned home. When it is impossible to return a child home and ensure his/her protection, steps are then take to create a new permanent family through adoption.

> If adoption proves to be impossible, long-term foster care with relatives or other foster parents may be the only permanent alternative. For these children the permanency goal is to provide as secure and nurturing a family environment as possible. For selected older youth who have demonstrated the capability and expressed the desire to live independently, the permanency goal may be a successful transition to self-sufficient independence.

Most substitute care settings fall under two broad categories: foster family care and residential care; residential care involves group homes and institutions.

Foster families provide a normal family environment for the child. The foster home chosen is ideally the least restrictive setting that is most similar to a natural family and most compatible with the child's needs, and that is in close proximity to the child's home and community. The placement is considered temporary, used until the child can be reunited with his family, adopted, or prepared for self-sufficiency.

Residential care, provided through Group Homes and Institutions, provides total substitute care for children removed from the home. Such care is also considered temporary. Group Homes and Institutions may also offer a variety of specialized programs for children with special needs, for example, unwed teenage mothers or mentally or physically handicapped children.

In our interviews with DCFS caseworkers, we learned of several problems with the substitute care system. We were told that it is a constant struggle to get enough foster homes to meet DCFS needs. Periodic recruitment campaigns give low returns. Another problem is foster home drift. Though the purported goal is permanent placement as early as possible, many children remain in foster care for several years, often drifting from one home to another. This problem was attributed to DCFS' emphasis on the crisis situation that causes state intervention in the first place. Protection of the child from immediate harm is considered central, so the child may be removed from the home before the possibility of stabilizing the family is thoroughly explored. Once the child is in a more stable environment in the foster home, the caseworker may tend to forget him and not exercise vigilance in seeking an adoptive family. The huge caseloads of the social workers adds to this situation; they are constantly working on the immediate needs of newly referred children and cannot adequately follow up children in foster care. Another big problem is staff turnover. A new social worker will tend to concentrate on those cases with more immediate needs, letting the children in stable situations slide.

c. Follow-up of Services Purchased

For the most part, the services we have been discussing are long-term and require continual monitoring and review by caseworkers. After the intial investigation is completed by DCP (formerly by

CPS) and the intial action taken (e.g., protective custody), the case must be turned over to caseworkers who will follow it on an on-going basis.

In Cook County, DCP hands the case over to CPS. CPS follow-up is discussed in the section on the Division of Child Protection. Outside of Cook County, all functions are handled by multi-service workers; in Cook County, multi-service workers handle all follow-up except that involving abuse.

G. Conclusion

In this chapter, we have described the Department of Children and Family Services' several functions, focusing on the Department's attempts to protect abused and neglected children. We have seen that these functions are performed by five divisions: Child Protection, Management and Budget, Policy and Plans, Program Operations, and Youth and Community Services. For specific accounts of DCFS in action, see this report's case studies.

DCFS' protective services have improved in the last few years; the hotline and central register are notable examples of this improvement. But improvement must continue: DCFS is still not the efficient, smoothly organized entity that Illinois' children need.

Chapter 3

SELECTED LEGAL ISSUES RELATING TO CHILD ABUSE AND NEGLECT

A. Early Illinois Juvenile Statutory and Case Law*

Official response to child care in Illinois historically consists of the assumption of governmental control over children who either had violated the law or who were without proper parental or custodial care. Early measures treating these types of children, without differentiation between the two, were markedly different from the measures employed today. The emphasis of the legislature in the 1800's was on confinement and institutionalization of these children. Historically, the state attempted to gain legal control over placement of children, but these attempts were challenged in court almost as soon as statutes were enacted. We will recount a brief history of attitudes and measures on the part of the legislature and the courts in Illinois to handle the problems that have evolved into what is now known as child abuse and child neglect.

In 1863, the Illinois legislature enacted a statute (Ill. Priv. Laws 1863 ch. 14, §8) authorizing justices of the peace to commit two categories of children between the ages of six and sixteen: (1) children who violated the criminal law and (2) children who were vagrants, destitute of proper parental care, or growing up in mendicancy, ignorance, idleness or vice. By 1869, in the case of Fletcher v. Illinois (52 Ill. 395), the Illinois Supreme Court refused to accept the concept that parents have unlimited discretionary power over their children, holding that "parental authority must be exercised within the bounds of reason and humanity." The court found that a father's imprisonment of his blind son in a cold, damp basement made it "monstrous to hold that, under the pretense of sustaining authority, children must be left, without the protection of the law, at the mercy of depraved men and women, with liberty to inflict any species of barbarity short of actual taking of life."

The broad commitment authority of the 1863 legislation cited above was challenged in the 1870 case of People ex rel. O'Connell v. Turner (55 Ill. 280), which involved a 14-year-old boy who had been committed to the Chicago Reform School under the general statutory authority to arrest and confine for "misfortune." In a scathing attack on parens patriae (an English concept whereby a court of equity, exercising the Crown's paternal prerogative, could declare a child a ward of the Crown when the parents had failed to maintain the child's welfare), the Illinois Supreme Court ordered the boy's release on the grounds that commitment of a poor or neglected child who had not committed a crime violated his constitutional rights. The court in its opinion discussed parental rights and the difficulty of defining a proper standard of parental care. In declaring the neglect statute unconstitutional, the court stated:

*See articles authored by (1) Mason P. Thomas, Jr., and (2) Dr. Rowine Hayes Brown, et al., listed in the Bibliography, both of which examine this subject in greater detail.

> ...If, without crime, without the conviction of any offense, the children of the State are to be thus confined for the "good of society," then society had better be reduced to its original elements, and free government acknowledged a failure.
>
> ...Why should children, only guilty of misfortune, be deprived of liberty without "due process of law?"

This decision of the Illinois Supreme Court was regarded as socially irresponsible by the reformers who believed so strongly in institutional care for crime prevention. The State Reform School Act was revised in 1873 to correct the constitutional deficiencies: commitments were limited to criminal offenders, the right to commit during minority was eliminated, and commitments for parental neglect were abolished. The primary significance of the case is its standard for determining when parental conduct justifies state intervention and removal of the child's custody: "gross misconduct or almost total unfitness on the part of the parent...clearly proved." The legislature, in 1877, showed concern for these problems by approving "[a]n act to prevent and punish wrongs to children" (Offenses Involving Children, Ill. Rev. Stat. ch. 23, ¶ 2354):

> It shall be unlawful for any person having the care or custody of any child, wilfully to cause or permit the life of such child to be endangered, or the health of such child to be injured, or wilfully cause or permit such child to be placed in such a situation that its life or health may be endangered.

This Act withstood a 1971 challenge of unconstitutional vagueness in People v. Vandiver (51 Ill. 2d 525, 283 N.E. 2d 681). Currently, any person convicted under this Act is guilty of a Class A misdemeanor, while any subsequent offense constitutes a Class 4 felony.

Three years prior to the adoption of the above act, the General Assembly had enacted a law proscribing cruelty to children and others (Offenses Involving Children, Ill. Rev. Stat. ch. 23, ¶ 2368), which currently reads as follows:

> Any person who shall wilfully and unnecessarily expose to the inclemency of the weather, or shall in any other manner injure in health or limb, any child, apprentice or other person under his legal control, shall be guilty of a Class 4 felony.

This law likewise withstood a challenge of unconstitutional vagueness, in a 1978 case entitled People v. Virgin (60 Ill. App. 3d 964, 377 N.E. 2d 846).

Because neglected children no longer could be committed to reform schools after the O'Connell case, institutions under a new name--"industrial schools"--were created to care for such children around 1875. These schools were intended for children who were legally classified as "dependent," which was a term statutorily defined similar to that of a neglected child. Although such

schools were usually organized by private sectarian groups, they received public funds. The county of residence was required to pay ten dollars per month for the support of each child committed to an industrial school. The Supreme Court of Illinois on several occasions upheld the constitutionality of the industrial school act; relying on parens patriae, its 1870 position in the O'Connell case was reversed and the practice of committing neglected children to such sectarian institutions without following traditional concepts of legal due process was endorsed.

Also receiving public funds, pursuant to an 1885 law, were private groups engaged in the investigation of cases involving cruelty to children and the prosecution of parents, such as the Illinois Humane Society (known as the Illinois Society for the Prevention of Cruelty to Animals prior to 1881). This law provided that fines collected from the prosecution of cases involving cruelty to animals and children would be used for these agencies' support.

Nineteenth century Illinois legislation authorizing institutional commitment of neglected children, and cases interpreting these laws, reflect the sequential development of institutions under various names in which neglected children were mixed with child offenders. Child-saving organizations seemed to agree that, if society were to achieve a realistic approach to crime prevention, there should be no real distinctions between neglected children (then legally classified as "dependent") and child offenders.

Establishment in 1899 of a juvenile court in Cook County, Illinois, marked the first implementation of a separate judicial framework whose sole concern was directed to problems and misconduct of youth. The redefinition of the state's relationship to the child was not really an innovation but rather was based on the old English concept of parens patriae.

Civic, social and professional leaders in Chicago, concerned over the punitive applications of the criminal law to child offenders and the large number of children who were then confined in local jails and county poorhouses, provided the momentum for the establishment of the first juvenile court. In 1898, a committee of social leaders and lawyers was formed to draft a bill and work for its enactment. The bill, entitled "An act to regulate the treatment and control of dependent, neglected and delinquent children," was enacted by the General Assembly near the end of its 1899 session (see Ill. Rev. Stat. Ch. 37, ¶ 701-1 et seq.).

The juvenile court was a product of political compromise between private sectarian interests that operated the industrial schools and state welfare authorities who believed strongly in state-operated institutions for dependent and neglected children. The 1899 juvenile court law continued the blurring of distinctions between neglected, dependent and delinquent children and the practice of mixing these children in the same institutions. Like the industrial schools that preceded it, the juvenile court possessed

broadly defined jurisdiction over neglected children, with little thought having been given to the rights of parents and children. The terms "dependent" and "neglected" were used interchangeably in the 1899 juvenile court law, and these terms were defined in words describing conditions believed to lead to crime in the early nineteenth century: the definition included any child under age 16

> who for any reason is destitute or homeless or abandoned; or dependent upon the public for support; or has not proper parental care or guardianship; or who habitually begs or receives alms; or who is found living in any house of ill fame or with any vicious or disreputable person; or whose home, by reason of neglect, cruelty or depravity on the part of its parents, guardian or other person in whose care it may be, is an unfit place for such a child; and any child under the age of 8 years who is found peddling or selling any article or singing or playing any musical instrument upon the streets or giving any public entertainment.

The 1899 Illinois statute incorporated the concept of parens patriae by providing that "the care, custody and discipline of a child shall approximate as nearly as may be that which should be given by its parents...." It encouraged family placements that would result in adoption, and it gave the individuals or agencies to whom a child was committed broad authority over the child as guardian of the "ward." Such individuals or agencies were given certain parental rights, including the right to place the child in a family home and to consent to the child's adoption without notice to or approval of the child's parents. The general aim of the law was to displace certain broadly defined types of parents who were viewed as failures and to substitute the state as parens patriae.

The Chicago juvenile court system became the model for juvenile court legislation that was rapidly adopted throughout the United States. By 1909, twenty states and the District of Columbia had enacted such laws; all but three states had a juvenile court system by 1920.

With the development of the juvenile court, the law of neglect changed somewhat. Juvenile court statutes began stressing issues of parental fault, parental actions or omissions, moral environment, adequacy of physical care, and a proper home. Courts, in interpreting these statutes, began incorporating the standard of the "best interests of the child."

Because of the expansion of juvenile probation services under the juvenile court movement, the need to remove children from their homes by institutional commitments for protective reasons has declined. The availability of juvenile probation services has provided a new resource for supervising children in their homes. The juvenile courts in Illinois had furnished protective services for youngsters, originally secured from private, voluntary agencies dependent upon community money-raising activities.

In 1963, the General Assembly created the Department of Children and Family Services (see Ill. Rev. Stat. Ch. 23, ¶ 5001 et seq.), in response to recommendations of the Illinois Report for the 1960 White House Conference on Children and Youth. Since the creation of this department, the Juvenile Court has utilized the protective services available through it.

Few have decried the very existence of the juvenile court or questioned seriously its underlying premises. Most objections are in derogation of what the juvenile court has become, since its procedures have been altered gradually to conform to requirements of the United States Constitution. See, for example, dissenting opinions in two United States Supreme Court cases--In re Winship, 397 U.S. 358, 375-76 (1970) (Chief Justice Burger dissenting) and In re Gault, 387 U.S. 1, 78-81 (1967) (Justice Stewart dissenting).

Modern critics state that the juvenile process has been endowed with all the trappings of the criminal process and has lost its informal, nonadversary character. It is well to remember, however, that at the same time the juvenile court established a benevolent, protective, nonadversary relationship between the child and the state, it also effected a loss of procedural rights upon children, a loss that was obscured for over half a century in attempting to serve the best interests of the child. Throughout the history of the juvenile court movement, children have been denied procedural rights that they had enjoyed previously, on the basis that the proceeding was civil and not criminal, that it was a nonadversary proceeding, and that the juvenile court was able to protect the interests of the child as well as serve the interests of society.

Reforms protecting against procedural arbitrariness, while altering the procedural setting, have not prevented the juvenile court from attaining its basically ameliorative purposes, particularly at the dispositional stage. The protective policy has endured. Only by assuring a child of procedural fairness will a court be able to truly represent the child's interests and fulfill the state's now commonly accepted role of parens patriae.

B. The General Framework for Child Protection

According to Brian G. Fraser, former Executive Director of the National Committee for Prevention of Child Abuse, who was interviewed by Commission staff members, there are four factors indigenous to child abuse. We will repeat them here: (1) Because it is likely that one or both abusing parents were physically abused, neglected or deprived as children, child abuse apparently is a learned or conditioned behavior. (2) Abusing parents are isolated and have no friends, relatives or neighbors who can be called upon in time of crisis. (3) The parents have unrealistic expectations of their children. (4) There is usually a crisis of some sort which precedes and precipitates the abusive incident. When these four factors coalesce in a family, child abuse is likely to occur.

Child abuse legislation, if it is to be effective, must respond to all of the above problems. It must create a mechanism which combines different disciplines and different forms of expertise, according to Fraser, which will lead to a more effective delivery system and resolution of the complex issues involved in child abuse.

The current child abuse system is remedial, becoming operational only after the child has been abused. Fraser identifies the three steps that are involved: (1) the identification of the child believed to have been abused, (2) an investigation to determine if the child actually has been abused, and (3) the delivery of services and treatment to the abused child and his family.

Identification. Every state has enacted into law a mandatory reporting statute to ensure that reports are made and to facilitate the reporting process. All reporting statutes have a common purpose and format, but there is little uniformity because definitions, standards and procedures vary from state to state. State statutes typically define child abuse, mandate selected individuals (usually professionals) to report when they believe a child has been abused, designate at least one statewide agency to receive and investigate reports, provide immunity for good faith reports or provide criminal or civil provisions for non-compliance to encourage reporting, and abrogate the status of certain privileged communications. While effective child abuse legislation must provide a mechanism to ensure that all cases of suspected child abuse are properly identified and reported, any concerted effort to increase the number of reports must be matched with an effort to increase the capacity of the system to deal effectively with those reports.

Investigation. When a report of suspected child abuse is received by the appropriate state agency (in Illinois, the Department of Children and Family Services), it is screened and assigned to an agency caseworker for investigation. While all future actions will hinge on this investigation, Fraser feels that the majority of child abuse investigations are neither thorough nor properly conducted. The amount of time available to investigate each case is decreasing because the number of suspected child abuse reports has increased dramatically while the number of agency personnel responsible for investigating the reports has not increased substantially. One caseworker usually must formulate the diagnosis, the prognosis and the treatment plan. Because one individual rarely has substantive experience in all of the requisite disciplines, child abuse legislation should provide for cooperation between agencies, training and education of caseworkers, and the pooling of expertise of different professionals. Child abuse legislation must address the twin issues of limited resources and limited expertise.

Intervention. Implementation of the treatment plan constitutes intervention. Usually the treatment plan is voluntary, consisting of an agreement between the parents and, in Illinois, the Department of Children and Family Services. Voluntary implementation is monitored by the caseworker, who withdraws when it is

believed that the home environment has stabilized. Voluntary intervention is not appropriate in certain instances, however. For example, when the parents are unwilling to cooperate, the prognosis is poor, the injuries are severe, or there is a pattern of past abuses, involuntary intervention, i.e., implementation and monitoring of the treatment plan by a court, is indicated.

A model child abuse reporting statute was proposed in 1963 by the Children's Bureau of the U.S. Department of Health, Education and Welfare (now Health and Human Services), and two other models were developed by the American Medical Association and the Council of State Governments in 1965. All fifty states adopted some form of child abuse reporting statute between 1963 and 1967.

In January, 1974, the President of the United States signed into law the Child Abuse Prevention and Treatment Act (42 U.S.C. §§ 5101-5107) allocating federal money for the identification, treatment and prevention of child abuse, part of which was specifically earmarked for state use. For a state to be eligible for these funds it must:

(1) Provide for the reporting of known or suspected child abuse.

(2) Provide for an investigation by a properly constituted state authority upon receipt of a report of known or suspected child abuse. This investigation must be made promptly and if there is a finding of child abuse, the state must provide immediate action to protect the health and welfare of the abused or neglected child or any other child in the same home.

(3) Demonstrate that there are in effect administrative procedures, trained personnel, training procedures, institutional and other facilities and multidisciplinary programs and services sufficient to assure that the state can deal effectively and efficiently with child abuse. This must include provisions for the receipt, investigation and verification of reports; provision for the determination of treatment and ameliorative social services and medical needs; provision of such services; and recourse to the criminal or juvenile court where necessary.

(4) Have in effect a child abuse and neglect law that provides civil and criminal immunity for persons who report in good faith.

(5) Preserve the confidentiality of all records concerning reports of child abuse and neglect by having in effect a law that makes such records confidential and makes any person who permits or encourages the unauthorized dissemination of such records or their contents guilty of a crime.

(6) Establish cooperation among law enforcement officials, courts of competent jurisdiction, and all appropriate state agencies providing human services for the prevention, treatment and identification of child abuse and neglect.

(7) Ensure that in every case of child abuse that results in a judicial proceeding there is an appointment of a Guardian Ad Litem to represent the child.

(8) Show that the aggregate of state support for programs or projects related to child abuse is not reduced below the level provided during the fiscal year 1973.

(9) Provide for public dissemination of information on the problem of child abuse as well as the facilities and the prevention and treatment methods available to combat it.

(10) To the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

Child abuse reporting laws have broadened the duty of the community to intervene in family life for protective purposes. The reporting laws were added to an existing legal framework that already provided for state intervention to protect children in specified circumstances. This legal framework included criminal statutes and case precedents that limited excessive parental discipline, civil law precedents that governed child custody disputes, various state juvenile court acts, and state legislation that provided for protective services. The separate parts of this framework have developed somewhat independently so that legislatures, courts and scholars have seldom examined the framework as a whole in order to evaluate its effectiveness for child protection.

C. Illinois Legislation Impacting on the Child Abuse Problem

Ultimately, the prevention and treatment of child abuse and neglect depend less on laws and more on the existence of sufficient and suitable helping services for children and parents. A law may prohibit child abuse and neglect, and may mandate the rehabilitation of parents, but it cannot prevent or cure child abuse and neglect, nor can it rehabilitate parents. At best, a law can establish the institutional framework for the protection of children, and it can enunciate the philosophy that will guide a system as it deals with the individual problems of children and parents.

A summary of Illinois statutes that shape the framework of child protection in this state follows. Included, also, are synopses of selected legislation amending the pertinent acts in significant ways, which was passed recently by the 82nd General Assembly and signed into law. Only that legislation dealing with issues relevant to the Commission's investigation is discussed. (These amendments are discussed following the description of each act, and are referred to as "Public Act 82-____.")

1. Adoption Act, Ill. Rev. Stat. Ch. 40, ¶¶ 1501-1529. This Act specifies the practice and procedure involved in Illinois adoptions. This Act is to be construed in concert with the Juvenile Court Act, the Child Care Act of 1969, and the Interstate Compact

on the Placement of Children, discussed below. (Approved 1959. Effective January 1, 1960.)

a. Public Act 82-437 provides that a termination proceeding can take place "without regard to the likelihood that the child will be placed for adoption." Previously, an adoptive family had to be identified before a determination was made regarding the termination of parental rights due to the parent being unfit.

b. This Act amended in several respects the statutory grounds for parental unfitness in termination proceedings. Most importantly the definition of unfitness is rewritten to include a parent's failure to visit or communicate with the child as a ground. The court no longer must require a showing of diligent efforts by the authorized agency to encourage the parent to maintain contact with the child. It now is the parent's responsibility to strengthen the relationship with the child within twelve months after the neglect or dependent adjudication.

c. The Act gives any person over the age of eighteen who has cared for a child for a continuous period of one year as a foster parent the right to apply to the child's guardian for consent to adoption. The guardian must give preference and first consideration to this person's application. Juvenile Court still is the final authority as to the propriety of the adoption.

d. Public Act 82-225 provides that a parent's consent to adoption can be challenged by the parent on the grounds that it had been obtained by fraud or under duress or on any other grounds only within twelve months from the date the consent was executed. Previously, there had been no limitations period for actions to void or revoke a consent to adoption.

e. Public Act 82-224 provides that a child whose parent signs a final irrevocable consent to adoption or surrender, or whose parent is found unfit, is no longer to be considered a "related child," and such a parent is no longer to be considered a "parent of the child" who, before this amendment, had been granted certain rights in the future adoption of the child.

2. Interstate Compact on Juveniles, Ill. Rev. Stat. Ch. 23, ¶¶ 2591-2597. This Compact is an agreement between all states that provides, in relevant part, for the return to their home state of nondelinquent juveniles who have run away from home. (Approved August 1, 1961. Effective August 1, 1961.)

3. Criminal Laws. The Criminal Code of 1961, Ill. Rev. Stat. Ch. 38, ¶¶ 1-1 et seq., is replete with criminal offenses possibly applicable to child abuse and child abuse resulting in death; therefore, no attempt will be made here to discuss the entire range of possible charges. Worthy of special note, however, because it became law so recently (December 18, 1980), is "aggravated battery of a child" (Ill. Rev. Stat. Ch. 38, ¶ 12-4.3), which makes the infliction of "great bodily harm or permanent disability or disfigurement to any child under the age of 13 years" a Class 2 felony.

A new addition to the Criminal Code of 1961 is as follows:

a. Public Act 82-677 adds an "aggravating factor" in murder convictions. A defendant who at the time of the commission of the offense has attained the age of 18 or more and has been found guilty of murder may be sentenced to death if the murdered individual was under sixteen and the death resulted from exceptionally brutal or heinous behavior indicative of wanton cruelty.

A new addition to the Code of Criminal Procedure of 1963 is as follows:

b. Public Act 82-228 provides that whenever a peace officer arrests a person, the officer must question the arrestee as to whether he or she has children under the age of eighteen who may be neglected as a result of the arrest. If this is the case, the officer must assist the arrestee in placing the children in the care of a responsible person. When the officer has reasonable cause to believe the child is neglected, he must report it immediately to the Department of Children and Family Services. When a judge ascertains that an arrestee has children under eighteen who may be neglected as a result of the arrest, he must instruct a probation officer to report it immediately to the Department of Children and Family Services.

See Section E of the Introductory Chapter of this report for a synopsis of other new criminal laws which had been sponsored or supported by this Commission during the last session of the General Assembly.

In addition to the two criminal offenses involving children discussed in Section A of this Chapter (Ill. Rev. Stat. Ch. 23, ¶¶ 2354, 2368), prosecution for "child abandonment," a Class 4 felony (Ill. Rev. Stat. Ch. 23, ¶ 2361), as well as other specific statutory offenses against children codified in Chapter 23 of the Illinois Revised Statutes, is feasible.

4. Department of Children and Family Services Act, Ill. Rev. Stat. Ch. 23, ¶¶ 5001-5035.1. The purpose of this Act is to create a Department of Children and Family Services to provide social services to children and their families, to operate children's institutions, and to provide certain other rehabilitative and residential services as enumerated in the Act. (Approved June 4, 1963. Effective January 1, 1964.)

a. Public Act 82-726 provides for, among other things, moving children in the care of the Department toward the most permanent living arrangement and permanent legal status possible. To this end, a new case plan and case tracking system is implemented.

b. Public Act 82-969 establishes a Division of Youth and Community Services to be administered by the Department.

5. Juvenile Court Act, Ill. Rev. Stat. Ch. 37, ¶¶ 701-1--708-4. The stated purpose of this Act is to secure for each minor subject such care and guidance, preferably in his own home, as will serve the minor's welfare and best interests of the community;

to preserve and strengthen the minor's family ties whenever possible; and, when the minor must be removed from his own family, to secure for him custody, care and discipline, and in certain cases to place the minor in a foster home so that he may become a member of the family by legal adoption or otherwise. (The law and procedure under this Act is highlighted in Section E of this chapter.) (Approved August 5, 1965. Effective January 1, 1966.)

a. Public Act 82-223 amended a substantial portion of the Juvenile Court Act. The neglect adjudication is completely rewritten to be consistent with the Abused and Neglected Child Reporting Act definition and restructured into a subsection for "Neglected Minor" and a subsection for "Abused Minor." Those neglect cases which must be reported now are the same as those cases which may, if necessary, be prosecuted under the Juvenile Court Act. Also, the legislature eliminated that category of a "Neglected Minor" whose behavior was injurious to the welfare of others. The Law now reads as follows (additions to the law effected by this Act are indicated by underline; deletions are indicated by ~~strikeouts~~):

Sec. 2-4. Neglected or Abused Minor.

(1) Those who are neglected include any minor under 18 years of age:

~~(a)~~ whose parent or other person responsible for the minor's welfare does not provide the ~~who is neglected as to~~ proper or necessary support, education as required by law, or ~~as to~~ medical or other remedial care recognized under State law as ~~or other care~~ necessary for a minor's ~~his~~ well-being, or other care necessary for his or her well-being, including adequate food, clothing and shelter, or who is abandoned by his or her parents, or other person responsible for the minor's welfare. ~~guardian or custodian, or~~

~~(b) whose environment is injurious to his welfare or whose behavior is injurious to his own welfare or that of others.~~

(2) Those who are abused include any minor under 18 years of age:

(a) whose parent or immediate family member, or any person responsible for the minor's welfare, or any person who is in the same family or household as the minor, or any individual residing in the same home as the minor, or a paramour of the minor's parent:

(i) inflicts, causes to be inflicted, or allows to be inflicted upon such minor physical injury, by other than accidental

means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;

(ii) creates a substantial risk of physical injury to such minor by other than accidental means which would be likely to cause death, disfigurement, impairment of emotional health, or loss or impairment of any bodily function;

(iii) commits or allows to be committed any sex offense against such minor, as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include minors under 18 years of age;

(iv) commits or allows to be committed an act or acts of torture upon such minor; or

(v) inflicts excessive corporal punishment; or

(b) whose environment is injurious to his or her welfare.

(For informational purposes, the definition of a dependent minor under the Juvenile Court Act is any minor who is without a parent, guardian, or legal custodian.

(Most commonly, a child is dependent if he or she is without proper care because of the physical or mental disability of the parent, guardian or custodian. The disability may be mental or physical illness, alcoholism or drug addiction. The essential element is that the disability results in lack of proper care for the child.

(Additionally, a dependent child is one who has a parent, guardian, or custodian who with good causes wishes to be relieved for all residual parental rights and responsibilities [i.e., those rights and responsibilities that remain with the parent after the transfer of legal custody or guardianship of the child], guardianship or custody and who desires the court to appoint for the child a guardian who may consent to the child's adoption.

(Finally, a dependent child includes a minor who is without proper medical or other remedial care recognized under state law or other care necessary for his or her well being through no fault, neglect or lack of concern by his parents, guardian or custodian. Parental rights cannot be terminated, nor can the child be removed from the custody of his or her parents for longer than six months, if the dependency is based upon this latter definition.)

b. Public Act 82-453 provides that after a court prescribes shelter care and orders such placement for a minor, the minor may not be returned home without court involvement.

c. Public Act 82-233 (discussed in part already under subsection a, above) also details in very specific provisions those

statements and conditions which are admissible in evidence of abuse or neglect in adjudicatory hearings. The following now constitute prima facie evidence of abuse or neglect: medical diagnosis of battered child syndrome, failure to thrive syndrome, fetal alcohol syndrome, or withdrawal symptoms from narcotics or barbiturates at birth; or injuries sustained by a minor that ordinarily would not exist "except by reason of acts or omissions of the parent, custodian or guardian"; or the repeated use of addictive drugs by the parent, custodian or guardian.

d. The aforementioned Act makes proof of the abuse or neglect of one minor admissible evidence on the issue of the abuse or neglect of any other minor for whom the parent, custodian or guardian is responsible. The admissibility of other types of evidence is also liberalized under this Act.

e. Public Act 82-437 provides that if a child is over fourteen, the court may consider the child's wishes in determining whether the best interests of the child would be promoted by a finding that the parent is unfit so that parental rights can be terminated.

f. Public Act 82-437 reduces the standard of proof in termination proceedings. Prior to this Act, courts terminated parental rights to free children for adoption only when the parents were found to be unfit by "clear and convincing" evidence (unless the parents consented to the termination). This Act provides that a finding of unfitness of a nonconsenting parent is to be based only upon a "preponderance" of the evidence, unless the parents are minors, mentally ill or mentally deficient.

This reduction in the standard of proof is now unconstitutional. On March 24, 1982, the U.S. Supreme Court rendered its decision in Santosky v. Kramer (455 U.S. 745). At issue was a New York law requiring that only a "fair preponderance of the evidence" support a finding of unfitness in parental termination proceedings. It was held that before a state may sever completely and irrevocably the rights of parents to their natural child, due process requires that the state support its allegations by at least clear and convincing evidence. (But cf.: Lassiter v. Department of Social Services, 452 U.S. 18 [1981], wherein the U.S. Supreme Court held that the Fourteenth Amendment's due process clause does not require the appointment of counsel for indigent parents in every parental status termination proceeding.)

g. Public Act 82-973 and 82-969 are discussed in Section F of this chapter.

6. Child Care Act of 1969, Ill. Rev. Stat. Ch. 23, ¶¶ 2211-2230. This Act deals with the licensing by the Department of Children and Family Services of any person, group of persons or corporation operating any facility for child care, as defined in this Act. (Approved May 15, 1969. Effective January 1, 1970.)

* Public Acts 82-441 and 82-455 amended this law in many ways with respect to child care facilities and their licensing.

7. Crime Victims Compensation Act, Ill. Rev. Stat. Ch. 70, ¶¶ 70--90. This Act provides for compensation of victims of certain violent crimes and dependents of deceased victims for their pecuniary loss. While no compensation is to be paid to a victim who lives in the same household as the assailant at the time of applying for or receiving compensation, it is conceivable that the typical victim of child abuse could be eligible for compensation under certain circumstances (e.g., in instances where the perpetrator no longer resides in the child's home). Compensation may be made for medical, psychiatric and other expenses. (Approved August 23, 1973. Effective October 1, 1973.)

8. Interstate Compact on the Placement of Children, Ill. Rev. Stat. Ch. 23, ¶¶ 2601-2609. Over forty states, including Illinois, have enacted this Interstate Compact. Its stated purpose and policy is to promote cooperation and sharing between states in the placement of children in their care. It covers the placement of children in adoptive and foster homes located outside of Illinois, as well as out-of-state placements in a child care agency or institution where adoption is not contemplated (with some exceptions). The desired result of the Compact is that every child who requires a placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care. (Approved September 5, 1974. Effective October 1, 1974.)

9. Abused and Neglected Child Reporting Act, Ill. Rev. Stat. Ch. 23, ¶¶ 2051-2061.7. This Act requires certain enumerated mandated reporters (listed below)

> Any physician, hospital, hospital administrator and personnel engaged in examination, care and treatment of persons, surgeon, dentist, osteopath, chiropractor, podiatrist, Christian Science practitioner, coroner, medical examiner, school personnel, truant officer, social worker, social services administrator, registered nurse, licensed practical nurse, director or staff assistant of a nursery school or a child day care center, law enforcement officer, registered psychologist, or field personnel of the Illinois Department of Public Aid or the Department of Public Health, Department of Mental Health and Developmental Disabilities, Department of Corrections, probation officer or any other child care or foster care worker.... [Ill. Rev. Stat. Ch. 23, ¶ 2054]

having reasonable cause to believe a child known to them in their professional or official capacity may be an abused or neglected child to report immediately to the Department of Children and Family Services. The privileged quality of communication between any professional person required to report and his patient or client is abrogated, and does not constitute grounds for failure to report as required by this Act. Any other person may make a report if such person has reasonable cause to believe a child may be abused or neglected. This Act requires the Department of Children and

Family Services, upon its receipt of such reports, to protect the best interest of the child, offer protective services in order to prevent any further harm to the child and to other children in the family, stabilize the home environment and preserve family life whenever possible. This Act generally implements requirements of federal Child Abuse Prevention and Treatment Act, discussed in Section B of this Chapter. (Approved June 26, 1975. Effective July 1, 1975.) (Also, this Act was substantially revised by Public Act 81-1077; approved September 27, 1979; effective July 1, 1980.)

a. Public Act 82-453 provides that "any person who knowingly transmits a false report to the Department commits the offense of disorderly conduct under subsection (a) (7) of Section 26-1 of the 'Criminal Code of 1961.'"

b. The aforementioned Act also authorizes hospital administrators to give physicians who are keeping children in custody within the hospital the right to perform emergency medical treatment upon these children, under certain circumstances.

c. The aforementioned Act requires the Department to maintain a list of unfounded cases in the Central Registry when the subject of the unfounded report requests that the record not be expunged. The subject of the unfounded report must base this request on the alleged claim that the report was made in an intentionally false manner.

d. This same Act adds a new group of persons allowed access to the reports on file in the Central Registry. This new group includes "law enforcement agencies, physicians, courts, and child welfare agencies in other states [emphasis added] who are involved in suspected or indicated cases of child abuse or neglect and request information from the Department to aid in their assessment and service."

10. Domestic Violence Act, Ill. Rev. Stat. Ch. 40, ¶¶ 2301-1--2303-5. This new Act, which includes provisions amending other statutes also, expands the civil and criminal remedies for victims of domestic violence by enabling civil and criminal courts to quickly issue a protective order, enforceable by the police and carrying criminal penalties, to bar the abuser from the home. The new order will replace the current civil injunction, which can take as long as four to six weeks to obtain. It also will replace a juvenile court protective order, often used to separate an adult and child in incest and sexual abuse cases. (Approved September 24, 1981. Effective March 1, 1982.)

11. Child Sexual Abuse and Exploitation Treatment Centers Act, Ill. Rev. Stat. Ch. 23, ¶¶ 2081-2087. This new Act directs the Department of Children and Family Services to provide for the treatment and counseling of sexually abused children and their families, whenever possible, through community-based grants, when such sexual abuse or exploitation was inflicted by the child's immediate care-

giver. The purpose clause of this Act characterizes its mandate as a program designed to ameliorate, reduce, and ultimately eliminate the trauma of child sexual abuse and exploitation. (Certified November 12, 1981. Effective July 1, 1982.)

D. Criminal Prosecution of Abusing Parents

Over thirty-five states have statutes covering cruelty to children (see Ill. Rev. Stat. Ch. 23, ¶¶ 2354, 2368, discussed in Section A of this chapter). State penal codes which cover homicide and general assault and battery cases apply to a parent's or caretaker's bringing about the death of a child or inflicting physical harm upon a child. The plethora of criminal offenses with which a child abuser in Illinois already can be charged militates against recommending the enactment of any new Criminal Code legislation to deal with the problem.

It was indicated during the Commission's investigation that prosecution for child abuse is more likely in cases of sexual abuse, severe injury or death, and abuse by non-parents. Many professionals dealing with child abuse and neglect advise against prosecution except in unusual circumstances. Reasons given include: (1) Criminal courts do not have power to order treatment for family members who are not defendants (e.g., the spouse and child), and they lack the necessary support services to implement effective supervision and treatment. (2) Criminal prosecution may make the parent less cooperative in remedial procedures. (3) Criminal prosecution is less likely to deter child abuse than other criminal acts. (4) Criminal prosecutions in abuse and neglect cases are difficult because of evidentiary problems, the standard of proof required (beyond a reasonable doubt), and the prohibition against self-incrimination.

One Commission recommendation, to be discussed later in this chapter, suggests legislative guidelines for when child abuse and neglect reports should be referred by the Department of Children and Family Services for further investigation and possible prosecution. While the Commission takes a posture on the desirability of legislatively mandating that certain types of cases be referred to the appropriate law enforcement officials for investigation, no attempt is made to recommend actual prosecution in any specific category of case. Such decisions must be made strictly on a case-by-case basis. Once a case is referred for criminal investigation, a coordinated effort between the Department of Children and Famly Services and State's Attorney's Office should lead to the best course of action. A prosecutor's decision whether to accept alternative therapy in lieu of prosecution should depend on a reasonable evaluation of the plan's legitimacy and its responsiveness to agreed-upon goals.

Another suggestion for further coordinating civil and criminal functions involved the role of juvenile and criminal courts: Criminal prosecution for child abuse would be permitted only upon request of the juvenile court once a petition has been filed, and a guardian ad litem would be appointed to monitor and represent the child in criminal court actions. This concept warrants further research in the ongoing quest to facilitate increased coordination of the civil and criminal facets of child abuse cases.

One of our Commissioners, Senator W. Timothy Simms, has introduced Senate Bill 1564, which would create "The Abused Child Shield Law of 1982." Basically, this legislation is intended to provide an alternative to the personal appearance in court of a child who is the victim of sexual or physical abuse. The law would permit the State's Attorney to question the child in the judge's chambers while the testimony is being videotaped. The videotape then would be played in court as evidence. The defendant's attorney would have the right to cross-examine the child.

The State's Attorney may request that the judge order the defendant physically excluded during the videotaping of the testimony. If this happens, the videotape first must be shown to the defendant and his attorney, whereupon the attorney would be afforded the right to cross-examine the child.

The taping can be made at any time after the crime has occurred, even before the accused has been identified or arrested. If this should be the case, the court shall appoint a public defender to represent the "John Doe" defendant and cross-examine the child.

Senate Bill 1564 passed out of the Senate but failed to pass out of the House.

E. Overview of Juvenile Court Proceedings

Within 24 hours of its receipt of an abused or neglected child report, the Department of Children and Family Services must begin an investigation. Pursuant to its own rule, the Department is supposed to refer the following types of cases to the appropriate State's Attorney for consideration of criminal investigation or other action:

1. Reports in which a child is dead on arrival or dies after admission to a hospital as a result of suspected abuse or neglect; and

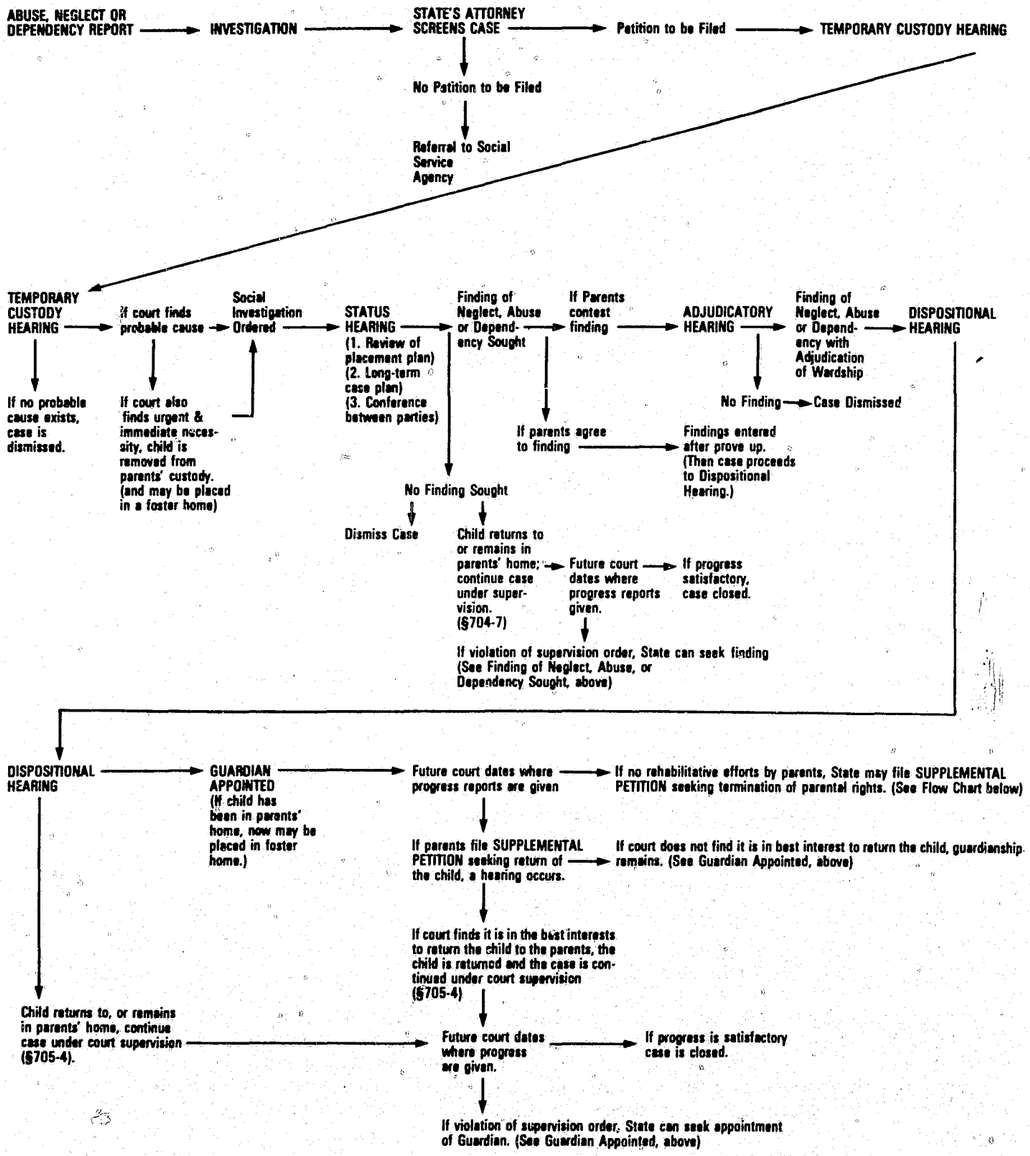
2. Reports in which the injury to the suspected abused or neglected child is severe, such as, but not limited to, fractures, burns, and subdural hematoma; and

3. Reports in which credible evidence is found that a child has been abused a second time, regardless of severity; and

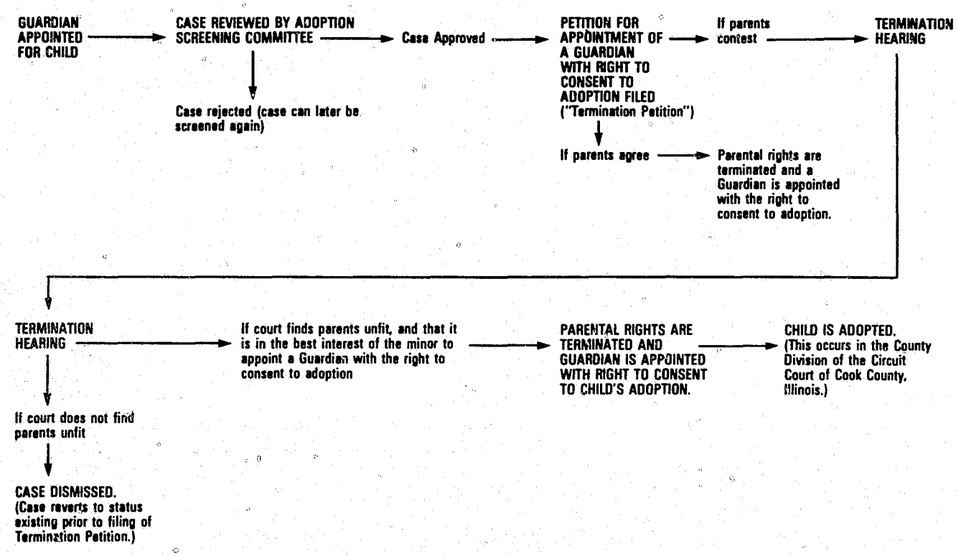
4. Reports of physical injury when evidence indicates that the child has been tortured.

Additionally, the Department shall refer to the appropriate State's Attorney cases in which it is determined that the child is in severe jeopardy from physical or sexual abuse or neglect and in need of protection beyond that which can be provided through comprehensive protective casework services. When there is reasonable cause to

NEGLECT, ABUSE AND DEPENDENCY PROCEEDINGS IN THE JUVENILE COURT OF COOK COUNTY, ILLINOIS



TERMINATION OF PARENTAL RIGHTS PROCEEDINGS IN THE JUVENILE COURT OF COOK COUNTY, ILLINOIS



suspect that a child has died as a result of abuse or neglect, the Department must report to the appropriate medical examiner or coroner.

Upon the Department's receipt of a report, it may offer social services to the family without having a petition alleging neglect filed in the Juvenile Court of Cook County.

Under both the Juvenile Court Act and the Abused and Neglected Child Reporting Act (both of which were discussed in Section C of this chapter), a child may be taken into "temporary protective custody" under certain circumstances. Any minor who is found in any street or public place suffering from any sickness or injury requiring care can be taken into temporary custody without a warrant by a law enforcement official. A minor may also be taken into temporary custody by a law enforcement official, employee of the Department of Children and Family Services, or a treating physician without obtaining the consent of the parents or custodian under three conditions: (1) where there is an imminent danger to the child's life or health, (2) where the parent or custodian is unavailable or has refused to give consent to removal, and (3) where there is no time to apply for a court order for temporary custody.

If the Department's investigation reveals a child is dependent, neglected, or abused, a petition for adjudication or wardship is filed. Natural parents, guardians, legal custodians, or responsible relatives must be notified of the temporary custody hearing. At this hearing, the State's Attorney presents the case for the State. Witnesses usually include social workers, police officers, the minor, and his parents. Hearsay evidence is admissible, and testimony can be compelled notwithstanding the Fifth Amendment right against self-incrimination unless the witness faces or is likely to face criminal charges as a result of the testimony. In addition to the State's Attorney, the child's attorney (usually the guardian ad litem, who must recommend to the court what is best for the child) and the parent's attorney (appointed by the court, usually from the Public Defender's office, if the parents cannot afford an attorney) also examine the witnesses.

After each party has presented its case, the court must either (1) find there is probable cause to believe the child is neglected, abused or dependent, or (2) dismiss the case. If probable cause is found, the court next must determine whether removal of the child from the home is a matter of immediate and urgent necessity for his protection. If it is, the child can be placed with a relative, in a foster home, or with a private welfare agency. Either the relative or the Department of Children and Family Services is then appointed "temporary custodian" of the minor. A social investigation of the parents, usually conducted by the Department, is then ordered to be completed within thirty days, in order to formulate a placement plan for the child. After being apprised of the results of the investigation, the State's Attorney at a status hearing (held thirty days after the temporary custody hearing) informs the court

whether it will seek a finding of neglect, abuse, or dependency, or seek to return the child to the parents under court supervision. If the parents do not agree with the disposition sought by the State's Attorney, the case is set for an adjudicatory hearing.

The issues to be decided at an adjudicatory hearing, which must be held within ninety days of the filing of the petition unless otherwise agreed, are (1) whether the child is abused, neglected or dependent, and (2) whether the child should be adjudged a ward of the court. At the adjudicating hearing, the burden of proof is a preponderance of the evidence, and because the rules of evidence for civil proceedings apply, hearsay is inadmissible. After all sides have presented their case, the judge makes a finding of neglect or dependency; otherwise, the case is dismissed. If found to be neglected or dependent, the minor must be adjudged a ward of the court so that the court can continue to exercise jurisdiction over the child and parents. If it is in the best interest and welfare of the child and public, an adjudication of wardship will be made.

The next phase is the dispositional hearing, at which time the court may (1) order the appointment of a guardian for the child, (2) allow the child to return to or remain in the parents' home under court supervision, or (3) emancipate the child pursuant to the Emancipation of Mature Minors Act (Ill. Rev. Stat. Ch. 40, 2201 et seq.). If court supervision is ordered, the case is continued for progress reports to determine if the family is complying with the supervision order. If the family satisfactorily completes the term of supervision, wardship is vacated and the case is closed. If the supervision order is violated, the State can seek the appointment of a guardian for the child. Certain protective orders also can be entered by the court to supplement the dispositional order; protective orders usually require a parent to commit or refrain from committing certain acts when a child is allowed to remain in or return to the parents' home.

Dispositional hearings are often deferred if the parents are engaged in family counseling; if the court has ordered a psychiatric evaluation of the family members--performed by the Juvenile Court's Department of Clinical Services or a private psychiatrist or psychologist--the hearing will be deferred until the evaluations are completed.

At the dispositional hearing, the court must determine that disposition which best serves the interests of the minor and the public: the standard of proof is a preponderance of the evidence, and hearsay evidence is admissible. If the parents are found to be unfit, unable or unwilling to care for the minor, a guardian can be appointed for the child. Such guardians can be either reliable, willing adult relatives or the Department of Children and Family Services, in which case the child will remain in a foster home. The case is continued for updated case plans to the court every six months by the guardian on the status of the child. Only when the child reaches legal majority or is returned to the custody of his parents and court supervision is completed will the case be

dismissed. During guardianship, parents retain certain rights and responsibilities such as visitation and supports. Termination of parental rights to free the child for adoption may be sought if the parents fail to exercise their rights and responsibilities with respect to the child.

It is important to note that formal dispositional hearings are rendered unnecessary if all parties voluntarily agree upon a certain type of disposition for the child.

Supplemental petitions to request a change in the status of a child (e.g., return of custody to parents, change of guardian, or termination of parental rights) or to seek the court's aid in obtaining certain services for a child may be filed at any time during the pendency of a case. Most such petitions, however, are filed after a guardian has been appointed.

If, after a guardian is appointed for the child, the parents do not make reasonable efforts or progress toward rehabilitation, or if the parents are unfit as defined in the Adoption Act (see Section C of this chapter), termination of parental rights may be requested by either the Department of Children and Family Services or a private agency. All parties must be served with notice of the filing of a petition to terminate parental rights. At the termination hearing, proof of parental unfitness must be clear and convincing evidence (see Section C of this Chapter). If the court finds the parents unfit, it then determines whether it is in the best interest of the child to appoint a guardian with the right to consent to adoption (which depends upon the likelihood of the child being adopted in the near future). The child becomes free for adoption upon a finding of parental unfitness, termination of parental rights, and appointment of a guardian with the right to consent to adoption.

F. Proposed and Enacted Revisions in Juvenile Court Law And Procedure

Two bills, Senate Bills (SB) 605 and 1231, dealing with the Juvenile Court Act (Ill. Rev. Stat. Ch. 37, ¶¶ 701-1 to 708-4), were introduced in the 82nd General Assembly and were given wide coverage. As originally introduced, both bills proposed the repeal of the Juvenile Court Act, SB 605 replacing the Act with a new "Juvenile Code" and SB 1231 replacing it with a new "Code of Juvenile Law and Procedure." Actually, both bills contained major portions of the structure and wording found in the Juvenile Court Act but new sections were added and old sections reworded. The Chairman of a Senate subcommittee which held hearings on the bills characterized SB 1231 as a "get-tough approach" and SB 605 as a "more lenient approach."

Subsequent to the preparation of prior sections of this chapter, an amended version of SB 1231 was signed into law on September 8, 1982, as Public Act (PA) 82-973. Consequently, a synopsis of this legislation is not contained in Section C of this chapter. Although the bill originally proposed a new Code, after study and public hearings, the Judiciary II Committee decided a complete revision

of the Juvenile Court Act was unnecessary and instead merely amended sections of the Act.

We believe it likely that these or very similar bills will be introduced in future sessions of the General Assembly. Therefore, we will include here not only a discussion of PA 82-973, but also a discussion of SB 605 and 1231 as originally introduced. Although these bills contained some provisions which do not relate specifically to this report, we will discuss each of these bills in their entirety because both have far-reaching implications for Illinois juvenile court law and procedure.

There are many differences between the two bills and between each bill and the Juvenile Court Act. Some of the differences are technical and others are significant, substantive changes. It would take many pages to summarize all of these differences. Instead, we will point out some of the major differences between each bill and the Juvenile Court Act. In reading the comparisons, the reader should note the differences between the two bills in their treatment of confidentiality issues, trial of juveniles as adults, and the categories of juveniles.

1. Senate Bill 1231 (Public Act 82-973)

PA 82-973 adds a section to the Juvenile Court Act which expands the instances where a juvenile may be tried as an adult. A minor of at least 15 years of age who is charged with murder, rape, deviate sexual assault or armed robbery when the armed robbery is committed with a firearm, will automatically be transferred to criminal court.

This act makes a number of changes regarding the confidentiality of records. Before revision, the Juvenile Court Act had a restrictive emphasis on law enforcement and juvenile court records. PA 82-973 defines "law enforcement records" and "juvenile court records" and provides that inspection and copying of law enforcement records shall be restricted to:

1) Any local, State or federal law enforcement officers of any jurisdiction or agency when necessary for the discharge of their official duties during the investigation or prosecution of a crime which would be a felony if committed by an adult.

2) Prosecutors, probation officers, social workers, or other individuals assigned by the court to conduct a pre-adjudication or pre-disposition investigation, and individuals responsible for supervising or providing temporary or permanent care and custody for minors pursuant to the order of the juvenile court, when essential to performing their responsibilities.

3) Prosecutors and probation officers in the course of criminal proceedings.

4) Adult and Juvenile Prisoner Review Board.

5) Authorized military personnel.

6) Persons engaged in bona fide research, with the permission of the Presiding Judge of the Juvenile Court and the chief executive of the respective law enforcement agency.

Inspection and copying of the juvenile court records shall be restricted to the following:

1) The child, his parents, guardian, and counsel.

2) Law enforcement officers and law enforcement agencies when such information is essential to executing an arrest or search warrant, or to conducting an ongoing investigation.

3) Judges, prosecutors, probation officers, social workers, or other individuals assigned by the court to conduct a pre-adjudication or pre-disposition investigation, and individuals responsible for supervising or providing temporary or permanent care and custody for minors pursuant to the order of the Juvenile Court.

4) Judges, prosecutors, probation officers in the course of criminal proceedings.

5) Adult and Juvenile Prisoner Review Boards.

6) Authorized military personnel.

7) Victims, their subrogees and legal representatives; however, those persons shall have access only to the name and address of the minor and the disposition of the Juvenile Court proceeding.

8) Persons engaged in bona fide research, with the permission of the Presiding Judge of the Juvenile Court and the chief executive of the agency that prepared the particular records.

Admissability of evidence in other proceedings is also different from the pre-amendment Act which placed strict limits on admissability. PA 82-973 permits admission of evidence given in juvenile court proceedings:

1) in subsequent proceedings under the Juvenile Court Act concerning the same minor; or

2) in criminal proceedings when the court is to determine the amount of bail, fitness or the defendant or in sentencing under the Unified Code of Corrections; or

3) in proceedings under the Act or in criminal proceedings

in which anyone who has been adjudicated delinquent is to be a witness, and then only for purposes of impeachment and pursuant to the rules of evidence for criminal trials; or

4) in civil proceedings concerning causes of action arising out of the incident or incidents which initially gave rise to the proceedings under the Act.

PA 82-973 provides for expunging law enforcement and juvenile court records when the child has reached age 17 or when all juvenile proceedings against the child have terminated, whichever is later, upon petition by the child in the following circumstances:

1) the minor was arrested and no petition for delinquency was filed with the clerk of the circuit court; or

2) the minor was charged with an offense and was found not delinquent of that offense; or

3) the minor was placed under supervision pursuant to the Juvenile Court Act and such order of supervision has since been successfully terminated.

Law enforcement records relating to incidents occurring before a person's 17th birthday which did not result in criminal proceedings and juvenile court records relating to any crimes, except murder, committed before a person's 17th birthday, if he has no convictions for any crime since his 17th birthday and either 10 years have passed since his 17th birthday or 10 years have passed since all juvenile court proceedings against him have terminated, whichever is later, may be expunged.

In addition to prohibiting a minor under 16 years of age from being confined in a jail or place ordinarily used for confinement of prisoners in a police station, PA 82-973 also provides that children under 17 must be kept separate from confined adults and may not at any time be kept in the same cell, room or yard with adults confined pursuant to the criminal law.

Regarding summons to appear in court, the act adds the provision that:

> When a parent or other person who signed a written promise to appear and bring the minor to court or who has waived or acknowledged service, fails to appear with the minor on the date set by the court, a bench warrant may be issued for the parent or other person, the minor, or both.

The pre-amendment Juvenile Court Act contained a provision for the continuance of a case under supervision before proceeding to findings and adjudication or after hearing evidence but before making a finding. PA 82-973 expands on this provision by providing the following:

1) A minor otherwise in need of supervision, a neglected or abused minor, or a dependent minor whose case has been continued under supervision may be permitted to remain in his home.

2) The period of continuance under supervision for a delinquent minor may not exceed 24 months.

3) When the hearing of a delinquent minor is continued under supervision, the court may require the minor to do any of the following:

a) not violate any criminal statute of any jurisdiction;

b) make a report to and appear in person before any person or agency as directed by the court;

c) work or pursue a course of study or vocational training;

d) undergo medical or psychotherapeutic treatment rendered by a therapist, or treatment for drug addiction or alcoholism;

e) attend or reside in a facility established for the instruction or residence of persons on probation;

f) support his dependents, if any;

g) pay costs;

h) refrain from possessing a firearm or other dangerous weapon, or an automobile;

i) permit the probation officer to visit him at his home or elsewhere;

j) reside with his parents or in a foster home;

k) attend school;

l) attend a non-residential program for youth;

m) contribute to his own support at home or in a foster home;

n) perform some reasonable public service work;

o) make restitution to the victim;

p) comply with curfew requirements as designated by the courts; or

q) comply with any other conditions as may be ordered by the court.

The proposed SB 1231 added a section requiring that in the following cases the juvenile be tried as an adult:

1. persons 14 or older who allegedly commit murder, rape, deviate sexual assault, heinous battery, home invasion, aggravated arson, or armed robbery in which a firearm is used;

2. persons 14 or older who allegedly commit any crime of violence classified as a Class 1 felony and who at the time of the alleged commission of such class 1 felony have twice been adjudicated delinquent for crimes which would be class 1 felonies if committed by adults; or

3. persons 14 or older who allegedly commit any crime which would be a felony if committed by an adult where the child previously had been charged with a crime which would be a felony if committed by an adult and these earlier proceedings resulted in waiver of jurisdiction by the juvenile court.

The definition of minor in need of supervision (MINS) as appearing in the Juvenile Court Act has changed to child in need of supervision (CINS) and was defined as any child under 18 who:

1. demonstrates disregard for or misuse of lawful parental authority of the child's legal guardian or custodian;

2. violates the compulsory education laws of the state of Illinois;

3. absents himself without permission of his parent or legal guardian or legal custodian from his approved place of residence;

4. demonstrates dysfunctional behavior as a result of excessive use of alcoholic beverages or drugs.

This definition is broader than that in the Juvenile Court Act because of the addition of alcohol abuse and runaways. SB 1231 enacted as PA 82-973 contains provisions for continuance of a hearing under supervision. A similar procedure was contained in proposed SB 1231 but was called "adjournment in contemplation of dismissal." Unlike the pre-amendment Juvenile Court Act and the enacted SB 1231, its use was limited to CINS and neglect cases. The purpose is "an adjournment of the proceeding for a period not to exceed 1 year with a view to ultimate dismissal of the petition in the furtherance of justice."

The court may order various terms and conditions during this period but must include that the child be in the respondent's custody, and that the child and the respondent be under the supervision of a child protection agency or other appropriate child welfare agency. If the agency fails substantially to provide the respondent with adequate supervision or to observe the terms and conditions of the order, the court may direct them to do so.

If the court determines that the respondent has failed to substantially observe the terms and conditions or to cooperate with the supervising agency and that the facts alleged in the petition are sufficient to establish CINS or neglect, the court may proceed to a disposition hearing and enter an order of disposition with the same force and effect as if an adjudicatory hearing had been held.

In addition to waiving any applicable communications privilege between any professional person and his patient or client, except the attorney/client privilege, as is provided in the current law, the proposed SB 1231 would also waive the husband/wife privilege.

Similar to the current law which provides that the court may make an order of protection, this bill would add that when the order of protection is made applicable to a parent or guardian, it may specifically require his active participation in the rehabilitation process and may impose specific requirements on him subject to penalty for contempt.

The proposed SB 1231 adds a provision for orders in addition to or in lieu of placement which may:

1. direct a child protective agency, or other duly authorized agency to undertake diligent efforts to encourage and strengthen the parental relationship when it finds such efforts will not be detrimental to the best interests of the child. Such order may include a specific plan of action for such agency or official including, but not limited to, requirements that such agency or official assist the parent or other person responsible for the child's care in obtaining adequate housing, employment, counseling, medical care or psychiatric treatment; and

2. direct a duly authorized agency to cooperate with the State's Attorneys Office to institute proceedings to legally free the child for adoption, and upon a failure by such official or agency to comply within 30 days after entry of such order, permitting the foster parent(s) in whose home the child resides to institute such an action with the State's Attorney.

Proposed SB 1231 added the requirement that if a law enforcement officer takes a child who is alleged to be abused or neglected into temporary custody, with or without a warrant, he shall

1. notify the Illinois Department of Children and Family Services that he has taken protective custody of the child; and

2. bring the child to a place designated by the Department of Children and Family Services for his purpose, unless the child is or will be presently admitted to a hospital.

A provision of this nature does not exist in the enacted SB 1231.

Proposed SB 1231 deleted the prohibition that a minor under 16 cannot be confined in a jail or place ordinarily used for confinement of prisoners in a police station and instead provided that children under 17 must be kept separate from confined adults and may not at any time be kept in the same cell, room or yard with adults confined pursuant to the criminal law. Enacted SB 1231 contains both provisions.

Proposed SB 1231 also provided a list of circumstances when a juvenile detention may be used, such as:

1. upon taking a child into custody for alleged conduct which if committed by an adult would constitute a crime;

2. while awaiting extradition as a runaway, escapee or absconder, pursuant to the Interstate Compact on Juveniles without the necessity of prior approval of the court.

Similarly, juvenile secure shelter facilities may be used without prior approval of the court for

1. children from this state who have runaway from their approved place or residence; or

2. children who are delinquent, or who are otherwise in need of supervision.

The enacted SB 1231 contains no similar provision.

Portions of the proposed SB 1231 which did not appear in the enacted PA 82-973, were contained in SB 623 which was signed into law on September 8, 1982 as PA 82-969. For example, "minor in need of supervision," as provided in the Juvenile Court Act, has been changed in PA 82-969 to "minor requiring authoritative or habitual truant, is absent from home without consent of parent, guardian or custodian, or is beyond the control of his or her parent, guardian or custodian. Proposed SB 1231 provided for changing "minor in need of supervision" to "child in need of supervision" and defined the new term in substantially the same manner in which "minor requiring authoritative intervention" is defined.

2. Senate Bill 605

The Juvenile Court Act classifies juveniles under its jurisdiction into four categories: delinquent, minor in need of supervision (MINS), abused or neglected, or dependent. SB 605 provides for only two categories. It retains the delinquent category, but eliminates the other three: These are replaced with a classification designated "family in need of supervision" (FINS). FINS is defined as:

a family with a minor:

a) who is beyond the control of his or her parents, guardian or custodian;

b) who has committed a private offense or whose behavior is injurious to his or her own welfare;

c) who has not received proper or necessary support, or medical, remedial or other care necessary for his or her well being, or whose environment is injurious to the minor's welfare;

d) who is abused;

e) who is without parent, guardian or custodian by reason of death, abandonment, or physical or mental disability of the minor's parent, guardian or custodian; or,

f) whose parents fail to provide education as required by law; except that no minor or family shall be included herein solely for the purpose of qualifying for financial assistance.

The case disposition choices available to the court for a FINS case are similar to those found in the Juvenile Court Act with two major changes. SB 605 provides that an order of disposition may require any of the parties respondent (parents, guardians) to:

i) attend and participate in counseling, whether public, private or through probation;

ii) cooperate with any agency;

iii) participate in visitation with the child, whether in or out of the home;

iv) participate in any court ordered or agency programs;

v) provide transportation to school, medical care for the child or any other court ordered program;

vi) participate in psychiatric or mental treatment;

vii) do any other reasonable acts for the rehabilitation of the family.

In addition, the court may order the Department of Children and Family Services, Department of Mental Health and Developmental Disabilities, Illinois Commission on Delinquency Prevention or any local probation agency to provide services to the minor or his family even though they had not been made the guardian or custodian of the minor.

SB 605 provides a penalty clause for violation of its confidentiality of records provisions. A violation is a Class A misdemeanor. The aggrieved juvenile may sue the violator for actual and punitive damages, including attorney's fees, and the violator may not assert as a defense any immunity, either qualified or absolute. Neither the pre-amendment Juvenile Court Act nor the enacted SB 1231 contain such provision.

The Juvenile Court Act provides that a law enforcement officer may take a minor into custody without a warrant and, if not released, the minor shall be taken before the court or to a place of reception for minors designated by the court. SB 605 expands upon this section by including specific procedures. Under this bill the officer shall have the following options:

1. make informal street adjustment and release;

2. make informal street adjustment with release to the parents; or

3. notify the parents and take the minor to a youth officer.

The youth officer may take one of the following actions:

1. station adjustment with release of the minor;

2. station adjustment with release of the minor to a parent;

3. station adjustment, release of the minor to a parent, and referral of the case to community services;

4. station adjustment, release of the minor to a parent, referral of the case to community services with informal monitoring by youth officer;

5. station adjustment and release of the minor to a third person pursuant to agreement of the minor and parents;

6. station adjustment, release of the minor to a third person pursuant to agreement of the minor and parents, and referral of the case to community services;

7. station adjustment, release of the minor to a third person pursuant to agreement of the minor and parent, and referral to community services with informal monitoring by a youth officer;

8. release of the minor to his parents and referral to a juvenile probation officer;

9. taking the minor to court or place of reception designated for minors; or

10. any other appropriate action with consent of the minor and parent.

In a further attempt to divert a minor from the formal court process, this bill expands upon the Juvenile Court Act which allows the juvenile probation officer to conduct a preliminary conference with the person seeking to file a petition, the prospective respondents and other interested persons. Efforts to adjust suitable cases without the filing of a petition may not extend beyond

three months. SB 605 provides a list of "non-judicial social adjustment plans" which the juvenile probation officer may make, including:

1. informal 6-month supervision within the family;

2. informal 6-month supervision with a probation officer involved;

3. informal 6-month supervision with release to a person other than parent;

4. referral to special education, counseling or other rehabilitative social or educational program; and

5. referral to residential treatment program.

SB 605 failed to pass out of the Senate.

Chapter 4

CASE STUDIES: CHILD ABUSE AND NEGLECT

Commission investigators reviewed dozens of case files in order to find cases that were representative of the types of cases dealt with by DCFS. We were not looking for cases that had been handled perfectly; nor were we looking for sensationalized cases that had been mishandled by everyone in the child protective network. Rather, we wanted to look at cases that seemed to reflect the typical problems that one might encounter in any review of child abuse and neglect cases. Each case is unique; each case has variables as individualistic as the victim, the parents, and the workers involved. But we looked for cases in which we could identify actions that were appropriate or inappropriate for the individual case. We looked for cases that reflected some of the problems we had discovered in our review of the child abuse literature. We looked for cases in which there had been extraordinary inter-agency cooperation, or the lack thereof. Finally, because we were specifically mandated by House Resolution 776 to do so, we did look for cases that might have been mismanaged by DCFS workers at one level or another. But we did not limit our search to those types of cases. While our case search was not totally random or scientific, it also was not based on preformulated opinion or suspicion.

A. Walter

On February 10, 1980, a young boy named Walter was abused by his mother's boyfriend. Allegedly, the boyfriend immersed Walter's hands into hot water, resulting in second and third degree burns. The boy's mother apparently was not home at the time and a babysitter claimed to know nothing of the incident.

The boyfriend took Walter to Mt. Sinai Hospital in Chicago for treatment of the burns; Mt. Sinai officials contacted both the police and DCFS.

Our investigators spoke with a Mt. Sinai social worker who handled Walter's case. He mentioned that the hospital has a Child Protective Team to deal with abuse cases. Because Walter was at Mt. Sinai from February 10 to March 13, his case would have been discussed by the team several times. The team viewed the case as quite serious. The team was not so much bothered by the injuries as by the atmosphere and conditions of the home. Although the boyfriend never admitted to the abuse, the team felt it was obvious that it had occurred.

The team received information about the home from DCFS workers and visiting nurses. They said that the mother appeared to be alcoholic; other children in the home appeared to be malnourished. The team decided that Walter should not be returned home unless

the boyfriend were removed from the home. Ultimately, he did leave the home immediately prior to Walter's hospital release.

After Walter's release, he was supposed to visit the hospital five times a week for rehabilitation as a result of the burns. Failure to do so would have resulted in some loss of the use of his hands. Initially, the mother was unable to make the appointments, or did not understand their importance. Finally, she agreed to bring Walter in three times a week.

Chicago Police Department records reflect that a DCFS CPS worker was called to the hospital, as were the police, on February 10. The CPS worker assumed temporary custody of Walter, and such custody remained in effect until the boy's release from the hospital.

The boyfriend was arrested on February 11 and charged with battery. At the preliminary hearing, Judge John P. McGury, on the motion of the State's Attorney, ordered the case stricken on leave to reinstate, apparently because there was neither a confession nor any witness to the crime.

Commission staff also spoke with the CPS worker who had handled the case. She knew little about the case because she had only been active on it for a short period of time. She had contracted with Central Baptist Family Services for counseling.

We also spoke with the liaison worker with DCFS who handled cases referred to Central Baptist Family Services. When we spoke with her in August of 1981, she was unaware of the status of the case. We subsequently learned that the case was closed on November 18, 1981.

We asked the liaison worker if the mother had to cooperate with the contractual agency; she said that the mother did have to cooperate or the case would be brought back before the court. The liaison worker's only other comment was that the six-month time limit that contractual agencies had to work with a family was too brief.

We spoke with the social worker with Central Baptist Family Services who had been the direct service worker for Walter when the case was first referred. She worked through a program called Emergency Caretaker and Homemaker Outreach (ECHO). The ECHO program deals only with cases of abuse and neglect and does not provide counseling or any other services in their offices; rather, all treatment is rendered in the home. When we spoke with the worker in May, 1981, she still was visiting the home weekly. However, she felt the case could be closed by ECHO soon thereafter. She mentioned that official court involvement had ceased on November 2, 1980, when the neglect case had been dismissed. After that time, the mother accepted services voluntarily.

The ECHO worker agreed that the nature of the burns that Walter sustained suggested deliberate abuse. One of the reasons her agency had remained active with the case was to assure that Walter would receive proper medical attention. She also mentioned the malnourished condition of the other children as a reason to continue working with the mother.

The ECHO worker told us the following services had been provided to the family: family therapy, parenting, home management skills, transportation for Walter to the hospital, nutritional education, and provision for both a homemaker and visiting nurse. The worker reported no contact between the mother and her former boyfriend. She felt that the incident had been a single, isolated case of abuse. She also felt that the mother had improved in her parenting skills and in the general supervision of her children. Finally, the worker said that one must appreciate the problems facing the mother: she was only 23 years old and already had six children to care for. She felt the stress level in the home must have been high, and the boyfriend's presence was the reason abuse had occurred.

Our case analysis indicates that the mother was provided useful services that should stand her in good stead. Treatment was adequate and the case was directed through proper channels until its resolution.

Finally, our analysis of DCFS and ECHO documents shows that several significant documents were missing from the DCFS file, including intake sheets and quarterly progress reports from ECHO to DCFS. Workers were unable to explain their loss.

B. Marie

On May 9, 1979, 15-year-old Marie, a junior in high school, had a fight with her mother. Her mother had refused to allow Marie to visit her boyfriend. Marie's mother is divorced and has a history of mental illness and alcoholism.

The next day Marie arrived at school with minor cuts on her wrists. When taken to the school social worker, Marie threatened to kill herself. The social worker called the girl's mother, who then came to the school with her own boyfriend and her attorney. Marie's mother showed no sympathy for the girl's problem; she refused to do anything except take Marie home and punish her.

The school social worker did not want to leave the matter there. She asked the vice principal and the principal for advice, then called the Hillside police and DCFS. The social worker wanted to have Marie hospitalized because of her suicide threats. The police agreed. The DCFS worker, however, thought that this was an insignificant case and advised that Marie be turned over to her mother. After several hours of haggling with the caseworker and DCFS lawyers (on the phone), both the school personnel and the police thought the caseworker's attitude irresponsible

and decided to handle the situation themselves. The police took Marie to University of Illinois Hospital for observation, where she remained for a brief period of psychiatric counseling.

On May 15, Marie was released from the hospital and was taken by a DCFS caseworker to a foster care facility for adolescent girls, the Living Center for Girls, on West Washington Street in Chicago, operated by the Volunteers of America. She continued to go to her high school in the suburbs.

About a month later, Marie ran away from the Living Center for Girls. The administration of the Center did not call the police, and for two or three days no one there knew what had happened to her. Finally, the Volunteers of America called DCFS and learned that Marie had returned home and become reconciled to her mother. Shortly thereafter, Marie married and left the state. After June 15, 1979, DCFS had no further contact with Marie, and closed the case on April 16, 1981.

We interviewed several of the persons involved in Marie's case. The school personnel felt that DCFS had not handled the case properly. When the mother, the apparent cause of Marie's distress, arrived at the school and insisted on taking the girl home to be punished, the DCFS caseworker sided with the mother. The police and the school personnel then had to take Marie to the hospital themselves. Afterward, neither the police nor the school workers were informed of Marie's discharge from the hospital or her placement at the Living Center for Girls.

The relationship between DCFS and the police is typically very poor; in this case it was no different. The police had no cooperation from DCFS in placing Marie in University of Illinois Hospital. Afterwards, the youth officer involved in the case was never informed of Marie's progress; he had to make several phone calls himself to find out what had happened. He told us that he was upset with the placement of a white suburban girl in a home in the heart of a black urban ghetto. He felt a placement in a more familiar area, nearer to her high school, would have been more sensible.

We would not call Marie's group home placement "inappropriate," but neither would we call it ideal. Frances Barnes, Director of the Living Center for Girls, told us that she had no specific termination date for Marie's stay there because the girl had run away sometime in the second week in June. She said that it was not at all unusual for girls to run away from the home, so the Center hadn't called the police, only DCFS. As to the appropriateness of placing Marie in the home, Barnes said that the majority of the residents are black but that race poses no problem. She described the facility as a sort of "United Nations." Barnes also said that they have had no problems based on location.

The DCFS file on this case is short and concise. Marie's case is not a classic example of abuse or neglect, but it suggests the kind of amorphous case with which DCFS workers, and others,

must sometimes deal. It illustrates some of the shortcomings of the Department, particularly in the area of limited resources. The DCFS caseworker who responded to the call of the school social worker saw the situation as mild and easily resolved; in contrast to many of the cases DCFS handles, it was. However, Marie was threatening suicide; the superficiality of her wrist wounds didn't mean her intention was necessarily superficial. Her placement in an unfamiliar and potentially hostile part of the city demonstrates not negligence but lack of resources. Luckily, and in large part owing to the efforts of the police and the school personnel, Marie's case ended well.

C. Jody and Susan

Commission staff pieced together the details of an abuse case within a single family that involved two sisters, Jody and Susan. The case is interesting for several reasons, not the least of which is the pattern of continued abuse by the mother. Interviewees told us that the abuse of one of the girls first surfaced in 1972. Records we examined also indicated that a child abuse report was made on February 28, 1972, but we found no copy of that initial report. The report had been made to Child and Family Advocates of Evanston (CAFA). Notes in the file state that the records were sent to the Evanston Hospital Administrator but never were returned.

Commission staff spoke with the Director of Social Services at Evanston Hospital regarding the case. She told us that she was fairly certain that a report of abuse of Jody had been made in 1972, but she had been unable to locate the file. She was not surprised that the report had been lost because reporting of abuse in 1972 was rather unsophisticated and informal.

The next contact we noted occurred when Jody was three years old. Evanston Hospital records indicate that she was admitted on March 18, 1973. Jody was treated for a severe burn on one foot. The report raises the possibility that the injury had been caused by abuse, but the incident never was reported to DCFS. However, the mother and Jody were involved for five months in counseling with the Family Counseling Service of Evanston and Skokie Valley. Counseling ended when the mother sent the child to Jamaica to stay with relatives. Staff at that time felt that some progress had been made with the mother.

At the time that Jody was sent back to Jamaica, her sister Susan already lived there with relatives. Both of the girls' parents were Jamaican natives. The cultural differences between Jamaica and this country were to become a significant issue in this case.

Our review of other documentation indicates that when Jody was admitted to the hospital in 1973, she had severe burns, and other marks and bruises. The mother claimed that her babysitter had beaten Jody and that Jody had been burned by pulling a kettle of hot water over onto herself. These documents indicate that counseling was weekly until Jody was returned to Jamaica for almost two years.

The next report of abuse came in November, 1975. The DCFS Central Register indicates that this report was investigated by CAFA (at that time, even abuse investigations were contracted out to private agencies in some cases). We determined that on November 24, 1975 a school community aide for a public elementary school in Evanston brought Jody to the school principal; Jody had marks on her back, a bruised lip, and an infection in one ear. When the aide had questioned Jody about the marks on her back, she had responded that she had been whipped. Jody's mother was called in by the principal the following day, at which time she was told that a referral would be made to CAFA.

CAFA case notes state that a home visit occurred the following day. Jody's mother told CAFA workers during the visit that the child did not act properly. The mother admitted she left Jody home alone because she could not trust babysitters; her lack of trust stemmed from an allegation of infidelity between her husband and one of the babysitters. The mother did not perceive her other child in the home, Karl, to be a behavior problem; Jody, though, presented a problem. To keep her in line, the mother whipped her.

These case notes state that an examination of Jody showed "old whip lash scars and welts across back and buttocks." The mother showed the CAFA workers the leather strap she used to discipline Jody. When a CAFA worker asked if her relatives in Jamaica had whipped Jody, the mother said they had. Karl, just two years old at the time, was described as very hyperactive and aggressive. The worker questioned the mother concerning some of his behavior (spittng, talking back to the mother), but the mother defended him and made it clear he never had been abused.

The CAFA assessment was that the mother was totally overwhelmed by her life. She was pregnant but still working and had very little time to herself. Her own mother had raised eleven children, and her upbringing had been very strict.

A CAFA document dated December 1, 1975, includes additional information about the initial incident and the family. One comment is: "Mrs. _____ sees her problems stemming primarily from Jody's attitude and behavior. The mother is a severely stressed woman who cannot adequately cope...." The notes included with this document indicate that the mother criticized Jody for lying and for "attempting to break up" the mother's marriage. The document states that the mother would be referred for counseling to the St. Francis Hospital Adult and Child Guidance Center; DCFS would be notified by mail; and the principal who had brought this case to light would be kept up to date regarding developments in the case.

Just as DCFS contracts out for most direct services, so did CAFA at that time contract with private agencies to provide treatment. CAFA case notes, as a result, are sparse. Several documents from 1976 repeat what we have already learned. The most

useful piece of information is a notation of another allegation of abuse. Supposedly, Jody was again abused on April 21, 1976, and taken to Evanston Hospital for treatment. Apparently the incident was reported; it was given a DCFS reporting number. However, no disposition of the case is reported, nor did we discover other references to the incident.

By April of 1976, Jody's mother had given birth to another child, Diana. At about the same time that the above abuse incident supposedly occurred, Jody was sent to Jamaica again. At this time, the mother was supposed to be in counseling at St. Francis Adult and Child Guidance Center, but because Jody was returned to Jamaica, counseling ceased, even though there were two other children in the home (Karl and Diana).

The Director of Social Services of Evanston Hospital told us that one of the problems with the case was that only the mother was involved in counseling. She felt that Jody should have been in therapy together with her mother. Jody did cause some of her own problems, she thought, and they might have been avoided in the future had she received counseling also.

Jody next came to the attention of school authorities on the morning of October 21, 1976. A social worker for her elementary school examined her after she came to class with bruises on her arms. School personnel decided to check further and discovered bruises and welts over her entire body. The social worker told one of our investigators that she never will forget having to soak Jody's legs in water in order to get her tights off, due to the amount of dried blood that was causing them to stick.

The girl was taken to Evanston Hospital and CAFA was called in to perform another investigation. The social worker told us that ordinarily she was very pleased with CAFA investigations; in Jody's case, though, she felt that CAFA had done an inadequate job, as had St. Francis Adult and Child Guidance Center. She told us that the treating psychologist at St. Francis refused to furnish school authorities with any records pertaining to Jody after October, 1976, citing his privilege of confidentiality. The social worker felt that he had been manipulated by the mother, just as she had tried to manipulate others involved in her daughter's care.

This CAFA investigation revealed both new and old whip marks on Jody. When CAFA workers interviewed the girl, she said that she had made her mother angry, and her mother had hit her with an ironing cord. She did not know what she had done to make her mother so angry.

When CAFA workers confronted the mother with the facts of the abuse, she said that a babysitter had told her that Jody had picked up her younger sister while standing near a window; the babysitter had been afraid that Jody was going to throw the baby outside. When she told the mother what had happened, the mother whipped Jody with an ironing cord.

CAFA held a staffing the following day with most of those involved at one time or another with the family. One of the workers said that the mother's attitude toward Jody was overly punitive; she mentioned that the mother had once told her that Jody was "evil." This worker expressed concern about Jody's remaining in the home.

From November, 1975, to May, 1976, a psychologist worked with the mother on a weekly basis. Occasional homemaker services were provided. The father refused to participate in counseling of any kind. CAFA terminated the case in 1976 with the following notation:

> Dr. _____ felt that at the time of termination some stresses had been reduced and there had been some improvement in child management and "moderate relief of personal upsets." He recommended that therapeutic treatment with the family be continued when the family was more receptive to it.

The termination report also states that Jody is a scapegoat for chronic abuse and that such abuse stops when treatment services are provided, only to begin again when those services are withdrawn. Recommendations were that Jody be placed in a protective environment, that the parents undergo psychiatric evaluation and counseling, and that the condition of the two younger children be monitored to be certain they were not being abused.

A psychiatric evaluation dated March 14, 1977, states that the mother sees her children as "miniature adults" and could not develop a proper attitude toward the children. His recommendation was that Jody remain out of the home and that additional psychiatric evaluations of the mother be made.

Subsequently, Jody was placed in foster care for about fifteen months, returning home in March, 1978. A doctor who had worked with the family previously recommended that Jody be returned home with strict supervision; instead, she was placed in foster care.

Meanwhile, Jody's mother was referred to Associates in Crisis Therapy, Inc. (ACT). ACT therapists were to develop an assessment of the mother's capacity "to parent" Jody, were to determine the child's therapy needs, and were to develop a counseling relationship with the entire family. Involvement with the family began in July, 1977. One of the early notations in the case file is that counseling sessions were interrupted in the summer of 1977 by the mother's return to Jamaica. The mother returned to arrange for her daughter by a previous marriage, Susan, to come to the states to live. The following description of the family is valuable to a full view of the home situation:

> Their participation is more passive than active not solely from resistance. They are both natives of rural Jamaica. Their culture, religion, and education has not prepared them to conceptualize in ways familiar to native urban middle class white Evanstonians. They are not good candidates for insight based psychotherapy. For them, the request by a stranger for personal information is rudeness. Our culture has allowed psychotherapists the permission to violate such social norms and ask questions about "personal business". In Jamaica such privilege is limited to the family. The judge can grant a psychotherapist the authority to ask, but he cannot convince the [parents] of how giving the answers will help them live their lives better. They have no model for that type of thinking. [The mother] had great difficulty accepting the notion of ambivalence and seemed perplexed by the idea of unconscious motivation. She feels what she feels. She does not feel anything she is not aware of feeling.

The assessment also mentions that Jody was not suffering from any emotional illness or psychotic reaction to her abusive home. She did not understand why she had been taken from her home or what she had to do to go back. She clearly wanted to return home. The official assessment was that she viewed foster care as "exile." Further, the assessment determined that it was likely that Jody had only been abused twice, and characterized the abuse as episodic rather than chronic. The assessment also recommended that the mother and daughter attend joint counseling sessions and that the two should begin unsupervised weekly half-day visits, overnight visits a month later, and weekend visits two months later.

Meanwhile, Susan came to this country. Evanston Police Department records indicate that she first came to their attention in July, 1978. A police officer picked her up following a runaway and, because he noticed bruises, took her to St. Francis Hospital for x-rays and other tests. The officer called DCFS; a worker removed her from the hospital, placed her in emergency care for a few days, and then returned her home.

Shortly before this incident, Jody was found to have been abused while in her foster home and was returned to the natural home. Shortly after her return, abuse of Jody began again. School officials wrote letters to DCFS after Jody appeared at school with a large bump on her forehead. Jody also told school officials that her sister Susan often was whipped for doing "bad things." Another letter was sent to DCFS three weeks later, after Jody came to school with burn marks next to her eye and on her ear. Jody told school staff that her mother twice had burned her accidentally while curling her hair. Finally, a letter to DCFS mentions that Jody stopped attending summer school after Susan's abuse became a matter of police record.

An ACT therapist submitted a progress report dated July 25, 1978, that discusses the entire family's therapy. The report states that ACT had been instrumental in persuading DCFS workers to return Susan to her home following an allegation of abuse made by an attending doctor at St. Francis Hospital. He says that "...our agency took the position that Susan and Jody were best treated in the context of their family."

This assessment adds a number of recommendations for continued supervision of the children. Recommended were continued evaluations for Susan; a clear statement of responsibility from the Juvenile Court judge assigned; presentation of the DCFS case plan in open court; allowing the parents to press a complaint against the abusive foster mother; the possibility of the mother taking a leave of absence from work; consequences for the parents being spelled out clearly if abuse were to continue; and being certain that pertinent ACT records were taken to court by DCFS workers at the next hearing.

ACT referred the family to Developmental Abilities Service (DAS) of Lutheran General Hospital in late July, 1978. DAS case summaries refer repeatedly to Jody's "history" of stealing and lying, mentioning at one point that her foster mother had abused her because of her stealing. These documents also are interesting because they present the first evidence that the mother had been abused as a child--not by her mother, but by her sisters. She transplanted this learned behavior to the United States and to her own children.

Although ACT had referred the case to DAS, it remained active with the family in counseling. One ACT document recommends that the DCFS caseworker remain mindful of past manipulative behavior by the parents; that the family should continue to be viewed as high risk, with the family being adept at denial and projection of blame; that efforts continue to be made to assess Susan's needs accurately; that the only male child in the family also be monitored for possible abuse; and, finally but most importantly, that the caseworker should be prepared to remove all of the children from the home should another incident occur, with the realization that such abuse is representative of a pattern of abuse and not just another isolated incident. The document also recommends that the caseworker keep in mind the possibility of utilizing Criminal Court to establish the father's culpability for failing to protect his children and the mother's inability to learn new "coping behaviors" regardless of the number of opportunities with which she had been presented.

The next document of note is a DAS report dated February 7, 1979. It indicates that Jody's abuse had indeed been chronic and not episodic, as had been reported earlier. One recommendation was that she receive psychotherapy separately from the parents. If Jody were discovered to have been abused a single time more, all of the children should be removed from the home, according to the report.

During the week of February 13, 1979, a public school nurse had checked Susan "from head to foot" and found the following: a swollen and bruised thumb; infected stitches on her forearm; a sore on her toe; and other marks. Susan explained away all of these marks as accidents of one sort or another. A school social worker writing to DCFS stated that it had not been unusual for Susan to appear at school bruised or scratched up. He added that it had been difficult to get Susan to admit what appeared to be

happening in her home. Just the week before this letter had been written, though, Susan had told school personnel that she was very frightened concerning her home situation and that she had been packing her bags because her mother had threatened to send her back to Jamaica. This letter was to present information only, not to make recommendations.

Such was not the case when the school social worker wrote DCFS again on March 21, 1979. The social worker had received a letter from Susan's mother indicating her dissatisfaction with school therapy for the girl. The social worker adds that it is customary to cease counseling in cases of parental disapproval. The letter ends:

> Therefore, unless school authorities or faculty report an incident of abuse, or if the court makes it possible for me to continue seeing Susan, I will discontinue service as of today.
>
> I am sorry to do this because I feel that it is in the best interests of the child that she receives social work services in school. It is important that I provide a monitoring function, as well as help Susan with school and home adjustment.

On March 16, 1979, by order of the Juvenile Court, Jody was removed from the custody of her parents and placed in the Lydia Homes for Children, part of the Lydia Home Association. Following placement, the parents contested the judge's order; he ruled that Jody remain under state guardianship. At this time, Susan remained in the home; DCFS was attempting to find long-term placement for Jody.

Commission investigators spoke with a social worker at the Lydia Home in June, 1981. Only three days prior to our interview, staff there had a discussion regarding the release of Jody to her parents. Several interested parties had attended the meeting, including a psychiatrist from Children's Memorial Hospital who had recently done a workup on Jody. He told the group that Jody should be sent home permanently. At the time of our interview, plans had been to send Jody home only on Sundays; further plans were to send her home for entire weekends and then permanently. One stipulation regarding her return home was that she receive twice-weekly therapy at Children's Memorial Hospital. The psychiatrist indicated that the parents should be involved in therapy with Jody but no plans had been made to provide for it.

After Jody was placed at Lydia Homes, apparently her sister Susan became the regular victim of abuse. A letter from a school nurse to DCFS states that Susan had come to her with swollen and painful bruises on one arm and scratches on the other. She admitted that the injuries had been inflicted upon her by her mother.

Subsequently, Susan was removed from the home and placed at Edison Park Home on March 7, 1980. Edison Park offered Susan a residential setting that kept her out of jeopardy and that provided her with therapy to understand and deal with her prior abuse.

She was allowed to attend her regular high school. A progress report of December, 1980, states that Susan had made a good adjustment to life at Edison Park. From April through October, 1980, the parents had attended thirteen counseling sessions with Susan at the placement. Jody and her social worker had also attended the last three sessions. They planned to continue attending, as a family, in the future.

Documents from Edison Park indicate that Susan's progress had been slow. Susan continued to exhibit anger toward her parents and, at the very best, had "mixed feelings about her family." One document recommended continuing placement, therapy with the entire family present, and one day per month in her natural home, unsupervised. These documents also make it clear that Susan must have been abused on a regular basis while living with maternal relatives in Jamaica.

We learned through interviews with DCFS staff that both girls were allowed to return home for visits after a judge had placed a protective order on the mother not to use physical discipline on them. At one court appearance, the mother was cited for contempt of court because she had physically punished Jody, in spite of the prohibition.

A DCFS caseworker told us that this case was unusual for two reasons: first, because the two younger children were allowed to remain in the home following a finding of abuse of the two older siblings; second, because it is unusual for DCFS to remain involved in a case for so long. She added that DCFS had given this family more chances than many families receive. She said the real problem with the case was that the parents cooperated, to a greater or lesser extent, in counseling, but the abuse continued anyway.

DCFS told us that Jody was returned home on July 20, 1981, with the stipulation that she continue therapy at Children's Memorial Hospital. A DCFS worker was hopeful that the mother also would become involved in family therapy. This same worker told us in August of 1981 that Susan was not to return home in the forseeable future because she still was not getting along with her mother. At that time, the mother was still participating in therapy at Edison Park.

Many of those whom we interviewed mentioned Jamaican culture as a problem in this case. All agreed that Jamaican discipline is much more physical and rigorous than is considered acceptable in this country. The mother simply transplanted to this country the discipline that she had learned there. Also, both girls were used to such discipline because both had spent at least part of their lives in Jamaica. Jamaican culture tends to place male children on a pedestal; that explained why the older girls were abused while the son remained unhurt over the years.

In this particular case, the Evanston public schools had an extraordinarily active and positive role. Case files are replete with letters and other documents from school officials and social

workers regarding both girls and their problems at home and in school.

Apparently, the father did not see any reason to participate in therapy until it was obvious that he would not regain custody of his children. The mother manipulated the system as best she could to regain control of her children. Although she participated in counseling, she learned little.

One of the school officials deeply involved with the case mentioned the abuse by the foster parent on Jody. She noted that DCFS caseworkers had indicated in case notes and other documents several times that Jody had provoked the abuse. She complained that DCFS should make it clear to foster parents that they will not be receiving children who are entirely "normal" for placement in their homes. She felt in this case, and as a matter of general policy, that foster parents should be made aware of the nature of a child's problem and behavior and that all foster parents should receive appropriate training. She said that instead of preparing foster parents for mental, physical, and behavioral problems, DCFS workers instead waited for problems to surface in foster placements. Even then, in most cases, children were removed from the foster home and returned to the original abusive setting, as happened with Jody.

If this same case came into the child protective system today, its outcome should be very different than it has been with this family. DCFS' Division of Child Protection (DCP) performs all investigations of abuse reports. An agency such as CAFA would not be involved in the case initially at all. An agency such as CAFA might become involved as a community resource providing specific services, such as counseling, once the abuse is "founded." The State Central Registry should have been an aid in this particular case because it keeps track of all cases of alleged or founded abuse for a number of years. Sending a child to another country could not thwart the system today, at least in theory.

If this case came to the attention of DCFS today, therapy would be handled in the same way--through contractual agencies. Hopefully, however, more of an effort would be made to coordinate services and to assure that both mother and daughters attended therapy together. Hopefully, today DCFS planning would include the father as a more active participant; we also hope that planning would be done on a long-term basis earlier than it was in this case. Also, the mother's ability to manipulate should have been recognized early on, and stronger action by DCFS and/or the court might have been taken. The suggestion of the psychologist at St. Francis Guidance Center to provide counseling at a time when the family was more receptive to it should not have been used as a reason for all counseling to stop. The family should have been referred elsewhere.

This case presents what some psychiatrists described as a pathological attitude by the mother toward at least one of her daughters. Compounding this problem was that of cultural differ-

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT

TYPE OF CA/N	PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
PHYSICAL ABUSE	Unexplained Bruises and Welts: - on face, lips, mouth - on torso, back, buttocks, thighs - in various stages of healing - clustered, forming regular patterns - reflecting shape of article used to inflict (electric cord, belt buckle) - on several different surface areas - regularly appear after absence, weekend or vacation Unexplained Burns: - cigar, cigarette burns, especially on soles, palms, back or buttocks - immersion burns (sock-like, glove-like, doughnut shape on buttocks or genitalia) - patterned like electric burner, iron, etc. - rope burns on arms, legs, neck or torso Unexplained Fractures: - to skull, nose, facial structure - in various stages of healing - multiple or spiral fractures Unexplained Lacerations or Abrasions: - to mouth, lips, gums, eyes - to external genitalia	Wary of Adult Contacts Apprehensive When Other Children Cry Behavioral Extremes: - aggressiveness, or - withdrawal Frightened of Parents Afraid to go Home Reports Injury by Parents
PHYSICAL NEGLECT	Consistent Hunger, Poor Hygiene, Inappropriate Dress Consistent Lack of Supervision, Especially in Dangerous Activities or Long Periods Unattended Physical Problems or Medical Needs Abandonment	Begging, Stealing Food Extended Stays at School (early arrival and late departure) Constant Fatigue, Listlessness or Falling Asleep in Class Alcoholic or Drug Abuse Delinquency (e.g. thefts) States There is No Caretaker
SEXUAL ABUSE	Difficulty in Walking or Sitting Torn, Stained or Bloody Underclothing Pain or Itching in Genital Area Bruises or Bleeding in External Genitalia, Vaginal or Anal Areas Venereal Disease, Especially in Pre-teens Pregnancy	Unwilling to Change for Gym or Participate in Physical Education Class Withdrawals, Fantasy or Infantile Behavior Bizarre, Sophisticated, or Unusual Sexual Behavior or Knowledge Poor Peer Relationships Delinquent or Run Away Reports Sexual Assault by Caretaker
EMOTIONAL MALTREATMENT	Speech Disorders Lags in Physical Development Failure-to-thrive	Habit Disorders (sucking, biting, rocking, etc.) Conduct Disorders (antisocial, destructive, etc.) Neurotic Traits (sleep disorders, inhibition of play) Psychoneurotic Reactions (hysteria, obsession, compulsion, phobias, hypochondria) Behavior Extremes: complaint, passive, aggressive, demanding Overly Adaptive Behavior: inappropriately adult inappropriately infant Developmental Lags (mental, emotional) Attempted Suicide

From The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect, by Diane D. Broadhurst and James S. Knoeller, U.S. Department of Health and Human Services, User Manual Series, August 1979, p. 15.

ences. At some point it is only logical that DCFS decide that a family must conform to societal standards of child care or forfeit the right to care for children who are being abused. In this case, the mother had years of professional counseling to learn from her mistakes and correct them, but she never did. Any parent whose only comment about the abuse sustained by Jody at the hands of her foster mother is, "she put bruises on top of where I marked Jody," has a problem that demands serious treatment.

Commission staff had occasion to address several issues regarding this case with a DCFS supervisor. He told us that he felt the case had been handled extremely well and that in some ways it was a model case. The supervisor explained that he felt that all of the family members were actively communicating with one another through counseling sessions. At the time of our interview in 1981, the goal was still reunification of this family.

It is important that professionals and others learn to recognize indications of child abuse. School personnel in this case paid close attention to the two girls and were able to intervene when they felt that the girls were being abused.

D. Paul

Paul was born on October 21, 1978. He sustained injuries to his leg on May 24, 1979, allegedly as a result of parental abuse. Paul was hospitalized the following day and DCFS took custody of the child on May 30, 1979. On April 11, 1980, Judge Arthur N. Hamilton entered a finding of neglect regarding the parents and cited them for maintaining an environment injurious to the health of their child. Paul was then placed in foster care, in which he remains to this day.

The natural parents in this case had a prior history of abuse with DCFS. Their daughter, Diana, born November 20, 1974, was placed in adoptive care in 1979 after being abused by her parents. Another daughter had died in the home, supposedly of Sudden Infant Death Syndrome, in 1977. Some caseworkers viewed the death as highly suspicious, but there was no evidence to substantiate death by unnatural causes.

One of the people we interviewed was an assistant state's attorney who had been the CPS worker on the case while employed at DCFS. After receiving an anonymous call on May 24, 1979, with respect to Paul's injuries, she told us, DCFS workers contacted the family and persuaded them to take Paul to Illinois Masonic Hospital for treatment. Doctors there stated that Paul's injuries could not have been self-inflicted or caused in the manner described to them by the parents. The former CPS worker told us that she made a very quick determination that the parents were unfit and that adoption would be the best course to pursue for Paul's sake if drastic steps could not immediately rehabilitate the parents. She mentioned that this was the only case she could

recall in which such a decision had been made so quickly; she was influenced principally by reading of the parents' prior history of abuse and by the attitude and lack of concern shown by the mother. The worker was also concerned that while the father might not have been an active abuser, he did not appear to be strong enough to prevent further abuse from occuring. She added that Paul's injuries seemed to be duplicates of Diana's abuse and that neither parent would even admit that Paul had been injured. Finally, the mother completely refused to cooperate in any way with DCFS. She had asked both parents to sign the service plan but they refused, saying there was nothing wrong with them and that they didn't need any help.

A Commission investigator also spoke with an emergency room social worker at Illinois Masonic. She was a member of the hospital's SCAN team (Suspected Child Abuse/Neglect) that made the determination that Paul probably had been abused. She told us the parents said that Paul had injured his leg by sticking it between the slats of his crib. The social worker told us that even if he had done what the parents had described, he would not have sustained a chip fracture and heavy bruises to the leg. She did not think it likely that Paul would have wedged his leg through the slats because he did not appear to be a very active baby.

Paul also had a bruise on his nose, a bruise on one upper eyelid, and a bruise on his right buttock. The mother explained these injuries away by saying that her son was very active. However, the social worker told us that the child was so inactive that originally he had been diagnosed as "developmentally delayed."

The social worker also told us that the mother appeared to be defensive, guarded, and agitated. When asked questions about Paul's injuries, she often would answer, "none of your business." Following Paul's admission to the hospital, both parents did visit, but the mother did not come as often. The social worker felt that the father acted appropriately toward his son, while the mother did not. Both parents refused all offers of counseling from staff at Illinois Masonic.

A Commission investigator interviewed the DCFS worker who took the anonymous child abuse telephone call and who interviewed Paul's parents on May 24, one day before the parents brought the baby to the hospital. (This was not the CPS worker assigned to handle the case after Paul's hospital admission.) She told us that she was unaware of any prior abusive history with this family when she made the home visit on May 24, because the previous abusive incidents had occurred in another county. At the time of those incidents, the state had no computer soundex system which could have alerted her to an abuse history in another part of the state.

When she went to the parents' home to interview them, she knew that Paul had been abused. She told us that the parents could offer only poor excuses and inconsistent explanations regarding the baby's injuries. At the time, she felt that there

was no way the child could have incurred the injuries as described by the parents. She also mentioned that she had seen the same types of injuries on abused children before, and had heard the same sorts of explanations from parents before. Further, she felt that Paul was too "placid" a baby even to attempt to climb through his crib as the parents had described.

We asked why the worker did not demand that the parents take the child to the hospital immediately, or why she had not taken emergency custody of the child. She responded that, although the mother denied the seriousness of the situation, by the time she concluded the interview, the parents "might" have been willing to take Paul to the hospital on their own. Also, the father had been very cooperative. Furthermore, since she knew the case to be serious, she said she knew a follow-up team from DCFS would be sent to the home the following morning if the parents failed to take the child to the hospital. As we have noted, the parents took Paul to the hospital the following afternoon.

When we asked the worker if she would handle the case differently today, with the aid of hindsight, she said that she would: "Knowing what I know now about her [Paul's mother], I would get the police."

Commission analysis of DCFS records reveals that on May 25, 1979, a CPS worker called a DCFS field officer in Kankakee, requesting information on the other child in the family, Diana, who had been adopted. The CPS worker learned from the field officer that DCFS was involved with the family in 1975, when Diana was only three months old. At that time, 75% of Diana's ribs had been broken and were in eight different stages of healing, she had a skull fracture, and she was extremely malnourished. The field officer said that the parents appeared to have no remorse for what they had done, and though DCFS workers "practically lived at their house" for a period of time, no improvement ever was made.

This same field officer also said that after Diana had been placed in foster care, the parents never attempted to visit her until she had been in placement for more than a year. Even after that, they failed to show up for most of their scheduled appointments. After two years, the parents went to a mental health center for therapy but refused to cooperate in counseling. This worker also recalled that, over a year before, she had received a call from a Chicago hospital stating that a sibling of Diana had been brought in DOA at age two months. At the time of her death, she weighed less than her birth weight.

The DCFS records also indicate that the mother had given an entirely different account of Paul's injuries to an emergency room nurse than she had given to others involved with the case. She told the nurse that Paul had hurt himself when she left him in a chair to go get the mail. She said that he had fallen out of the chair and sustained injuries that way.

When the mother left the hospital the day that Paul was admitted, she refused to allow hospital personnel to feed him any fruits or vegetables, stating that he needed only whole milk and meat. By the time he was released from the hospital, he had gained weight and no longer appeared malnourished, and had become more active.

On June 7, 1979, the CPS worker made the following recommendation:

> Due to the past history of this family, no evidence that the [parents] have taken any action that would enable them to become effective parents, Paul's serious injuries, and the [parents'] lack of remorse, uncooperativeness; this worker believes that Paul's interests will best be served by quickly freeing him for adoption if the [parents] do not make any effort at rehabilitation.

The final notation in the record is that the case was being referred to another worker for private agency long-term foster care, with the recommendation that Paul be placed in a prospective adoptive home.

Basically, the DCFS plan was to continue to maintain Paul in foster placement, provide needed medical care for him, and allow the natural parents their court-ordered visits. Children's Home and Aid Society (CHAS) was to provide counseling for the parents each week, supervise visits between the natural parents and Paul, and continue to submit regular progress reports to the Juvenile Court as required.

In speaking with the CHAS social worker assigned to this case, we learned that the worker knew very little about the history of the family she was treating except that a daughter had died and another had been placed in adoptive care. The worker was unaware of the reason for termination of parental rights for Diana. She did know that the parents had been involved in some sort of counseling regarding their daughter Diana but that it had failed. The worker said that the parents had been very vague about this counseling and only told her that it took place somewhere in Will County.

The worker explained that her function was to assist the parents in understanding the proper attitude toward their son and to assist in the supervision of parental visits. She told us that the parents consistently had denied abusing Paul, that they felt they had been the victims of "vengeful" neighbors who had made the anonymous call, and that the court had based its decision on what had happened with their daughter Diana.

She was seeing the parents weekly when we interviewed her. While there had been some cancellations, generally the parents made their appointments. However, the worker mentioned that the parents were resistive to the intended effects of counseling: they saw counseling as a means to regain custody of their child,

rather than as an opportunity to correct their own problems. She described their interaction with Paul: the father consistently was affectionate and "fatherly" toward Paul in his visits, while the mother was much more nervous and sometimes did not show up for visitation.

The CHAS worker told us that the mother is a very immature woman. As a child she was abandoned and subsequently spent a great deal of time in foster homes. She had never developed trust in parental figures. The worker saw hope in the father's approach to his son, though.

The worker told us that though it was apparent the parents had been neglectful toward Paul at the time he was hospitalized, she did not feel that they had abused him. When asked how she would feel if Paul were immediately returned to the parents, she told us that she did not feel the parents would abuse him. She quickly added that she had her apprehensions about the mother, though. She characterized the mother as a very needy person herself, and that if she had a bad day, undoubtedly she would deal with her own problems and probably neglect Paul. Then the worker also mentioned that the parents both lack good common sense and would be likely to neglect Paul's medical needs. (A tumor in Paul's kidney was diagnosed after he had been placed in foster care.)

The worker told us that the parents would be up for review in July, 1981. She conceded that they might not be granted custody of Paul but that she wanted to continue counseling and not "throw in the towel."

During our second conversation with this worker, we learned that her original case plan was developed on February 24, 1981. The father signed the plan on March 17, but the mother was not present to also sign. Later, when she read the plan, she refused to sign it because she did not agree that she needed weekly counseling, nor did she agree that she needed to strengthen her parenting skills.

On October 20, 1981, both parents signed a plan developed by the CHAS worker. The new plan called for bi-weekly visits at the CHAS offices between the parents and Paul, supervised by CHAS workers. Each of these visits would be followed by one hour of counseling with the CHAS caseworker. The parents were expected to acknowledge marital problems that led to Paul's abuse, acknowledge parental problems that led to Paul's removal from the home, and show serious concern and common sense regarding Paul's medical condition and what to do if he suddenly became ill.

Commission staff also analyzed CHAS documents that reflect chronological contacts with the parents. There were a total of 42 contacts that should have included visitations with Paul and/or counseling with the CHAS caseworker. Of the 42 contacts, the parents cancelled without cause 24 of them. Following each such cancellation, a letter was sent to the parents, informing them of

their obligation to appear or cancel contacts in advance and with good cause. Of the 18 contacts that were made, three were partial in that they involved only one parent, the parents just visited with Paul, or the parents just came for counseling.

It is interesting to note that the parents failed five of eight contacts after the new plan was developed. Further, after the service plan expired on January 19, 1982, CHAS continued counseling without any new service plan. As of March, 1982, counseling by CHAS continued in spite of the decision to terminate their parental rights to Paul.

A Commission investigator spoke with a supervisor in Adoptions for DCFS, who told us that Paul's case was transferred to the Adoption Unit in November, 1980. She told us that the plan of DCFS Adoptions was not to offer any direct service to the parents but to allow CHAS to continue its counseling, with occasional DCFS monitoring. She added that workers in Adoptions had seen little parental progress and felt that counseling could go on forever with nothing changing.

This worker explained to us the necessity of having a good service plan signed by both parents. In the absence of such a plan, at a hearing to terminate parental rights, the parents could claim that they had never known what was expected of them and therefore were incapable of meeting agency goals.

Following a February 20, 1981 screening of this case, CHAS did not consider adoption to be the best plan for Paul. The DCFS Adoptions worker, on the other hand, thought it to be the best plan by far, based on the length of time that Paul had been in foster care, his age and degree of attachment to his foster parents, his medical problems, and, most importantly, the lack of progress by the natural parents. She made it clear that if the natural parents really could indicate some progress, then termination of their rights would be reconsidered.

Our investigator asked her what would happen if a couple decided not to rehabilitate but to attend counseling regularly in order to get their child returned to them. She admitted that if a family were sophisticated enough to know "how the game is played," there would not be much anyone could do about it. As long as parents show an interest in their child, there is not too much that workers or court personnel can do about it. She also commented that someone can go through long-term counseling and get nothing from it. Her unit was in the process of devising a service plan that would minimize the possibility of anyone attempting to simply drift through the system in this way.

In May of 1981, a Commission investigator interviewed the assistant state's attorney handling the case. She told us that she felt the parents had achieved a good deal of progress toward rehabilitation; at the same time, they had far to go before Paul could be returned to them. She told us that, based on information presented at the most recent hearing, there were insufficient grounds for termination of parental rights.

The assistant state's attorney told us that she too had been impressed with the father's attitude toward his son, but the mother left a good deal to be desired. She also said that the court will not terminate parental rights based on the action or inaction of only one of the parents. Both parents must be found to be unfit.

We asked the assistant state's attorney how the court or the workers assigned to a case could determine whether parents really were being rehabilitated or simply going through the motions. She stressed that standards in these cases are necessarily very subjective, but a good social worker will notice any inconsistencies in approaches to the child taken by the parents. Such inconsistencies should be enough to raise doubts concerning the parents' real motives toward regaining custody of the child.

She told us that if the parents continued to make progress, the adoptions screening committee would not seek termination of parental rights. She added that, in all likelihood, another six-month extension would be granted at the next court hearing and a revised service plan to prepare both Paul and his parents for his return home would be implemented.

Since these interviews, we have learned that the case went before the screening committee on March 5, 1982, at which time DCFS filed a petition for termination of parental rights. The basis for the petition was failure by the natural parents to correct behavior and make reasonable progress toward rehabilitation. We were told that if the parents decided to contest the termination decision, as they had done with their daughter Diana, the case might go to trial around September, 1982. Based on other cases of this nature, the trial probably would take a year to complete. If uncontested, we were told, Paul could be free for adoption in six months.

E. Lucine

The fifth case of abuse that we will present occurred in Des Plaines, Illinois, on July 11, 1980. Two-month-old Lucine was taken by her mother to Holy Family Hospital. The case came to the attention of the Des Plaines Police Department and a police officer called DCFS on the same date to notify them of an injury to a child.

Lucine's mother told DCFS caseworkers that her husband came home from work about 3:30 p.m. and found Lucine crying. He sat down on the floor next to her, grabbed her by the right arm and leg, and flipped her over so that she fell on her knees. He then took Lucine upstairs to change her, where he held her upside down and dropped her on the bassinet. The mother took her to the emergency room for treatment of a fractured right leg. Lucine was admitted for further observation. Eventually, her leg was put in traction, and she was treated for head, neck, and back injuries.

Although DCFS registry checks indicated no prior abuse history, DCFS workers learned that the father had beaten both his wife and his daughter on several occasions.

At the time of this incident, Lucine had two older sisters living in the home with her. When CPS workers contacted the mother following Lucine's hospitalization, she told them she planned to move the other girls to her brother's home in Chicago, where they would be taken care of by their grandmother. CPS workers also learned that Holy Family Hospital Emergency Room records reflected treatment of Lucine just two weeks earlier. At that time she had been treated for bruises on the buttocks, arm, and face.

CPS arranged for Holy Family Hospital personnel to examine Lucine's sisters for possible signs of abuse before they were placed with their uncle. Neither showed any sign of physical abuse.

On July 11, the father was arrested and charged with beating his wife and aggravated battery of his daughter.

We examined the case notes of the principal CPS investigator assigned to this case. They reflect a five-day period of investigation. This worker characterized the abuse of Lucine as the most serious that could be designated on the investigation form.

On July 14, he contacted staff at Holy Family Hospital, representatives of the Des Plaines Police Department, the family doctor, the mother, and both of Lucine's sisters. The following day he spoke with the investigating officer of the Des Plaines Police Department. The day after, he spoke with the girls' aunt and other officers of the Des Plaines Police Department.

The Des Plaines police report confirms much of what is stated in the DCFS case notes, adding some detail. When the father came home about 3:30, the family's two dogs began to bark and Lucine began to cry. The father offered Lucine a bottle, which she refused. He then shattered the bottle against the wall, saying, "If she doesn't want her bottle, she'll starve!" Next he flipped the child over in mid-air so that she landed face-first on his leg. Finally, the father carried his daughter upstairs, shook her by the leg, and dropped her head-first from about six inches above the changing table. When his wife confronted him, he struck her in the throat and then gave her Lucine.

Without a telephone, the mother had to wait for her own mother to get home with a car.

The CPS investigator's notes state that the mother claimed to have seen bruises on Lucine four to six weeks before July 11, and that she may have seen similar bruises on her other daughters. She said that she suspected her husband of beating the girls but could never prove it because he never did it in front of anyone--until he broke Lucine's leg. Although the mother compared her husband to an "animal" who would kill her daughters if left alone

long enough, she had dropped her intentions of pursuing a divorce because she had no money to live on her own.

The CPS worker's recommendation was that the mother and the grandmother be given a chance to take care of the children, as long as "extensive counseling and protective services monitoring" were provided to both of them. It was also recommended that resources be directed toward getting the mother involved in community-based counseling so that she could respond appropriately to her children's needs in the future (that is, she should not wait several hours to take one of her children to the hospital if badly injured).

When these case notes were written, the father was already incarcerated. The notes state that when he is released from prison, he must be given intensive counseling if he is to return home so that the abuse will not recur.

The case was referred to Family Guidance Centers. The Glenview FGC was to provide intensive counseling and protective service monitoring.

Commission investigators spoke with Bruce Paynter, a Cook County Assistant State's Attorney, who confirmed that the father had been arrested and charged with aggravated battery and battery for the injuries inflicted on his wife and daughter. When we spoke with Paynter on October 23, 1980, he told us that several hearings had been held but that the case had not yet come to trial because the father had an unrelated jury trial on a burglary charge pending in DuPage County that was to begin on November 17. Paynter said the outcome of that trial was crucial to his own handling of the trial for aggravated battery and battery.

Paynter mentioned that all child abuse cases are difficult to prosecute in court, and this one was no exception. One factor that probably would enter into the discussion in court was simply the mother's word against the father's. Further, it was unclear from several reports whether Lucine's leg might have been broken before the father picked her up and dropped her. If Lucine had been irritable before that, as apparently she was, she might have sustained the injury some other way. That the parents struggled with one another while the father continued to hold onto Lucine further obfuscated the issue; it might be difficult, Paynter told us, to prove that the father had caused the injuries and not the mother--or both parents together, inadvertently.

Paynter wanted to await the outcome of the other trial before settling on a prosecuting strategy. If the father were found guilty of burglary in DuPage County, he could accept a plea agreement on the battery charges and the father would have to serve his two sentences concurrently. If the father were found innocent on the burglary charges, Paynter said he would not initiate a plea agreement with him but would go to trial.

Ultimately, the father pled guilty to the burglary charges and was sentenced to three years in the Department of Corrections' minimum security facility, where he was to undergo psychiatric testing following alleged suicide attempts. The father entered into a plea agreement on the charge of aggravated battery and, on February 24, 1981, was sentenced to four years in prison. The four-year sentence was to run concurrently with the three-year sentence for battery, less time served. Lucine's father was paroled on April 2, 1982, with discharge from parole scheduled for July 11, 1984.

Our investigators spoke with a DCFS supervisor regarding this case. He told us that he had visited the home himself and found the mother's house orderly and the children fine. He said that the mother hoped to receive her GED and eventually find a job. Because the mother was doing well and the father was still in prison, DCFS closed its case on the family on September 16, 1981. The supervisor told us that before closing the case, DCFS staff told the mother how to apply for Aid to Dependent Children (ADC) benefits and how to contact Parents Under Stress for support.

We also spoke with two representatives of the Family Guidance Centers. Family Guidance Centers provide comprehensive mental health services to both children and adults for a variety of problems. Under the Center's DCFS contract, comprehensive psychosocial treatment and intervention for abused and neglected children and their families, when referred by CPS, are provided. The goal of these services is to keep children out of placement.

We were told that the mother had been receiving two hours of counseling each week, beginning in July, 1980. One of the workers told us that the mother was only 19 years old and already had three children to care for. She had been extremely dependent on her husband and even upon her mother, with whom she lived intermittently. The mother knew the father was abusive but did not know what she could do about it. She had wanted a divorce but did not have money for legal fees or to raise the children. The mother was very nervous just seeing her husband at the trial and was very anxious about his being released from jail.

At the time of our interview, we were told that the mother had become more realistic about her situation, had been looking for new living arrangements, and had acquired a night-time job at a pizza parlor. Because she had been living with her mother, no homemaker services were proferred. We were also told that one of the older daughters had adjusted well to the changes in her life, but that Lucine still did not trust people.

The mother and her children received counseling at Family Guidance Centers from July, 1980, to August, 1981, when the agency closed its case with the family. Final recommendations were that the mother apply for ADC benefits; that she continue working toward her GED; that she find a "satisfying" job and appropriate day care for her three children; and that she contact Parents Under

Stress--virtually the same recommendations as those referred to by DCFS. The case is now officially closed.

F. Conclusion

1. An Overview of the Problem

I thought I was the lowest-down sonofabitch that could ever walk, to harm my child that way. After I beat her, I felt guilty the whole damn day. I would sit home and think about how rotten I was. Then I would tell myself that if she didn't deserve it one way, she deserved it another. She was trouble, but she didn't deserve what I was dishing out.

*

A lot of times, I hoped somebody would have caught up with me. I was sending her to school with black and blue marks all over her and she couldn't sit down. But the Chicago schools never said nothing. It really seemed like they could have cared less. It was only when I moved out to the suburbs that the schools caught up with me.

*

The way you were raised is the way you swear you will never raise your kids and it ends up that way because you don't know any other way to do it.

These comments were all made by parents who had abused their children. They were quoted anonymously in an article in the Chicago Sun Times on March 6, 1980. All were members of Parents Anonymous, a national group that gets abusive parents together to discuss any problems that members may have, and which will be discussed later in this concluding section.

Some abusive parents love their children very much. Some do not intend to hurt their children. Others do not seem to comprehend what they are doing to their children. Some of these parents are victims themselves--victims of abuse when they were children, victims of spouse abuse, victims of an isolation with which they cannot deal. Many have become parents while still very young. They have no idea what a parent's responsibilities are or how to care for and properly discipline children. Many neglect their children simply out of ignorance, not malice.

Others are malicious. Some intend to harm their children. Some, as we will see in the next chapter, inflict such harm that their children die. Luckily, these people are in the minority.

Regardless what a parent's intention may be, the result can be the same. An abused child is just as abused if the abuse is inflicted intentionally or by "accident."

The amount and intensity of violence in our society--particularly toward the young--is a logical starting point in understand-

ing the dynamics of child abuse and neglect. One book that addresses this issue is Behind Closed Doors: Violence in the American Family, by Murray A. Straus, Richard J. Gelles, and Suzanne K. Steinmetz (1980).

All findings come from a 1976 survey of 960 men and 1,183 women. The major limitations of the study are lack of results from single-parent families, an interview completion rate of 65%, and exclusion of data from families in which all of the children were under the age of three at the time of the survey.

The early statistics indicate that American attitudes toward slapping and spanking seem to be very liberal. Seventy percent of the respondents viewed slapping or spanking a 12-year-old as necessary; 77% thought that such an action was normal; and 71% viewed either act as "good." The authors discovered that childless persons more often sanctioned slapping and spanking than did those with children of their own. Younger respondents were more likely to view slapping and spanking as necessary, normal, or good. The greatest number who saw these sanctions as necessary were under 30. However, a significantly high number of respondents over 50 agreed.

According to the authors' projections from this study, the following would occur sometime between the ages of three and seventeen for the average American child: 71% of children would be slapped or spanked; 46% would be pushed or shoved; 20% would be hit with an object; 8% would be bitten, kicked or punched; 3% would be threatened with violence with a gun or knife or would have a gun or a knife used on them; and 73% would experience some form of violence at the hands of their parents.

The authors' research told them that males tend to be beaten or more severely punished more often than females, perhaps because our society thinks that violence "toughens them up."

These three researchers repeat the opinion cited earlier in this report that Midwesterners seem to be more violent toward their children than people from other areas of the country.

The authors conclude from their research that unless we want violence to escalate in American families, we must change some of our most fundamental attitudes and beliefs.

According to two of the foremost experts on the subject of child abuse and neglect, Ruth S. Kempe and Henry Kempe (Child Abuse, 1980), abuse occurs in the presence of four factors: (1) the parents have a background of emotional and physical deprivation and perhaps abuse as well; (2) a child is seen as unlovable or disappointing; (3) there is a crisis; and (4) no effective "lifeline," or link to sources of aid, exists at the moment of crisis.

The Kempes state:

> With child abuse the whole family is disturbed and not each needy member alone. Experience over the past twenty years has taught us that it is futile, and even disastrous, to return an abused child repeatedly to a family that exists in name only, that is not and never will be capable of providing a nurturing environment, and that may well destroy the child unless he is promptly and permanently removed. But is it possible to make such grave diagnostic assessments of families early in treatment? In general, it is not only possible, but essential--and often lifesaving. Further, to stop incurable parents from destroying their child is an act of mercy not only to him but to them as well. This is one of those areas where society must look after the best interests of all concerned, through early intervention by the court as parens patriae.
>
> All the disasters we experienced took place in situations where optimism about the successful progress of therapy was allowed to overrule the evidence.

The Kempes cite the fourth factor--the absence of a "lifeline"--as the most significant factor in child abuse situations. In an article entitled "The Role of Individual and Social Support in Preventing Child Maltreatment" (in Protecting Children from Abuse and Neglect: Developing and Maintaining Support Systems for Families), Benjamin Gottlieb presents a list of "impediments to formation of supportive social ties." They are:

--Family members lack the skills necessary to maintain supportive relationships.

--Family members participate in few social situations so that there is little opportunity to form supportive relationships.

--Family members are overburdened by the demands of everyday living to the point that there is no time to develop personal attachments.

--Family members subscribe to the norm of self-reliance in matters pertaining to the management of stress, particularly stress relating to the parenting role.

Family isolation as a contributing factor in child abuse and neglect leads the Kempes, in Child Abuse, to state:

> Child abuse is less common in families who have other relations living with them. Children in these extended families can count on a number of loving adults for protection and care. If families could come to lead less isolated lives in the community, so that the arrival of a new baby in the neighborhood were again a reason for community celebration and the parents could turn for support to a larger circle of neighbors and friends, then children's well-being would be far better assured.

Jose D. Alfaro directed a study entitled "Summary Report on the Relationship Between Child Abuse and Neglect and Later Socially Deviant Behavior," for the New York Select Committee on Child Abuse (1978) ("the first, and perhaps the only, legislative committee devoted solely to the issues of child abuse and neglect"). In this study, both child abuse and neglect are placed in the broader perspective of the victim and abuser in society. The study makes clear, through specific findings, that unless abuse and neglect are addressed immediately and comprehensively, other members of society will pay a price.

The report's preface quotes Dr. Shervert Frazier, once Deputy Director of the Columbia University Psychiatric Institute, who refers to his study of murderers, all of whom had been "the victims of remorseless physical brutality when they were children," and also to Judge Nanette Dembitz of New York City Family Court, who said that "the root of crime in the streets is the neglect of children." The study suggests a "definite relationship" between child maltreatment and juvenile criminality: "[M]altreated children have a significantly greater likelihood of becoming delinquent or ungovernable. Though the data is conservative, the rate of juvenile delinquency among families in which abuse or neglect have occurred is considerably higher than among the general population of children living in the same communities."

The authors refer, in their section on specific findings, to the fact that they relied on official records for their information. They note that one problem with reliance on official records is simply that child abuse and neglect are under-reported: despite registries, hotlines, and publicity, child maltreatment is not reported as frequently as it occurs.

Nevertheless, the study found that as many as 50% of the families reported for abuse or neglect had at least one child taken to court as either delinquent or ungovernable; in the county with the most complete set of records, 64% of the families were in that situation. In the county with the best reports, the rate of juvenile delinquency and ungovernability among children who had been reported as abused or neglected was five times greater than among the general population.

In three counties, 35% of the boys and 44% of the girls reported to a court as either delinquent or ungovernable had previously been reported as abused or neglected. Children reported as abused or neglected tend to be more violent than other delinquents. As an example of this violence ratio, the study points out that in the general population of delinquents, less than 1% of all delinquency contacts were related to homicides, but among the abuse/neglect delinquents, this percentage was an incredible 29%.

Finally, selected short excerpts from the study's conclusion follow:

One fact is resoundingly clear: a considerable percentage of children, as seen in both the 1950's and the 1970's sample, were abused or neglected and reported as delinquent or ungovernable when they were older.

An important factor in the relationship between child maltreatment and juvenile misbehavior, highlighted in this study, is the amazing lack of services provided to most children and families. The complaint that we have improved reporting laws but few services are available to respond to new cases is almost universal.

In both samples in the study, the prime services provided, if they are to be called that, were either placement or casework supervision, and for most cases, nothing else. It is possible, of course, that the families involved needed nothing else, but the outcome in terms of the later problems of many of the children indicates that more was needed, unless the children and parents are going to be discarded as hopeless. The criticism that child protective services does not do much for the child--that it is oriented towards helping the parents--is not a novel perception, but it is true. Most services, most child protective efforts, are directed towards getting the parents to stop the abuse or neglect. Little is done to help the child overcome the experience of being abused or neglected. Abused and neglected children need mental health services to undo the emotional damage of child maltreatment.

Many of the families in the study required intensive, long-term help--perhaps for a generation or more. In one sense, they got it in the form of repeated but intermittent involvements with the child protective or juvenile justice systems as individual problems were brought to the attention of agencies and courts. But there was no long-term commitment to supporting families with an organized array of services to help them overcome their problems. We must face the fact that some families will require this kind of help for a long period of time.

2. Neglect vs. Abuse

One of the findings in the report prepared for the New York Select Committee on Child Abuse, cited above, is: "The placement rate in child neglect cases was higher than in child abuse cases, indicating that neglect is a more intractable problem." The report states that "[t]his finding indicates that neglect may be more difficult to treat than abuse, that protective agencies find abuse more amenable to treatment. As the major study on child neglect indicates, neglect 'is chronic, pervasive, resistant to specific treatment, and transmitted in inter-generational cycles.'"

One of the series of User manuals from the National Center on Child Abuse and Neglect is entitled Child Neglect: Mobilizing Services. Its authors are Carolyn Hally, Nancy F. Polansky, and Norman A. Polansky. This 1980 manual mentions that CPS should

take "lead responsibility" for the marginal or neglectful family and should not prioritize its services to respond only or most quickly to children who apparently have been physically abused. Of course, some hard decisions regarding response and treatment must be made based on the severity of the case, but the authors make the point that neglectful situations frequently lead to abusive situations, and neglect can be fatal.

The report's definition of neglect follows:

> ...a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience available present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities.

There are many definitions of neglect. Strangely enough, many state laws that mention child neglect are silent with regard to a definition, or provide a definition so broad that it can be applied to almost any child's situation.

The authors indicate that abuse generally is made up of a single or series of discrete occurrences, whereas neglect tends to be chronic. They state that neglect often occurs in family situations in which one or more parent is unable to form a personal relationship with a child.

In discussing treatment, the authors indicate that it is preferable for children to remain in their own homes, as long as protection and aid can be provided so that the children are not neglected. Problems with removal of a child include the marginal quality of many foster homes, the general lack of resources (such as foster homes) in many areas, the trauma to the child, and the tendency of neglectful parents to "replace these children with more children." Finally, the authors say that it is cheaper to maintain children in the home than to remove them, a possible consideration in some cases. The two types of care recommended as being very helpful in most neglectful situations are day care and homemaker services. Homemaker services involve volunteers or "professionals" being sent to a home to teach basic skills such as providing meals, maintaining the upkeep of the home, and budgeting income. The authors state that homemaker services are the most promising new service, an area that they recommend be expanded.

The authors spend a good deal of time discussing placement of children from neglectful homes. Several excerpts from their discussion follow:

> ...the plan to place a neglected child with a substitute family must be part of, not independent of, an overall treatment plan designed to meet the individualized needs of the child and his or her parents. ...The responsibility for making the decision should be shared by a team of professionals--the CPS and foster care supervisors and workers, a pediatrician, a

> psychologist, a child development specialist, the juvenile/family court judge--and by the family members....The parents and the child should participate as fully as possible in these decisions.

The decision to place may be clear-cut or obfuscated by many factors. Placement should occur in the following situations:

> The child is in immediate danger due to: severe malnutrition; environmental failure to thrive; abandonment by the parents; severe parental mental illness; or severe parental substance abuse.

> The family is experiencing a situational and temporary crisis, such as hospitalization of the mother, and emergency services such as 24-hour homemaker services are not available.

However, in many cases the weaknesses of the parents in meeting their children's needs must be weighed against their strengths, as well as against the children's attachments to the natural parents.

The authors address services that should be provided to natural parents also:

> In most current foster care programs, treatment for the biological parents does not receive sufficient attention. Improved housing, better public assistance, job training, and better physical health care can improve these parents materially. Supportive counseling, supplemental services, and hospitalization are necessary for some of these parents. Many of these parents require therapy for intrapsychic or personality problems that have prevented them from being adequate parents and productive members of society.

The authors of the User manual conclude that many neglected children may die or become physically handicapped. Those who do not almost always become "psychologically crippled."

This entire issue of neglect is addressed in a paper entitled "Neglect: Is It Neglected Too Often?" by Al Kadushin in Child Abuse and Neglect: Issues on Innovation and Implementation (1977).

Kadushin states that neglect is ignored far too often compared with the attention and focus given to child abuse. As evidence, Kadushin refers to the late adoption of state laws requiring mandatory reporting of neglect; the literature, which shows that between 1967 and 1977, only three books were written about child neglect, all by the same authors; and the fact that at the conference at which Kadushin's paper was presented, only two of 24 workshops focused exclusively on neglect. Kadushin finds this state of affairs puzzling, to say the least, because every statistic he analyzed showed that many more children are neglected than are abused. The National Clearinghouse on Child Abuse and

Neglect showed twice as many cases of neglect when compared with abuse, using 1975 statistics. This information showed that in states with larger cities (such as New York and Michigan), the ratio of neglect cases to abuse cases was as high as 6:1.

To explain this apparent imbalance, Kadushin suggests that neglect is "less medical" and is not included in the umbrella term "battered child syndrome" and is therefore easier to ignore; that neglect is far less "dramatic" and therefore easier to ignore and consider inconsequential; and that provision of services for neglect cases is more expensive, since much neglect results from controversial social issues such as unemployment.

One of the sources to which Kadushin had referred in stating that only three books had been published that dealt with neglect was Child Neglect: Understanding and Reaching the Parent (1972), by Norman A. Polansky, et al. Polansky was also the author of the HEW report, Child Neglect: State of the Knowledge.

These authors state that child abuse and neglect need not go hand-in-hand:

> We have seen children who are well-fed, well-dressed, well-housed and yet treated cruelly....We have seen other children who undergo cold and malnutrition and periodic abandonment, but have never been struck or even physically punished by a parent.

They also mention the problem of definition when dealing with neglect: "...there is no established yardstick for measuring the point at which child care has sunk so low as to be called neglect."

The authors see family poverty and "infantile" attitudes and behavior by adults as the most common causes of neglect. These infantile adults are unable to make fine distinctions among their ideas; think concretely and never abstractly; have trouble solving any sort of problem; react in all-or-none terms; cannot cope with frustration or failure; are inflexible; demand immediate gratification of their needs; and have consistently poor judgment about others. The most obvious and consistent characteristic about infantile adults is that they are extremely self-centered and care for themselves first and foremost. The authors state that, rather than loving, these adults develop "clinging" relationships.

According to a pamphlet published by the Children's Division of the American Humane Association entitled Neglecting Parents: A Study of Psychosocial Characteristics:

> The way in which these [neglecting] parents deal with reality is known to the caseworker who has carried a caseload with a high proportion of character disordered clients. The fact that approximately 31% of the group distorted reality, 22% denied reality and almost 5% were out of touch with reality indicates a real problem for the caseworker.

Reality distortion seems to be common among neglecting parents, allowing them to continue acting inappropriately toward their children.

Breaking the Cycle of Child Abuse, by Christine Herbruck, a group sponsor for Parents Anonymous in Cleveland, explores specific areas of the abuse/neglect spectrum. Herbruck distinguishes between physical neglect, emotional neglect, and emotional abuse, which has been done only rarely. She describes the dynamics of physical neglect as follows:

> Physical neglect, as its name implies, is exactly that--the neglect of the physical needs of the child. Failure to provide medical attention, proper meals, adequate and appropriate clothing, and routine body care constitutes physical neglect.... As with all types of abuse, physical neglect is a sign that something is wrong in the parent's life. Physical neglect demonstrates that for some reason, such as a recent divorce, a death, or more complicated personality reasons, the parent is not taking adequate care of the child. Parents who neglect their children often neglect their homes as well....
>
> [N]eglecters are not "harder" to treat; rather, they require different treatment. Unlike abusive parents, the energy level of neglecting parents is often so low that for them to get to appointments with their therapists is practically impossible and, therefore, treatment falters at the early point. The therapist may need to make many home visits in the beginning.
>
> Frequently, adults who neglect their children are so full of and enervated by their own problems that they have no energy to spare. Typically, the neglecter has very little drive or initiative and lacks both motivation and the desire to follow through. The adult caught up in a pattern of physical neglect may alternate long periods of sleep with times when he or she sleeps sporadically or not at all. This type of person rarely goes out of the house and has few, if any, close friends. Just living seems to be the extent of the coping ability of the adult who physically neglects.

On the subject of emotional neglect, Herbruck writes:

> Emotional neglect is the neglect of the emotional needs of the child....Emotional neglect differs from emotional abuse in that nothing harmful is actually said or done to the child. In fact, not enough is done, period....Children who have been emotionally neglected seem to grow up with an unclear or vague idea of who they are. Many don't perceive themselves as being good or bad; they simply don't perceive themselves as being anything at all.
>
> Neglect in its most extreme form results in the "failure-to-thrive" infant--a baby who both physically and emotionally does not develop normally....Babies without adequate stimulation, handling, and love do not thrive. While emotional neglect of any form leads to underdevelopment of some aspect of the child,

infants graphically show the actual failure-to-thrive syndrome.

Failure-to-thrive infants may begin as undemanding babies; even if they don't, they're forced to become that way. When their needs are never met, they stop making them known. They cry seldom or for only brief periods of time because they've learned that nothing happens when they do cry. Parents brag about what "very good" babies these infants are because they never cause any "trouble." A failure-to-thrive infant can grow and change from a listless, thin baby into a fat, lively one in a few weeks in a hospital setting where the attendants respond to his or her needs.

Herbruck's comments about emotional abuse directly follow these comments about neglect:

Emotional abuse is a side effect of every other form of abuse. It can be administered on its own, however, without the presence of any of the other types....Emotional abuse creates a stifling and crippling atmosphere which is difficult to describe but easy to recognize. It severely damages the child's sense of self. It occurs when an adult uses weapons such as guilt or fear to influence a child's behavior. Parents who make their children feel so guilty that they can't leave home, for example, or who threaten illness, death, or desertion if their behavior doesn't change are emotional abusers. The flow of words and feelings is often insidious, but the total effect is devastating. Although such a parent can and often does use harmful words against his or her child, it is the force of emotions behind the words which hurts the child the most. The child is left with feelings of inadequacy and helplessness.

We hope we have shown that neglect can be just as harmful--even more harmful in its long-lasting effects--as abuse. Emotional damage can be as severe for the neglected child as for the battered child, and more serious in its effects on the whole society.

As the National Center on Child Abuse and Neglect User manuals referred to earlier in this section state,

The fate of neglected children concerns all professionals involved in child protection. Their parents have survived to adulthood, but it is often uncertain whether the children will. Should these children escape premature death, and fortunately most survive, they run a chance of being physically handicapped. That they will be psychologically crippled, however, is more than a chance; it is a probability. Society does not know everything there is to know about developing happy, competent people; however, in the last century society has learned that people with good biological potential may, nevertheless, become intellectually stunted and burdened by emotions that include anger, anxiety and intense loneliness. It does not require extraordinary sensitivity to feel badly for others whose chances at happiness are wasted. How does

society benefit when children survive physically only to be socially and emotionally damaged? Nor it is possible to turn away from the parents of these children, for they did not choose to be this way.

And, besides, these families are members of society. They affect everyone. Along with pity, society is experiencing a rising sense of alarm. There is now evidence that children who have been maltreated, especially neglected, are more likely than others to be delinquent; moreover, their crimes are more likely to be crimes of personal violence. These families also consume common resources without contributing proportionately to their renewal. In a time of declining American affluence, everyone shares in the burden of the unproductive. Legislation aimed at social control applies to all, but it appears particularly relevant to people unwilling or unable to instill workable consciences in their children. Social reactions, such as holding parents personally responsible for thefts and assaults by their children, are understandable. CPS workers and other professionals in human service fields can only hope that such reactions will prove ego-supportive rather than merely punitive for parents with whom they are involved.

3. Adolescent Abuse and Neglect

Abuse and neglect of teenagers are similar in many ways to abuse and neglect of younger children, yet there are some important differences. Adolescent Abuse and Neglect: Intervention Strategies is a manual published in January, 1980 as one in a series from the Office of Human Development in Washington. It stresses that there is a problem in identifying adolescent victims of abuse and neglect because these children do not resemble the "typical" victims. They are usually 12 to 18 years old and are often big, strong, and generally healthy. The manual presents statistics that show that actual abuse--often very serious--is quite common among adolescents and is an area often overlooked by social service agency personnel. Furthermore, abuse and neglect among these children tend to recur with a greater frequency than do abuse and neglect among younger children. A good deal of adolescent abuse arises as a result of emerging sexuality in children, particularly in girls, and as a result of feelings of independence developed naturally by adolescents.

The manual stresses that adolescent neglect cases outnumber abuse cases almost two to one. The following excerpt from the manual deals with neglect:

Neglectful families' lives are chaotic and disordered; difficulty in coping is apt to be generalized rather than limited to child-rearing....Parents frequently play the role of the older sibling rather than parent to their children, and compete with them over whose dependency needs will be met....Neglected adolescents:

1) usually approach the tasks of adolescent development with generalized developmental lags and evidence of behavior disorders and/or withdrawal;

2) may be quite aggresive and exhibit antisocial behavior;

3) often have problems with internalization of controls;

4) may appear emotionally healthy, but may have psychosocial and cultural deficiencies that may eventually bring them to the attention of schools, hospitals, and mental health facilities;

5) may be at extremely high risk for early pregnancy; and

6) may exhibit extreme withdrawal and suicide gestures in very serious cases.

The manual distinguishes between neglect originating in childhood and neglect beginning when children become adolescents. When children are neglected only when they reach their teens, often it is because the parents give up their responsibilities because they feel that they no longer can control their children, particularly if the children "test" their parents excessively. It may also be because parents often take on new responsibilities themselves, such as new jobs and returning to school, once their children are "raised" and the parents feel that they can fend for themselves fairly well. In these cases, the children in the home are leftovers from the "old life."

Because of the problems presented by adolescents, the manual suggests that CPS designate one or more specialized adolescent caseworkers to handle cases involving adolescent abuse and neglect. These specialists would be able to recognize the indicators of abusive or neglectful behavior. The manual says that behavior may be the only clue to abuse or neglect. A specialized CPS worker could then design an individual service plan for each child.

One of the strongest points stressed in the manual is that inter-agency cooperation is essential to treatment of adolescents--and any other abused or neglected population, for that matter. In fact, the manual addresses the very issue of distrust among personnel assigned to or working on a case.

4. The Conflict Between Children's and Parents' Rights

Cases of abused and neglected teenagers often raise the issue of the child's rights vs. the parents' rights. Adolescents often assert their emerging independence, forcing courts and child welfare agencies to confront the issue of the adolescents' rights as young adults. One must bear in mind that this subject applies to all abused and neglected children, including the younger victims who are unable to assert their rights on their own.

Commission staff reviewed a series of three articles concerned with foster care, adoption, and the concept we mentioned briefly before of "permanent foster care." All of these issues are pertinent to our discussion, particularly the final option, which seems to be the newest and most radical suggestion for alternative care for abused and neglected children. The three articles are all by Andre P. Derdeyn, a psychiatrist with the Division of Child and Adolescent Psychiatry of the University of Virginia Medical Center. The first article was co-authored by Walter J. Wadlington III and published as "Adoption: The Rights of Parents v. the Best Interests of Their Children" in the Journal of the American Academy of Child Psychiatry (1977). A summary from the article's abstract makes clear its focus:

> Adoption for the benefit of children is a relatively recent historical development which continues to be influenced by the concept of children as the property of their biological parents. Substantial changes in current practices can occur primarily through new legislation stipulating that the interests of the children are to be at least equal to the rights of their parents.

Previously, of course, the rights of parents superceded by far the best interests of the child.

The authors refer to several court decisions in their discussion of the adoption issue. One 1972 case included a statement by a judge that the natural mother has an "unqualified right to withdraw consent to adopt." Another states that the burden rests not upon the natural mother to show that a child's welfare would be enhanced by the child's being returned, but rather by the non-parents to prove that the mother is unfit and that the child's well-being requires separation from the mother.

The authors comment that the presumption that a child should always stay with his natural parents serves to "avoid a consideration of what actually would best serve the child's interests." They cite a 1972 court decision that determined that the welfare of the child is not a controlling factor in adoption cases. They add, "Generally, it is only after the rights of the biological parents are so terminated that the court will assess a proposed adoption according to whether it promotes the child's best interests." They make it clear that when a natural parent contests an adoption proceeding, the welfare of the child is "quite secondary" to the interests of the parent. Courts are very reluctant to terminate parental rights. The authors also allege that when the courts do terminate parental rights, it is often to punish the parents for previous extreme behavior, not to place the child in the best possible situation.

The authors recommend a change in legislation to provide more detailed and clearer criteria for the decision-making process in adoption cases. They recommend a specific statutory provision that the best interests of the child be weighed at least equally with the rights of the biological parents. Their conclusion also is useful:

> The most important impediment to the court's response to the child's needs is a preoccupation with the concept that biological parents have something closely akin to a legal property right in their children. Because of the lack of legal tradition regarding adoption in the English common law, adoption in this country is always statutory and the statutes are comprehensive and detailed. Any major change in adoption practices requires a change in the laws.

Derdeyn published another article entitled "Child Abuse and Neglect: The Rights of Parents and the Needs of Their Children" in the American Journal of Orthopsychiatry (1977). In this article, Derdeyn mentions that most authors and researchers have held that state intervention in family affairs should be kept to a minimum and that children not be removed from their homes until extensive efforts have been made to rehabilitate the natural parents and the home situation. He mentions that state responsibility for such rehabilitation has grown and has been "formalized" by the idea that statutes providing for termination of parental rights include a "familial right to treatment" clause or philosophy.

Derdeyn mentions what were at that time recent New York court opinions requiring two findings in order for parental rights to be terminated: a finding of "permanent neglect," and a finding that the responsible agency "must have not failed in its duty to encourage and strengthen the relationship between mother and child."

Derdeyn goes on to point out that right now, the most "hotly contested court involvement" occurs at the time parental rights may be terminated. Instead of this being the critical moment, he feels that the initial decision to remove a child from his home should be the most critical decision in the matter. He says that the burden should rest on the state to prove that removal is absolutely necessary for the well-being of the child. He continues:

> The truly momentous decision is the removal of the child from the home in the first place, and this juncture needs to be recognized as the critical moment it is for the child, the family, the agency, and for the decision-making process itself. [The court] is in many ways not faced with what appears to be a momentous problem: the parents are not currently abusing or neglecting their child, and the child is apparently being adequately cared for in foster placement. A frequent response of the court is to find that termination of parental rights is not warranted, but that the child requires continued foster care.
>
> It is at the time of removal that the weight of parental rights should be exerted, in order to allow the parents to keep their child if the state cannot establish that they cannot care for their child adequately.
>
> Once the child is removed...the burden should shift to the parent or parents to establish that their rights should not be terminated or that they are capable of caring for the child.

So Derdeyn has proposed that, instead of placing children in foster care and then, after the sense of urgency has passed, leaving them there unadopted because of the issue of parental rights, parents' rights should be asserted strongly when removal is first contemplated. If the child is placed in foster care, then the parents should have to prove their right to the child.

Derdeyn's somewhat general discussion is continued in the next issue of the American Journal of Orthopsychiatry, in an article entitled "A Case for Permanent Foster Placement of Dependent, Neglected, and Abused Children." Basically, his position is that a good compromise between long-term foster placement without the severance of parental rights and adoption would be what he calls "permanent" foster care. The difference between this type of foster care, "normal" foster care, and adoption, is that while parental rights are not severed, parents would be unable to regain custody. Thus, they still would be able to visit their children placed in this type of care. Derdeyn states that this situation might be better for the child when the relationship between the child and his foster parents is better than the relationship between the child and his natural parents, but when, for whatever reasons, parental rights could not be terminated. Derdeyn's description of this type of care follows:

> Permanent foster placement should be considered in those situations where strong emotional bonds have developed between foster parents and foster child. Such a legal arrangement would ensure the stability and continuity of the foster parent-foster child relationship. In addition to serving families where there is an established good relationship between foster parents and foster child, permanent foster care would be applicable to some unadoptable children. Children currently in long-term foster care for whom adoption is of diminishing likelihood are those who are older, of minority race, or suffering from some handicap. Others are not free for adoption due to agency inertia or judicial maintenance of parental rights. In addition, some children continue to have important emotional ties to biological parents who can never take care of them, and the termination of the relationship with biological parents required by adoption would be undesirable for them.

We have presented this option to adoption because it has had some consideration, not only in the child abuse literature but among some social service agencies, according to Derdeyn. Also, probably Derdeyn is very aware that this situation exists in de facto form in some states anyway. Many children do languish in a single foster placement with no termination of parental rights. These children are luckier than children who are shifted from home to home, but they still face the problem of not really belonging to any one person or family. Derdeyn's solution appears to be meant to remedy a situation that already exists and that he views as unfortunate, at best.

Derdeyn's final comments on this issue follow:

> It is apparent that the parental right issue is and will remain a major block to adoption. When a dispute between a biological parent and a third party involves termination of parental rights preparatory to adoption, parental right is very often the determining factor. If parental rights are not directly confronted by means of an attempt to terminate those rights, however, custody may be determined by what the court decides is best for the child's welfare. The weakness of this arrangement with regard to continuity of the child's relationship with the foster parents is that the biological parents may continue to challenge the foster parents' custody of the child. With the advent of increased rights of foster parents, it appears possible that in certain circumstances, the foster parents' right to custody might be made a permanent one.

The major reason Derdeyn proposes this plan, of course, is that it could be a way to "beat" the courts' reluctance to terminate parental rights. His argument that this type of care may be better than adoption because the natural parents still have visitation rights is flawed; many children would be more harmed than helped if subjected to having to understand and deal with two sets of "parents." It seems likely that judges would be no more amenable to using permanent foster care because use of such care theoretically severs permanently any possibility that the natural parents could regain custody. Judges are affected in their decision not only by emotional bonds between the biological parents and their children, but also by the possibility that the parents may be able to rehabilitate, regain custody, and reconstitute a "normal" family. Permanent foster care does little to address these concerns on the part of a judge. So the argument that the natural parents be able to visit their children seems to be shallow as the rationale to setting up such a radical, new, and problematic system.

Permanent placement as defined by Derdeyn would be legal in this state, however. If DCFS maintained legal guardianship over a child, it could initiate permanent placement under the law and still maintain control of parental rights of visitation.

Kris Olmstead and Bruce Rubenstein, both from DCFS, told us that the Department does place children in what is called "long term foster care." This concept approaches the permanent placement concept with no legal designation or determination as proposed by Derdeyn. Both told us that DCFS does not place children in foster care with the purpose that they be adopted. Department philosophy is that the natural parents should be provided support and time to rehabilitate so that they can regain custody of their children and resume normal family life. However, as a matter of practicality and humanity, if a child in foster care becomes available for adoption, the foster parents are often given the first opportunity to adopt. In some cases the foster parents are chosen partially because of their interest in adoption and their ability to move from being foster to adoptive parents. Finally, the foster parents are usually chosen if the emotional bond between them

and the child is obvious and if the foster family has become the real meaningful family for the child.

Bruce Rubenstein told us that the basic premise of foster care and the premise of permanent placement contradict one another. Rubenstein was totally opposed to Derdeyn's proposed plan. Olmstead told us that such a plan with older children (over 10) might actually be in the best interest of the child. She told us that it might be feasible to recruit foster parents especially for permanent placement care, but more likely it would be used with an existing foster relationship in which the need for security for the child could not be obtained, for whatever reason, through adoption. She offered the example of an eight-year-old child who had been in foster care for three years. If this child had only one natural parent living who was sentenced to 20 years in prison, permanent placement would offer both the child and the foster family the permanency they would require if the parent refused to surrender parental rights.

We were told that one of the key factors to this plan was the emotional investments made by both natural and foster parents. If a natural parent agreed, visitation could be arranged much as it occurs in a divorce proceeding, and if the child were old enough, the child could participate in the formulation of a visitation schedule. However, if permanent placement were entered into without some agreement on the part of the natural parents, it would be likely either that the natural parent would cease visitation or that the natural parent would utilize visitation rights to continually threaten the placement.

Pertinent to the issue of permanent placement is a new initiative by DCFS called permanency planning. Though the Department has planned for long-term care for its wards for years, the Department is now going about it in a more directed fashion. The DCFS publication Hotline reported in its Winter, 1981-82 issue that almost 1,200 children went through a new case review system that is intended to assure permanent planning for DCFS wards by the end of October, 1981, the second full month of the new case review system. The system is mandated by a recent amendment to the DCFS enabling act, discussed in our chapter on legal issues.

DCFS Director Gregory L. Coler said that the new system was "inspired in part" by federal law that requires case planning and review "as an absolute condition for federal reimbursement." Coler is quoted in this publication as saying:

> No longer will kids be permitted to drift in foster care while the state shells out more and more money for clothing, room, and board with little concern for either the child's psyche or his future.
>
> In this age of unprecedented demand on declining federal resources, we will also be getting the most efficient use of our funds.

We will conclude our presentation of arguments about the rights of children and parents and the issue of adoptive and related care with several references to one of the most popular books recently published on the subject of child care. Before the Best Interests of the Child, by Joseph Goldstein, Anna Freud, and Alberg J. Solnit (1979), begins with the premise that a family structure (but not necessarily either legal or biological) is the best structure for rearing children, and that dissolution of the family should occur only in limited and narrowly defined circumstances. Any effective intervention program must be minimal and must create or recreate as quickly as possible a stable family for the child involved.

A child's psychological need for family should override almost all other concerns, and the state, according to the authors, never should be more than a temporary caretaker. The authors state that families have three basic rights: parental autonomy to make decisions for the child; a child's right to "autonomous parents"; and a privacy from intervention. They elaborate that a child has the right to a family unit that corresponds to a child's sense of continuity and structure. This family need not be biological but may be constituted in one of several other ways, including foster care.

The authors say that the state should intervene only in the following circumstances: when parents request that the state take the child from their custody; when the caretaker of the child either requests adoption or refuses to surrender the child to natural parents; when the child's parent or caretaker dies and no other arrangement has been made for the child; when parents physically abuse or neglect the child; when parents refuse medical treatment that is lifesaving and non-experimental; and when parents request legal assistance or an adjudication is made that a child needs legal assistance.

The authors present a proposal even more lenient than those recently enacted into Illinois law. Under their proposal, foster families may request and be granted adoption of any child under three years of age that they have had for more than one year and any child over three that they have had for two years. The original parent then surrenders parental rights and the only possible objection to prevent adoption would come from the child.

The recurring theme in this book is minimal intervention by the state, together with a demonstrated value in the best interests of the child.

5. Prevention Efforts

The Herbruck volume cited earlier (Breaking the Cycle of Child Abuse) states, "Ninety percent of all abusive homes can be made safe; some of the parents may never have all of the patience or good humor possible, but their homes can be made emotionally and physically secure for their children."

One of the key issues in current thought about child abuse and neglect, however, concerns prevention. Obviously, we would prefer to prevent abuse than to have to treat it. One expert in the important area of prevention is Gertrude J. Williams, whose 1980 article "Toward the Eradication of Child Abuse and Neglect at Home" was reviewed by Commission staff.

Williams points out that the Child Abuse Prevention and Treatment Act specifies that prevention of abuse is a major goal; she also points out that prevention has received "miniscule attention in child abuse and neglect programs...." She cites data from federal studies that indicate that child abuse treatment programs generally seem to work at about 50% effectiveness. She indicates that one of the problems with these programs may be their general assumption that the abused child should be returned home in the vast majority of cases. She is adamant in her rejection of such ideas:

> It cannot be assumed that a child has formed a bond with an abusive or neglectful mother....Furthermore...an abused child's wish to remain or return to the mother may stem from a masochistic rather than a growth-enhancing attachment. In such a case, a child's attachment to an abusive or neglectful mother may be more damaging than the effects of separation.

Williams favors freeing children for adoption as soon as possible when the case clearly warrants separation between parent and child.

Williams attacks the lack of family planning and abortion counseling as causative of a good deal of abuse and neglect. Her criticisms also carry over to other areas of American life, including a number of "textbook myths" about roles members of our society must play.

Williams recommends the development of programs whose purpose is to find alternatives to keeping a child and parent together. She describes these efforts as alternatives to what we now have and titles them "child-oriented programs."

She speaks of "socially sanctioned violence against children":

> The eradication of child abuse cannot be accomplished if the attitude persists that corporal punishment of children is a right of parents [and teachers].
>
> Corporal punishment is not a necessity in the teaching of children. It has been abolished in schools in Denmark, Finland, Holland, Israel, Japan, Norway, the Soviet Union, and Sweden.

Finally, she cites fourteen separate sources who "have emphasized the ineffectiveness and irrationality of the corporal punishment of children and have suggested effective, growth-inducing, nonviolent alternatives to disciplining and instructing children."

These final findings are also reflected in a document recording the proceedings of the National Conference of Representatives from Government, Media, and the Academic Community, sponsored November 20-21, 1978, by the Annenberg School of Communications of the University of Pennsylvania and the Bush Center of Child Development and Social Policy, Yale University. The proceedings are entitled Conference Recommendations on Child Abuse: Report of Representatives from Government, Media, and the Academic Community and were edited by Catherine J. Ross and others. The document reports that all representatives at the Conference condemned corporal punishment in the schools even though, at that time, only four states banned corporal punishment. Specific suggestions for eliminating corporal punishment from schools included "...passage of state and federal legislation or administrative regulations prohibiting it, monitoring of schools by parents, government agencies, and advocacy groups, and training teachers in alternative methods of discipline and classroom management" (emphasis theirs).

One of the appendixes of this document includes a number of specific recommendations for the prevention and treatment of child abuse and neglect. Several will be paraphrased here:

1) Separate definitions should be developed for terms including "abuse" and "neglect" for the separate purposes of legal, research, clinical, and social service functions.

2) School personnel should receive in-service training dealing with alternatives to corporal punishment.

3) "All states should institute interdisciplinary panels to undertake continued scrutiny of local laws to insure that those laws preserve the delicate balance between the rights of children, the family, natural parents and the state."

4) Parenting education should be required in school for children ages 6 and up and should also be available on a voluntary basis "in a variety of settings" for interested adults. "The Office of Education, National Institute of Education and similar agencies on the state level should identify, develop and distribute sample curricula."

5) Every community should inventory child and family welfare services and make the services available through a "single-door referral service." Volunteers could play a crucial role in this step.

6) "Continuing research and evaluation are needed to test the effectiveness of various approaches and programs and to improve our understanding of what causes child abuse."

7) Public interest groups should meet with media representatives to develop media campaigns emphasizing prevention. Television should also donate time during prime time for commercial messages.

8) "The communications industries should devote more space to more realistic and balanced news coverage and dramatic portrayals of children and family life."

9) Research into child abuse and neglect should be increased and such research "should be integrated into the mainstream of scholarship in established disciplines."

10) Chief advocates working for the well-being of children should address themselves to concomitant issues affecting the general climate of the country.

11) "State and local governments and private companies should join the national government in efforts to enhance family life."

Other experts advocate more immediate, short-term preventive efforts, such as early identification of "at-risk" parents, before any actual abuse or neglect occurs. Phillip Coltoff and Allan Luks, in Preventing Child Maltreatment: Begin with the Parent (An Early Warning System) (1978), describe such at-risk parents:

> These parents often have such psychological and social characteristics as a sense of incompetence and poor self-esteem, great difficulty in seeking and finding pleasure in the adult world, social isolation, a strong belief in the value of punishment, a family history of abuse and a serious lack of ability to empathize with a child's condition and needs.
>
> These characteristics manifest themselves in visible danger signals--problem drinking, repeated job loss, unwanted pregnancies at a young age, poor utilization of medical care, birth complications, unrealistic expectations of their children and an inability to maintain children on various behavior and school schedules--that can be spotted by trained professionals as possible precursors to physical or emotional abuse.

6. Self-Help Groups and Voluntarism

Closely related to efforts at prevention are self-help groups. Parents Anonymous was established in California in 1970 as a national self-help organization. By 1974, the national group had 90 chapters in the United States and Canada and it has grown tremendously since then. Parents Anonymous is, basically, a crisis-intervention program whose primary objective is helping to prevent "damaging relationships" between parents and their children.

According to Cassie L. Starkweather and Michael S. Turner, authors of an article entitled "Parents Anonymous: Reflections on the Development of a Self-Help Group" (in Nancy Ebeling and Deborah Hill's book Child Abuse: Intervention and Treatment [1975]), the primary appeal of Parents Anonymous lies in two general areas: the inadequacy of present methods of responding to abusive parents in anything other than "moral or punitive" terms, and "openness

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and honesty among members, their easy accessibility during crises and their feeling of urgency in finding concrete 'do it now' approaches to dealing with their problems."

Interestingly enough, members of Parents Anonymous often express fears of seeking help from professionals because they perceive large differences in education, sex, and social status, which can become communication and understanding barriers. Many members indicated that the kinds of relationships that they can establish with other parents through the organization form a sharp contrast to this fear and expectation. The authors also note that many times this fear of professionals serves as a smokescreen for "a parent's difficulty in admitting the problem to himself."

The founder of Parents Anonymous of New York, Gertrude M. Bacon (a former Family Court judge), in a 1977 article published in Victimology, describes the group as follows:

> Parents Anonymous is a self-help group of parents who offer immediate relief to parents who feel they are abusing or neglecting their children. We offer a 24 hour telephone service in the U.S....Our basic concept is parents helping each other to help themselves, by continuous communication through the phone and meetings, to change our habits on a day to day basis. Parents Anonymous is a non-profit group, completely autonomous, with no agency affiliation. All services are free. Our basic rules of privacy and confidentiality are strictly followed.... Our primary objective is the rehabilitation of damaged relationships between parents and children, by instilling within the parents the strength and self-confidence to rechannel our destructive attitudes and actions into constructive ones by changing our habits on a daily basis.

Bacon goes on to make the point that one of the major reasons that Parents Anonymous is not ever agency-affiliated is so that the parents involved in the group will come to help themselves and will realize that whatever good results occur have been as a result of their own good efforts. She adds that too often members of society refuse to recognize a child abuser as another human being; even well-intentioned outside organizations may have prejudices against the members or the methods of the group.

Bacon presents ten ideas that parents who may be on the verge of abusing their children should consider:

1) The first step to handling anger toward children is accepting the fact that their feelings are "honest, human, and universal feelings."

2) Parents must learn to handle their anger without damaging their children.

3) Parents should learn not to create situations that will make them angry unnecessarily.

4) "A child lives what he learns," which parents should remember before applying disciplinary measures.

5) Often children are not the cause of a parent's anger.

6) The most important thing about Parents Anonymous is that if offers someone to talk to.

7) "Children who tend to ignore high-decibel commands will often respond to a quiet request for understanding or cooperation."

8) Being a good parent does not mean never yelling at a child; it means spanking only appropriately, after a child has been warned and understands the consequences of his actions.

9) A good test of whether a parent should yell or spank his children is whether it is working; overdoing either usually means that it has no positive effect anymore.

10) "[T]ry to change your child by changing yourself. The way to change is little by little, day by day."

A 1978 publication by Isolde Chapin, "Children Are for Loving: Volunteer Involvement in the Treatment and Prevention of Child Abuse and Neglect," maintains that volunteers can help both abused children and their parents.

The author states that volunteers can help both abused children and their parents. This may be especially pertinent given reduction of social service funding at the federal and state level. Commission staff members have attended conferences--since announcement of federal budget cuts--in which the volunteer issue was presented as extremely important precisely because of the proposed and expected cuts in social service dollars. Chapin states that volunteers can provide crisis intervention and the teaching of parenting. She stresses that child abuse is occurring every day everywhere and that volunteers are needed to address the problem. One of the most effective groups of volunteers are former abusive parents themselves.

Volunteers can be used to assist as parent aides, to provide parent education, information, and referral services, to provide temporary homes and adolescent counseling, and to act as advocates in juvenile court.

Another in the series of User manuals published by The National Center on Child Abuse and Neglect, which we have referred to earlier, is entitled Parent Aides in Child Abuse and Neglect Programs, by Carla D. Gifford and others. The manual offers advice concerning situations appropriate for intervention by parent aides. Situations in which such parent aides should not be used

include when parents have sexually abused a child, when parents are also involved in spouse abuse, when parents are alcoholic or addicted to drugs, and when parents have severe emotional problems, such as psychosis.

The manual states that CPS workers should supervise the work of parent aides through biweekly telephone calls. These CPS workers must be on-call 24 hours a day for crisis intervention and must be willing to incorporate information regarding parent aide involvement with the family in the official case file.

According to this manual, parent aides must spend at least four hours each week with the parent (and make additional phone calls), encourage the parent to take part in community-based social and educational groups, help out with transportation of children to and from school and to and from such things as medical appointments, help out in activities with the parents such as shopping and picnicking, and provide guidance in such areas as budgeting and helping with child care needs.

The manual also lists things that parent aides should avoid doing. The list includes becoming too emotionally involved with the situation; becoming overly involved with the child (in fact, the manual recommends that parent aides not become involved with the child at all unless supported in these efforts by the parents); discussing the abusive or neglectful situation directly with the parents unless the parents initiate the discussion; and accusing a parent of being a "bad" parent. Obviously, the emphasis is on constructive help, not criticisms of the parents or attempts to work with the children. However, the manual stresses that if parent aides become aware of further abusive or neglectful behavior on the part of the parents, the behavior must be reported to the CPS worker. CPS workers also must be able to ask the parent aides to assist in the assessment of potential harm to a child. The manual states that, if necessary, parent aides can testify in court on behalf of the parents but that they should not be utilized to testify against the parents.

This manual mentions that the parent aide/parent relationship should be terminated when the aide, the CPS worker, and the parent aide program director all agree that the client should be able to depend on his/her own resources. Contact between the aide and the parent should decrease gradually, and the parent should be informed that contact can be reinitiated should she need it. A number of specific exercises and steps toward training for potential parent aides are also provided.

Chapter 5

CASE STUDIES: CHILD ABUSE AND NEGLECT RESULTING IN DEATH

For Fiscal Years 1977, 1978, 1979 and 1980, reported cases of child abuse deaths numbered 53, 75, 57, and 101, respectively. The reliability of these state-wide totals is questionable, however, because they were compiled prior to the major amendments to the Abused and Neglected Child Reporting Act which were enacted and made effective in 1980.

Prior to FY 81, the eight DCFS regions did not necessarily report all child abuse deaths to Springfield. Not only were reports not collected centrally, but the reports were not finally categorized as founded or unfounded. Therefore, statistics from FY 81 and FY 82, during which time the computerized State Central Register was operational, should be more accurate than those of previous years.

In FY 81, the first year that DCFS classified cases after they were reported, 176 child abuse deaths were reported, but only 93 of these were "indicated." In FY 82, reported deaths dropped to 123, of which only 70 were indicated.

Commission staff examined in detail many cases of child abuse and neglect in which a child's death was the result. We developed these cases from a variety of sources. Some came directly from newspaper accounts. Others were called to our attention by interested citizens. Commission investigators also conducted an extensive review of DCFS case files, both in Cook County and in other parts of the state, to find cases that were "typical," cases that were mishandled, and cases that were handled particularly well.

In general, we found that the system had failed at one point or another when a child's death occurred. Sometimes fault lay with DCFS; other times the fault lay in part with workers of private agencies, the police, the courts, or other parties. In some cases, we determined that nothing could have been done to prevent these occurrences.

This chapter focuses on those cases in which portions of the child protective and child welfare systems were called into play before the child's death occurred. Our point, after all, was to identify deficiencies in the system and develop recommendations to ameliorate these deficiencies in the future.

A. Tracy

This case occurred in Chicago, and involves the death of 18-month-old Tracy.

On April 18, 1979, the principal of an elementary school in Chicago reported a case of suspected child abuse to the Chicago Police Department. A six-year-old boy named Michael, who was Tracy's brother, had come to school that morning with lacerations on his arms, legs, and other parts of his body. Initially, he told the principal he had been cut by falling down, but he changed his story and said that his father had whipped him. (The "father"--not the natural father but a boyfriend of Michael's and Tracy's mother--later was to admit he had hit Michael with a belt that morning before school but that the cuts had occurred in a fall.)

Michael was hospitalized and a DCFS worker notified. DCFS, after investigating the incident, entered into an agreement with Michael's and Tracy's mother in which she agreed to undergo counseling if Michael were allowed to return home from the hospital. The boyfriend, James Brown, was arrested by Chicago Police Department officers and charged with battery. After being convicted, he was sentenced to six months' court supervision.

On June 7, 1979, Chicago police responded to a call at Cook County Hospital. Michael's and Tracy's aunt, a 15-year-old who was then living in their household, was admitted with bruises and lacerations over her entire body, possible internal injuries, and some of her teeth knocked out. She told police she had been attacked by an unknown male as she was walking home (to her sister's house).

On June 11, 1979, Chicago police responded to a call at St. Bernard Hospital. Tracy had been admitted for treatment of blows to the head. Tracy also had numerous cuts and bruises elsewhere on her body. Police questioned the mother, who, although initially denying it, admitted that her boyfriend, James Brown, had beaten the child. The mother also told police that Brown had beaten her sister with a skillet, knife and metal bar, which resulted in her hospitalization. After presentation of testimony to a grand jury, Brown was indicted on charges of aggravated battery and armed violence in connection with all of these incidents.

On June 13, 1979, Tracy died of her injuries. Brown was then indicted for murder.

A "purchase of service" worker in DCFS' West Area Office, who was primarily a liaison between DCFS and private service providers, was interviewed by us. She had been assigned this case following CPS' placement of the two children (Michael and his aunt) remaining in the home after Tracy's death. They were both placed in foster care through the Children's Home and Aid Society (CHAS). The DCFS worker told us that she worked with CHAS workers to develop a plan for the children but was not supposed to provide direct service herself.

She told us that although it is DCFS procedure, it is not very common for the various workers assigned to a case to sit down together to develop a unified plan. The DCFS family caseworker is kept abreast of developments by the DCFS liaison worker's forwarding of reports from any private agency involved. She added that before private placement is used, a fairly well-developed plan is created. As of the time of our interview, the Department had custody of the children and was going to ask the court for guardianship. At that time, the mother was not pleased with CHAS and the liaison worker was trying to develop alternative counseling plans.

Our investigator spoke with a DCFS multi-service worker assigned to the case. His role in the case was limited. As the multi-service worker to whom the family was assigned, he would normally work with the family to help them resolve their problems. In this case, however, because the two children were in private placement, he was working only with the mother.

The multi-service worker's major job was to find and coordinate counseling for the mother. He mentioned that if the children had been placed in foster care directly by the Department, and not through CHAS, then he would have their files and be responsible for provision of services to them as well.

This worker confirmed that coordination of efforts between himself and CHAS was primarily through phone contacts and written correspondence. He said that he had never spoken to the liaison worker for DCFS. He admitted that DCFS procedure calls for all parties to get together when a case is opened to determine mutually beneficial goals, but he added that heavy caseloads frequently prevent that from happening. His caseload at that time was 40 families, totalling about 80 individuals receiving care.

The worker told us that unless a child could be placed for adoption, or unless counseling efforts could change the parenting skills of a parent, a child was forever doomed to remain in foster care. About the only other viable alternative was placement of the child with a relative, though that too was still technically foster placement.

Our review of the DCFS case files on Michael and his aunt revealed that both case files are almost exact duplicates of one another; in fact, one file contained the original of a social investigation and the other file contained a carbon copy of the same social investigation. Neither file had any information on the medical or educational condition of the two children, even though DCFS had been maintaining the files since June 12, 1979. In fact, the most recent documents in the case files were the case transfer summaries, dated October 11, 1979, which indicated foster placement of Michael and his aunt. There was nothing in either file from CHAS or the specific foster homes, nor were there any summaries from any DCFS workers on the service provided these children or the mother. Though both files indicated that DCFS obtained temporary custody of the children on June 12, 1979, there was no copy of any court order in either file.

Each file contains a 30-day review form with planning objectives. Neither was an original; both were copies that failed to

distinguish separate goals for the two children, in spite of the range in age of the children being placed. No record indicated which, if any, of the goals had been obtained, and the most recent date for any objective to be reached was January, 1980.

The case transfer summary mentions the hospitalization of Tracy. It indicates that when she was brought to the hospital for treatment, she was unconscious and barely breathing. She also had burn scars and old bruises on both arms, cigarette burns and old puncture wounds on the bottoms of both feet, and scratch marks on her face and body.

The recommendations for future service for the two children include continued foster placement; individual therapy for the aunt; continued counseling for the mother; and close monitoring of the mother after the birth of her new baby (she was pregnant at the time). The summary notes the following: "This is a priority as _____ has a chronic pattern of involvement with violent men; and abuse to any child in her care is likely until this pattern changes."

In order to determine the type of treatment being offered to this family, the caseworker from the Foster Care Division of CHAS who had been assigned to this case was interviewed. The worker acknowledged that there had been some contact with the DCFS caseworker, but there had been no meetings to provide planning. He said that he had "minimal" contact with the DCFS liaison worker.

The private agency worker said that it is the exception when he will be called upon by a DCFS caseworker to arrange a planning meeting or even to inquire about a given child's progress in placement. As a result, he said, the private agency caseworker provides all the care and monitoring.

The worker told us he had counseled the mother, but she began to view him as an antagonist and discontinued appointments. The worker then arranged with the DCFS multi-service worker for an alternative form of counseling with another agency; however, as of the interview date, he had not heard from DCFS regarding success or failure of the new counseling group.

Apparently CHAS often does provide counseling to a mother even when her children have been placed in a CHAS foster home. In Tracy's case, the mother refused to participate in counseling and probably lost an opportunity to work with the same caseworker who was counseling her children.

To determine how the case against James Brown had been handled, we interviewed Cook County Assistant State's Attorney Joseph Locallo. He told us that several problems occurred during Brown's trial that eventually resulted in a plea negotiation. Tracy's mother "flipped" on the stand and altered the story she had given the police and prosecutors. She said that she had been in the bathroom and did not see what had happened when Tracy was hurt, greatly weakening the state's murder case.

There also was a problem getting some expert testimony admitted into evidence. A physician from St. Bernard's Hospital had agreed to testify that Tracy's injuries fit the classic abuse scenario. The judge, however, sustained objections by the defense and would not permit him to render an expert opinion. Locallo said that this ruling was consistent with other cases he has handled involving expert medical testimony.

Because of these factors, Locallo believed Brown might be acquitted on the murder charge. He therefore agreed to reduce the charge from murder to involuntary manslaughter, in exchange for a guilty plea.

Locallo told us that the aggravated battery charge filed because of the aunt's beating never went to trial because she was a very emotional girl who was generally unwilling to discuss the case. He added that she had been corresponding with Brown while he was in jail and that she seemed to be unwilling to testify against him.

Ultimately, Brown pled guilty to involuntary manslaughter on March 4, 1980, and was sentenced by Judge John Powers Crowley to a two-year term in the Illinois Department of Corrections.

As mentioned earlier in this account, Brown had been sentenced to six months' court supervision (without a probation officer's supervision) following his abuse of Michael. That matter had been continued to November 6, 1979, at which time the court ordered the defendant dismissed because the terms of supervision were fulfilled satisfactorily. Actually, while Brown was on supervision, he committed two other criminal acts: the beating of Tracy's aunt and Tracy's beating that resulted in her death.

We contacted Cook County Assistant State's Attorney Edward Rothchild to ask about a sentence of supervision without use of a probation officer. Rothchild told us that such supervision amounts to no supervision at all; the file is put into a drawer and six months later it is pulled out for a hearing. At this next hearing, often the defendant's presence is waived unless the court has information that the person under supervision has committed another criminal act. Rothchild speculated that, in this case, the court was not informed of the murder charge pending against Brown, so Brown's presence at the hearing was waived. A procedural problem certainly is indicated by the termination of Brown's supervision at a time when two serious criminal charges were pending against him.

We spoke with two CPS supervisors regarding entry of information into the DCFS system. They told us that deficiencies we had found in case reports were related to lack of adequate staff in the Information and Referral Unit. DCFS had been short on both professional and clerical staff. When we mentioned our difficulties in finding information on the children in this family, we discovered that there were problems because DCFS was handling three names that all related to the same case: Brown, and the

two different last names of Tracy and Michael. The different abuse reports had not been cross-listed, and the State Central Registry had no information regarding abuse of a person with Tracy's last name.

We were told that there were problems within the Department regarding cross-indexing. The supervisors with whom we spoke emphasized that the real problem was lack of manpower, not any "fault" within the Department.

As we have noted, DCFS determined in one of its original assessments that the mother in this case was at-risk with her other children. Her children were removed from her care not because she was actively abusive toward them, but because she had a chronic pattern of involvement with violent men. The mother played a passive role in the abuse of her children; therefore, DCFS wisely removed her children from the home after Tracy had died from her injuries.

As in all the cases we reviewed, DCFS provided services for the children and the mother through private agency channels. And, as we have seen at least once before, the mother encountered problems in initial counseling and requested alternative therapy.

Finally, we found problems with missing documentation in the DCFS files. We have often encountered missing and inaccurate information. This case provided the additional problem of our not being able to find information because there were several names involved in the case. DCFS staff admitted there had been errors when the information was first logged in. We are fairly certain that these errors would not occur today, with the revamped and more sophisticated State Central Registry. Still, adequate documentation remains a problem within the Department.

At the conclusion of our investigation the two children were in the foster care system and probably will remain there.

B. Erika Boyd

Chicago Police Department records state that officers were summoned on February 9, 1980, to an apartment on the city's north side. Chicago Fire Department paramedics had already been contacted by an anonymous caller, had arrived, and were preparing to transport the victim, 4½-year-old Erika, to Edgewater Hospital.

Police officers spoke with the girl's mother, Darlene Boyd, and her boyfriend, Larry Bey. Bey gave several conflicting accounts of incidents leading up to Erika's injuries, but eventually admitted that he had spanked the girl and had hit her with an electrical cord. Her mother, Darlene Boyd, also admitted hitting her with the electrical cord, but neither would explain how Erika sustained severe head injuries.

When Erika arrived at Edgewater Hospital, a nurse contacted CPS. According to the initial CPS report, Erika had sustained

"multiple contusions, abrasions and welt-type injuries over the entire surface of her body; also sustained subdural hematoma, causing extensive intercranial pressure...."

Both Boyd and Bey were arrested. Boyd was charged with single counts of aggravated battery and cruelty to a child. Bey was charged with the same offenses but two counts of each.

On February 15, 1980, Erika died from her injuries. Both Boyd and Bey were then indicted for murder. They were found guilty of involuntary manslaughter on December 30, 1980, and sentenced to terms in the Illinois Department of Corrections. Boyd was to serve three years and Bey was to serve eight years.

In some ways, this case appeared to be straightforward, but other elements of the case were puzzling, such as the fact that there had been no previous reports of abuse to Erika.

We spoke with an attending nurse in Edgewater Hospital's Emergency Room. She had been on duty when Erika was brought in semiconscious on February 9, 1980. She recalled that when Erika was brought to the hospital in critical condition by paramedics, her injuries and bruises immediately suggested the possibility of abuse. The nurse also recalled that Boyd, the girl's mother, was with her when she was admitted but would say nothing except that she had found Erika in a beaten condition. She also remembered Boyd's saying that she would say nothing more until she had an attorney present. This response, and Boyd's lack of concern for the girl, confirmed for all involved their suspicions that Erika had been abused.

Erika was moved to the trauma unit soon after admission. A neurosurgeon on duty recommended that she be transferred to Children's Memorial Hospital.

While Erika was being transferred, the Emergency Room nurse contacted DCFS. She remembered that the CPS worker seemed genuinely concerned with the severity of the case and was impressed with how he handled it over the telephone.

Commission investigators also spoke with Dr. Robert Kirschner, a Cook County Medical Examiner who performed the autopsy on Erika Boyd. He told us that Erika had sustained a subdural hematoma and that the actual cause of death was head injuries. He added that she must have been severely beaten with some solid object, such as a stick, and that she had been whipped with an electrical cord. Kirschner said that had Erika lived, she would probably have had "residual effects" from repeated blows to the head.

Kirschner said that it is sometimes difficult to determine exactly how injuries have been sustained in abuse cases and that some cases are difficult to prove because there may be no obvious connection between external and internal injuries. Often, there are no exterior injuries, even though there may be subdural hematoma and extensive brain damage. He said that Erika's case was

obviously abuse, however, because Erika had sustained injuries from head to toe. He also said that these cases would be easier to prove if clear pictures were taken of the children and their injuries as soon as possible after admission to the hospital.

Kirschner showed us Chicago Police Department photographs taken while Erika was still at Edgewater Hospital, which show the bruises but not other areas of injury. Another set of photographs taken by the Medical Examiner's Officer was complete, but because of the time lag between the injuries and the photographs, many of the bruises had disappeared or were fading away. Kirschner added that many hospitals do not bother to take photographs and that when the police take them, they should be prepared by trained evidence technicians.

Kirschner added two further points of interest. The first is that in his experience with abuse cases, it is simple for a parent to blame another child for injuries when there is more than one child in the home. Many of these cases go unfounded. The second point, a procedural one, is that his office will now contact DCFS anytime it conducts an autopsy on a child of whom DCFS is unaware. In these cases, a DCFS nurse will come over and discuss the case with the performing pathologist. He said that these cases are handled very well.

We will report the comments that Kirschner made in his autopsy report:

> This 4 year old black female was severely beaten about the head, trunk and extremities. She developed a subdural hematoma and associated cerebral injury as a result of this beating. Many of the contusions and abrasions of the skin show a U shaped, loop patterned marking characteristic of the injury inflicted by a loop of electrical cord or similar instrument. There are other contusions that suggest that a stick or similar weapon may also have been used. This child's death was caused by the injury she sustained in this incident.

Kirschner added the final notation to make clear the cause of death. Technically speaking, Erika died of pneumonia. But that pneumonia was caused by injuries that had been inflicted upon her.

All CPS contact with Erika's family had been by telephone, and most contacts had been with police and hospital staff. No CPS worker went out because Erika's survival was unlikely, there were no other children involved in the case, and both the perpetrators had been arrested. Even though they expected Erika to die, CPS workers did file the appropriate papers to obtain temporary custody of the girl if she survived. (We were told that a DCFS nurse had visited the hospital while Erika was there, but nothing could be found in the file to confirm that any such visit ever had been made. Such visits usually would be documented by reports in the case file.)

Erika's case illustrates the tremendous need for greater public awareness of the realities of child abuse and the extent of the problem: private citizens need to make reports of abuse because mandated reporters do not see all cases of abuse. Nobody in the child protective system became aware of Erika's abuse until it was too late.

Cook County Assistant State's Attorney Lawrence Hyman told us that the case against Boyd and Bey was going to be a bench trial but at the pre-trial conference the defendants agreed to plead guilty to charges of involuntary manslaughter. At the conference, Bey admitted that he had repeatedly hit Erika with an extension cord. Boyd did not reveal her role in the abuse except to say that she "briefly" whipped Erika with the same cord.

As the result of this plea-bargaining, Judge Thomas Maloney sentenced Bey to eight years in prison. Hyman told us that the judge probably would have imposed a stiffer sentence had Bey's previous arrest record included arrests for child abuse or related crimes. (Though Bey had a three-page arrest record dating back to March, 1963, most of the arrests were for offenses such as theft, unlawful use of a weapon, and numerous assaults.)

Judge Maloney sentenced Darlene Boyd to three years in prison.

Hyman mentioned that he had seen potential problems with the case. He referred to the fact that Erika had died, technically, of pneumonia contracted after surgery to relieve pressure on her brain, the result of injuries she suffered in the beatings. Hyman said that in his opinion, the defense could have argued that the surgery and the resultant pneumonia were the cause of death. Hyman also mentioned that there were no external head injuries. In such a case, the defense could have argued that it was unclear which injuries could have been caused by blows to the head and which might have been caused by neurosurgery.

Commission staff also spoke with Judge Maloney. He told us he had given Bey what is termed an "over-extended sentence." He said that involuntary manslaughter carries a sentence of five years but that the sentence can be increased up to double that period of time depending on aggravating circumstances. Judge Maloney took into account Bey's prior arrest record and the heinousness of this particular crime in his sentencing decision.

Judge Maloney took into account mitigating circumstances in sentencing Darlene Boyd to three years in prison. She had no prior arrest record. The judge also mentioned the difficulty in pinpointing the actual perpetrator in a child abuse case: he said that neither of the defendants would admit to inflicting the head wounds. As a result, he felt that murder could not be proved.

As this report is being written, Larry Bey is serving his sentence in Stateville Correctional Center.

Darlene Boyd was remanded to the custody of the Department of Corrections and was sent to the Dwight Correctional Center in December, 1980.

Dwight Correctional Center

Commission staff spoke with several different personnel at Dwight over a ten-month period. Boyd's correctional counselor told us that very little information accompanied Boyd on her transfer sheet when she first came to Dwight. She did know that Boyd had abused her child, though. Her file also contained a statement from Hyman indicating the circumstances of Erika's abuse as well as the details of Boyd and Bey's arrests.

The counselor told us it is always a problem when an inmate is transferred with little information in the file. She said that Boyd was a very private person who asked to be held in protective custody during most of her stay at Dwight. Boyd never volunteered any information about the abusive incident. Whenever the counselor brought it up, Boyd remained silent, leading the counselor to believe that Boyd could not admit to herself what she had done.

Boyd was scheduled for release on August 7, 1981. Her counselor told us that she had accumulated enough "good time," a one day credit for each day served without incident, for her release to occur before she had served half of her sentence.

Besides the correctional counselor, we spoke with a mental health counselor at Dwight. Both agreed that there was much more opportunity for counseling to occur at Dwight than in any of the men's prisons because the population was quite small in comparison. We asked the mental health counselor how she felt about Boyd being released without having received any effective counseling. She responded that Erika Boyd's death was a "situational crime" in that Darlene Boyd was influenced by and went along with Larry Bey. She concluded that since Boyd would not be with Bey when she was released, she should not abuse any other children.

When we suggested that Boyd might become attached to another person much like Bey, the mental health counselor agreed that it was likely.

The correctional counselor said that either she or Boyd's other counselor had recommended psychiatric counseling as a condition or recommendation for parole. Then the correctional counselor called someone in Administration to determine the Prisoner Review Board's decision regarding Boyd's parole. She was told there were no recommendations or conditions on parole at all. Thus, all Boyd would have to do upon release is report monthly to her parole agent, stay out of trouble, and remain in Illinois.

We were told that prisoners from downstate Illinois often receive no recommendations for treatment or counseling because of lack of resources; Cook County has the best resources. The correctional counselor admitted that in Boyd's case, counseling given about child abuse had been inadequate.

In July, 1981, we asked the correctional counselor about a new program of counseling being phased in at Dwight by Child Abuse Unit for Studies, Education and Services (CAUSES). She told us that she had been involved in writing the proposal, but that very little had been done in terms of actual treatment. She added that some counseling had been provided by Dr. Nahman Greenberg and by Bernice Kravitz from CAUSES. Kravitz acted as liaison between inmates, counseling services, and private groups.

She said that though the proposal called for training of Dwight staff, it never occurred. Trained Dwight staff were supposed to help counsel inmates. The correctional counselor said that the program had not proceeded beyond the first or second phase of a five-phase program. She felt this was unfortunate because the program definitely was needed.

Commission staff analyzed the program narrative for the program, titled "Collaborative project with Dwight Correctional Center for Women (D.O.C.), The Department of Children and Family Services & C.A.U.S.E.S." Program objectives follow:

1) To provide <u>in-service training</u> to social service/mental health professional staff at Dwight in the assessment, interviewing and treatment skills and approaches for women residents with histories of infant/child maltreatment (child abuse).

2) To develop <u>screening</u> methods to assist in the identification of women with previous physical abuse of an infant or child and/or to identify women residents with children who are apparently at-risk of engaging in overt aggressive behavior towards one or more of their children.

3) To develop followup release services for women identified as abusive to their children.

4) To develop an improved system to facilitiate mother-child visitation.

5) To develop improved communications between DCFS and DOC regarding families being served in common.

The program narrative states that seminars will be given to Dwight staff on the origins, dynamics, and characteristics of child abuse; that "demonstration interviews with women residents known to have physically abused one or more children" will be conducted for Dwight staff; and that review of therapy at Dwight will be an ongoing objective.

The narrative also states that women will complete questionnaires focusing on possible previous problems with their children; that an inventory form will be developed "to identify abuse in the past or the future by measuring personality characteristics found in association with child maltreatment;" and that "women

known to DCFS for abuse of a child will be invited to talk about these matters for purposes of clinical services and with the recognition and understanding of not legally jeopardizing their situation or bringing about additional charges."

We spoke with the supervisory psychologist at Dwight concerning the program and were told that by May of 1981, about 50 of Dwight's 370 inmates had received service from CAUSES. These inmates need not have been child abusers; any inmate expressing a need for counseling regarding parenting skills was eligible to receive CAUSES' counseling. He said that Bernice Kravitz was the primary worker with these women; he also said that this part of the CAUSES project was successful beyond anyone's expectations.

We were told, on the other hand, that in-service training had been the most disappointing part of the CAUSES program. CAUSES was supposed to provide 16 in-service training sessions, but as of June 9, 1981, none had been conducted. He said he had yet to meet anyone managing or supervising any of the work being done, and the program was about to end on June 30 with no extensions that he knew of. The supervising psychologist felt that the portion of the program involving parenting counseling by Bernice Kravitz should be continued, even if funding had to be assumed completely by DOC.

Our conversations with Darlene Boyd's counselors at Dwight made it clear that there is a problem with making recommendations to the Parole Board. The correctional counselor told us that reports are submitted to the Board too soon after an inmate arrives without adequate time for counselors to assess an inmate's needs. This becomes an acute problem when an inmate serves only a short sentence. Also, while counselors can make recommendations to the Board in writing, they cannot be present at the hearing to emphasize special needs in any particular case.

The mental health counselor told us that, in Boyd's case, any recommendations given to the Board probably would be useless. She felt that this was the case most of the time.

The mental health counselor was encouraged by Boyd's request that some sort of counseling be set up for her following her release. She made an appointment for Boyd at the Lake County Mental Health Center in Waukegan. When our investigator mentioned that Waukegan seemed to be awfully far to travel, we were told that other mental health centers had been contacted and they had referred Boyd elsewhere each time. The mental health counselor admitted to us that she had no idea where Waukegan was at the time she made the appointment for Boyd.

The supervisory psychologist at Dwight told us that his staff does not "routinely" make recommendations for counseling for inmates who had been child abusers, though he admitted that in Boyd's case "it might have been a good idea." He blamed lack of training and manpower at Dwight for lack of adequate treatment for inmates. He added that Dwight's mental health component functions

the same as mental health units in communities: if a person does not want to cooperate with counseling, there is nothing that the staff can do about it.

He suggested that perhaps the Department of Corrections should adopt a rule that in cases in which a woman has been involved in a child abuse crime, counselors must recommend to the Prisoners Review Board that the inmate receive counseling upon release. This rule could be modified for instances in which an inmate responds to counseling while still incarcerated and staff does not think that she needs additional counseling after release.

We spoke with a doctor at the Lake County Mental Health Center, who said that Boyd had made an appointment but that she had not shown up. He added that no new appointment had been made. The doctor was not surprised, though; he told us that child abusers require some leverage to force them to make their appointments.

Darlene Boyd exercised her rights as a prisoner in the Illinois Department of Corrections system by refusing counseling. However, she was released with no recommendations or conditions placed upon her parole, in spite of her refusal to deal with the crime she had committed. The limited efforts by Dwight correctional staff to provide some aftercare for Boyd were easily circumvented. There is little to suggest that she would not repeat the crime for which she was sentenced.

C. Nicole

On July 17, 1980, three-year-old Nicole was pronounced dead-on-arrival at St. James Hospital in Chicago Heights. The following day, Medical Examiner Robert J. Stein performed an autopsy on the child and determined the cause of death to be hemoperitoneum (laceration of the liver) as the result of "blunt trauma." That same day, the girl's mother was placed under arrest by officers of the East Chicago Heights Police Department, charged with murder.

The first case of abuse of Nicole reported to DCFS occurred on November 24, 1979. A CPS worker took a call from a medical assistant working for a private doctor in Park Forest. The doctor had noticed "burn marks" and bruises on Nicole during a routine check-up. However, the doctor concluded that the "burns" might have been caused by a severe discharge. At the time of the examination, the doctor recommended that Nicole be admitted to Ingalls Memorial Hospital. The doctor planned to X-ray Nicole's arm, which was slightly swollen, and to perform blood tests. A CPS caseworker then called Ingalls Memorial just as Nicole was being admitted. The intake report was forwarded to another CPS worker who arranged a meeting with the mother.

The CPS worker met with the mother and her estranged husband who was visiting at the time. The worker felt that the mother was extremely depressed and possibly intellectually limited. The worker examined Nicole's four-year-old brother, Adam, and discovered several well-healed marks on his stomach and some old whip marks

on his legs. The mother was unable to explain the whip marks; she said she had never noticed them before. The marks on his stomach were from hot grease splashing on him while she was cooking, she said.

The worker's report is interesting for its initial assessment of the family in November, 1979. Excerpts from the report follow:

> The evidence of abuse is most prevalent in this family, so too is the ripeness of the mother to abuse. She is lonely, depressed, and without support. [She] received little or no nurturing as a child and has few parenting skills. She has grossly unrealistic expectations for Nicole and projects her own feelings of inadequacy to this child. Still, [she] related warmly with Adam, and he showed no signs of inhibition. [She] stated that she took Nicole to Dr. _____ because she fell down a lot and doesn't talk well. She stated that people tell her there's something wrong with Nicole, and she wanted to have it checked out. [She] reiterated what she'd told the hospital about the marks Nicole has; she has no idea how Nicole received them.
>
> [She] cried often throughout the interview and said it would hurt her to have the children removed. These children seem to represent still another attempt of [the mother's] to have her needs met. As far as being dangerous to the children, she did not at all strike me as one who would burn them. She admitted hitting the children with her hand and with a belt, but said she did not recall ever leaving bruises.
>
> There are two or three possibilities to be considered. Maybe, [she] has been abusive, perhaps at times when the children became too demanding about getting <u>their</u> needs met. Maybe, she was covering for her husband who, from her description, could very well be abusive. He's young and unhappy with his responsibilities.
>
> At any rate, further investigation is indicated here. [The mother] has expressed a desire to receive assistance and counseling, and homemaker services may be in order whether the children are removed or not.

Her report contains her supervisor's comment that the "...situation is high-risk and in need of immediate intervention."

The case then appears to have been assigned to another CPS worker. His first series of case notes cover the period from November 24, 1979, to March 27, 1980. The notes indicate that he visited the mother and Nicole at Ingalls Memorial on November 28, 1979. His notes state that Nicole had several injuries, all of which were explained away by Nicole's mother.

The next contact took place more than a month later, in spite of the previous note that the case was in need of immediate intervention because of its high-risk nature. This next contact consisted of a telephone call from the new CPS worker to Nicole's mother; she told him that her children were doing just fine.

Another month passed and the worker phoned the mother again. He got no answer. About a week later, he phoned again, and again received no answer. The day after this second call, February 14, 1980, the worker drove out to the home. No one answered the door.

In spite of all these failed attempts to establish contact, he waited for more than a month to recontact the family. He placed another telephone call on March 26, 1980, and found that the telephone had been disconnected. He then sent a mailgram to the home requesting a home visit, which finally took place on March 27, 1980. Case notes from the meeting indicate that Nicole appeared to be in good health, and the mother was pregnant.

The caseworker learned that the mother had gotten a job and that Nicole's paternal grandmother had been babysitting for the children. He gave the mother information about Parental Stress for help with her pregnancy, job, or children. His notes state that the mother was "not likely to intentionally harm [the children]. We are closing the case on this family at this time." The report is dated May 8, 1980, two months before Nicole's death.

Other material in the DCFS case file deals with events that occurred after DCFS received notice of Nicole's death.

Commission investigators interviewed East Chicago Heights Chief of Police Jack Davis and Sergeants Charles McCary and George Nance about their roles in the case after Nicole's death. On July 17, 1980, at 4:45 p.m., Nance received a radio call that a child could not be awakened at her nearby home. He arrived within three minutes and found the mother standing in the doorway crying. Entering the house, he saw Nicole lying in a strange position on the living room couch "as if she had been placed there." Paramedics from the East Chicago Heights Fire Department already had responded and were trying to revive Nicole. Nance felt that the girl probably was already dead, partially because her body was cold. He told us the mother said to him, "...I don't know what's the matter....She had a cold a few days ago; she came in and laid down on the couch."

Paramedics could not revive the girl, and transported her to St. James Hospital. At the hospital, emergency room personnel worked on Nicole for about an hour. When she would not respond, she was pronounced dead-on-arrival at 6:02 p.m. Nance told us that while she was being worked on at the hospital, bruise marks were apparent "all over her body" and she was bleeding from her nose and her ears. Emergency room nurses confirmed the strong possibility of child abuse.

DCFS received a report of child abuse from a nurse at St. James Hospital at 7:49 p.m. on July 17, 1980. Sergeant McCary phoned in another report at 9:30 p.m. The CPS intake report states:

> Nicole was d.o.a. with multiple, extensive bruises over the body. The mother said the child came in and laid down, and she could not waken her when she went to give her a glass of milk. The mother-paramour tried to have the child picked up by an undertaker, but the hospital is holding the body.

Following the recommendation of DCFS officials, police took protective custody of Nicole's brother, Adam, at about 10:00 p.m. Adam was taken to St. James Hospital for an examination, and was placed in emergency foster care the next day.

That same day, July 18, 1980, both parents came to the East Chicago Heights police station. A DCFS worker was also present. The police asked the parents about a neighbor's report of hearing a child being whipped in Nicole's house early the day she died. The mother admitted that she could have beaten Nicole early that morning but had no recollection of the act. She attributed this to loss of memory or "blackouts" that she supposedly sometimes experienced.

She insisted, however, that she alone had caused Nicole's bruises. She explained that on the day of her death, Nicole had been playing with water in the toilet as she had done on previous occasions, so she whipped Nicole on her legs and buttocks. Nicole walked out of the bathroom, stumbled into a living room coffee table, and fell to the floor. The mother stated that she lifted Nicole onto the sofa and shook her. At that point, Nicole seemed to be gasping and having convulsions, so the mother telephoned for an ambulance.

Nance told us the father would allow his wife to talk to the police only when he was present, and seemed unconcerned about his daughter's death. Nance suspected that both parents were involved in the beatings, and fabricated a story to protect the father. Nance was skeptical of the father's story that he had been playing basketball when the last beating occurred, although a friend later corroborated this alibi.

After being advised of her constitutional rights, the mother, in the presence of an Assistant State's Attorney, offered the following version of what had happened to Nicole:

> Mrs. _____ stated in summary but not verbatim that in the afternoon hours she was home alone with victim and her four year old son. Victim took a glass of water from the toilet and defendant "walloped" victim with a belt. Victim fell and hit her chest on a cocktail table. Defendant picked child up and put her on the couch at this time. Victim was still breathing and defendant notified ambulance. Defendant further stated that she punished victim in past in same manner for same behavior. In fact, one week earlier, she "walloped" victim for the same behavior. Mrs. _____ told ASA...that she would give a court reported statement. However, upon talking to her attorney, she no longer wished to give a written statement.

According to Nance, Adam told him two days after Nicole's death that he had seen his mother abuse Nicole. CPS interviewed Adam the day after Nicole died. He told CPS workers that Nicole had been home all day because she was sick. When asked why she was sick, Adam replied that his mother had whipped Nicole. He said that his father had not participated in the whipping. Because of his age, however, Adam would not be allowed to testify at his mother's trial.

The three police officers described some of their problems in working on this case. They said they no longer had photographs of Nicole lying on the couch because the photographs had been turned over to the State's Attorney's Office. (When we mentioned that the State's Attorney had no photographs, the officers said that it would not be the first time that evidence photographs had been misplaced.) They were further frustrated because the neighbor who had heard the sounds of whipping refused to testify in court. They also said that they probably could have gotten a written confession from the mother, but waited for involvement from the State's Attorney's Office so that no "loopholes" could be used to challenge the confession.

The police mentioned no problems with CPS or other DCFS workers. They informed us, though, that after Nicole's brother had been placed with his father's mother, she allowed him to return to his father.

Nance called this case the worst he had ever worked on during his 21-year police career. He emphasized the emotional strain he was under, saying that he had worked on many homicides, but none had affected him as strongly as Nicole's.

DCFS case notes covering the period from July 17, 1980 (the day of Nicole's death) to August 26, 1980 describe a good deal of casework. The CPS worker contacted everyone who had even a remote connection to the case, including neighbors, the children's pediatrician, and the Cook County Jail psychiatrist, psychologist, and social worker who had been working with Nicole's mother. His analytical case notes provide a good perspective on this case:

> [The mother] came out of a family setting that offered little real mothering to her. Her mother deserted her as an alcoholic and she was raised in part by her older sisters and a stepmother. [The father] reported that her sisters used to beat her. Ms. _____ noted that there was little closeness between [the mother] and her mother, and she had to raise herself. [She] wasn't close to her own sisters and did not allow them to babysit for her children. [She] specifically requested that Adam be placed with people on [the father's] side of the family rather than with her own natural family.
>
> [Her] becoming a mother at 16 gave her little time to have all of her own developmental needs met. Unrealistic expectations on Nicole as evidenced by bruises left on her in November, 1979, over potty training incidents as well as unhappy marriage...

added to the pressure that [she] must have felt. [The father] told worker that he had taken [her] several times to a Family Services Center for counseling in Chicago Heights at [her] requests but this ended in the summer of 1979. Several of the family in retrospect felt that [she] needed psychiatric help but none suggested this to her.

None of the other relatives noted any serious physical abuse on Nicole. She was seen by two DCFS workers on March 27, 1980, and no evidence of physical abuse was seen. The family pediatrician, Dr. _____, who examined Nicole numerous times, was never able to find evidence of physical abuse on Nicole. Her last examination of Nicole on July 3, 1980 revealed no evidence of physical abuse. On the other hand, [the father] had been physically abusive to his wife on occasion and was in contact with his daughter within the time period that she could have received the blows that lacerated her liver causing her to bleed to death.

The worker's recommendations include: expert psychiatric care for the mother; clinical evaluation of the father to determine his ability to provide for Adam in the future; clinical evaluation of the mother if she is released from jail and one cannot be performed by her treating psychiatrist at Cermak Hospital; efforts to keep Adam in touch with his father and his other relatives; and limited, but unsupervised, visits during the day between Adam and his father. Later, the juvenile court allowed unsupervised, overnight visits. DCFS approved of this arrangement.

In January, 1981, a Commission investigator interviewed Cook County Assistant State's Attorney Michael Boyle concerning the case's progress. At the time of the interview, the mother had been found mentally fit to stand trial; a psychiatrist also certified that, in his opinion, she had been legally sane at the time the incidents involving Nicole occurred. Boyle was ready for trial. He agreed that the husband might have had something to do with the abuse, but said that such involvement could not be proved.

In the interim, the mother had given birth to a daughter, Louise. DCFS gained custody of Louise and placed her in foster care. The mother was released on bond sometime between September, 1980, and January, 1981. She went to live with her husband at his mother's home.

On December 19, 1981, Judge Cornelius Houtsma granted a defense motion for mistrial. The motion concerned the testimony of Dr. Robert Stein, the Cook County Medical Examiner. Basically, the central issue was that Dr. Stein originally designated the manner of death in his autopsy report on Nicole as "undetermined." Later, after consulting St. James' emergency room reports, Dr. Stein changed his opinion of the manner of death, testifying that it was "homicide." The defense had been given only a copy of the report with "undetermined" on it.

As soon as Stein testified in court that the manner of death was homicide, the defense moved for a mistrial, arguing that Dr.

Stein's testimony came as a surpise to them. Judge Houtsma sustained the motion for a mistrial and ruled that the state had the duty to inform the defense of the manner of death. In spite of this setback, the State's Attorney's Office was prepared to pursue the murder charge before Judge Dwight McKay, who had been assigned the case.

A new jury was selected on January 25, 1982. On February 24, the new trial began with a defense motion to dismiss the information and discharge the defendant "...based on the defendant's right to be free from double jeopardy [proscribed by the Fifth Amendment to the U.S. Constitution] which resulted from the State's Attorney's prosecutorial overreaching." The State's Attorney countered that it did not "overreach" by mistakenly providing the defense with only Dr. Stein's first finding and not the second.

Judge McKay sustained the defense motion and the charge against Nicole's mother was dismissed. The State's Attorney filed an immediate appeal, under which the case remains as this report is being written.

A brief summary of this case points up its flaws. DCFS probably was remiss in not monitoring the family more closely. The case should never have been closed. It is ironic that after Nicole died, DCFS did a good job on the case, providing foster placement for the children without delay and contacting all appropriate parties. However, Nicole might not be dead had DCFS monitored the case properly from the beginning and had services been provided to the family.

Response from the East Chicago Heights Police Department was appropriate, and the police investigation appears to have been adequate. Officers did their best to prove that the father had also been involved in Nicole's abuse and death, but there was insufficient evidence. Response was quick: officers promptly visited the home, notified DCFS of the abuse, and took Nicole's brother into temporary custody. The police openly admitted to us that they could have done more on the case, considering its severity, but felt that their lack of familiarity with child abuse cases may have hampered some of their investigative efforts.

Technical problems with the preparation and presentation of this case allowed the mother to go free. Regardless of the merits of various points of law, the woman who had been charged with her daughter's murder has been released and charges have been dismissed. Her children are in foster care, but her whereabouts are unknown.

D. Fleanice Gray

Murder charges were filed against Dorinda and Lawrence "Pedro" Gray of Chicago when the body of their two-year-old daughter, Fleanice, was found in an abandoned building on February 16, 1981. A newspaper account says that Fleanice's mother had gone along with the girl's stepfather in fabricating a story about the child's abduction in order to cover up the death, but that she finally broke

down and admitted to police that her husband had beaten the child to death. The story also mentions that DCFS had been involved with this family before Fleanice was killed.

One source of information on this case was Fleanice's maternal grandmother. She told the Commission that she first called the DCFS child abuse hotline in September of 1980 to report that Fleanice had been taken to the Woodlawn Hospital Emergency Room because of cuts on her forehead. The girl's mother said Fleanice was injured when she fell out of bed and hit her head on an ashtray.

The grandmother told us that she became suspicious of the treatment that Fleanice was receiving from her stepfather, when, on September 16th, Fleanice had to have her stitches removed and seemed "petrified" to leave the medical center with Pedro. Fleanice clung to her grandmother and asked to stay with her. The grandmother decided to call the police because of her granddaughter's reaction. The police discussed the situation with the family and Fleanice finally agreed to leave with her mother but, according to the grandmother, still avoided Pedro.

Sometime around October 14th, the grandmother heard that Dorinda and Pedro were taping Fleanice's mouth shut for some reason. She decided to call the police again and met them at her daughter's home. The grandmother said that during the conversation which ensued, Pedro did all the talking. She said she became very upset with her daughter for not explaining what had been happening with Fleanice. Finally, the grandmother hit Dorinda and then Pedro slapped the grandmother. Dorinda signed a complaint and the grandmother was arrested and charged with disorderly conduct.

According to the grandmother, she called DCFS the next day to report the mouth-taping incident. Two DCFS intake workers submitted an initial report on October 15th alleging that Fleanice had had her mouth taped shut as a reaction to her use of foul language. The workers recommended follow-up by CPS but added that immediate response was unnecessary because the case was not an emergency. A supervisor assigned CPS caseworker Doris Fair to the case on October 17th.

Fair contacted the grandmother, who told her that she wanted custody of Fleanice. Fair stated that she would investigate the charges and get back to the grandmother. Fair discussed the use of tape over Fleanice's mouth with both Dorinda and Pedro and advised them not to discipline their child in that way again.

A summary case review filled out by another DCFS worker states that Fair and the Grays also discussed the couple's admission that they hit Fleanice as an added disciplinary measure. Fair later told us she could not recall this discussion but added that she definitely had seen no evidence of physical abuse. She questioned Fleanice about the taping incident and could only offer that the child's reaction was "puzzling." Fair decided that Fleanice might be hyperactive and told the Grays that she would be returning with a nurse to examine their daughter.

Fair recontacted the grandmother and told her that she had found no indications of any serious abuse and was going to recommend that Fleanice remain in the custody of Dorinda and Pedro.

On October 27, 1980, Fair contacted CPS nurse Sharon Balcitis, a supervisor in the Division of Child Protection, to request that she conduct a physical examination of Fleanice. Balcitis told us that this type of request is a rather informal action on the part of a caseworker and no supervisory permission is needed.

Balcitis conducted a thorough examination of Fleanice and determined that, although the girl was active, she was not hyperactive. Balcitis found no signs of abuse, although she found a small bruise on Fleanice's head. Dorinda explained that this was the result of Fleanice hitting her head on an ashtray on the living room coffee table. Balcitis added that Fleanice was not apprehensive about the physical examination, and that she responded appropriately to both her mother and stepfather.

A case review written after Fleanice died mentions that Balcitis noted reddish spots on Fleanice's chest. Balcitis did not recall what the mother's explanation had been for the marks and added that they could not have been part of any abusive pattern, so her inability to remember the mother's response was insignificant. Balcitis remembered that she told the parents they probably should have Fleanice checked by a doctor for hyperactivity, since it was they who had been concerned that Fleanice might be overly active for a girl her age.

Fair recalled the service plan that she prepared on Fleanice's case and said that Dorinda signed it. It included an agreement to take Fleanice for a follow-up examination at either the Woodlawn Clinic or Wyler's Hospital, an agreement to allow visitation by the maternal grandmother, and an agreement not to tape Fleanice's mouth shut. The follow-up examination was never done, according to Fair.

While conducting further follow-up on the case, Fair spoke with members of Pedro's family on a couple of occasions. Pedro's mother gave Fair the impression that she did not want to get involved with the case or with her son's business. Fair added that she had the feeling that the mother might have been withholding something the first time she was interviewed, so Fair spoke with her again. After the second conversation, Fair was sure that her previous impressions were correct.

Fair did learn from Pedro's mother that another son had called the Chicago Police Department on October 4, 1980, to report that he suspected Fleanice was being physically abused. The police apparently could not find any evidence of physical abuse and issued a verbal "warning" to Dorinda and Pedro that the next time the police were called, DCFS would be notified. Fair told us that the police did not submit a report of any kind to DCFS with regard to this incident.

The maternal grandmother told us that she went to court on the disorderly conduct charge in late October. Both Dorinda and Pedro were in the courtroom with Fleanice, who, according to the grandmother, had bruises all over her face. The grandmother said that she called Fair, who told her that she was too busy to come out that day to investigate. The grandmother told us that she begged Fair to come out to investigate before the bruises faded, and that eventually she did. Fair allegedly reported that there was absolutely no evidence of any physical abuse of Fleanice.

Fair told us that she could not recall receiving any call from the grandmother regarding the bruises on Fleanice's face, and nothing in the DCFS file reflects that Fair ever spoke with the grandmother about this incident or that a report ever was entered.

Fleanice's grandmother, who had custody of the child from late November of 1980 to mid-January, told us that she noticed bruises on Fleanice's buttocks and thighs on November 25. She took the child to the Woodlawn Medical Clinic, where a nurse and doctor examined her. The medical records indicate that Fleanice was examined and found to have a tender nasal bone as well as the bruises her grandmother had noticed.

The doctor who performed the examination said it was never brought to his attention that Fleanice's grandmother suspected her injuries were the result of physical abuse. The grandmother admitted that she didn't want to get the doctor involved in any abuse investigation, but claimed that she did notify Fair of this incident.

Fair stated that she never received any information regarding the injuries or the medical examination performed on November 25. Fair said that had she been given the information, she certainly would have taken some action. She pointed out that if abuse had occurred, the doctor, a mandated reporter, should have contacted DCFS. No report was ever made. Fair remained dubious that this incident ever happened, because if it had, it would have only served to strengthen the grandmother's assertion that Fleanice was not being properly cared for.

Fair did indicate that the grandmother had given her a radiology report dated November 25, 1980 for an X-ray of Fleanice's nose, and a handwritten page which was attached to the report. The handwritten page was illegible so Fair had no idea that it pertained to the suspected incident. (Commission investigators were able to make out the report only after the examining doctor deciphered it.) Apparently the material was given to Fair by mistake. She had requested that the grandmother provide her with documentation that Fleanice had received a recent physical examination so that she could be enrolled in a day-care program. Fair said that she notified the grandmother that the records received were not adequate and that the grandmother never indicated the records in question pertained to the physical abuse allegation.

Fair told us that the Fleanice Gray case was officially unfounded on December 24, 1980, during a routine case review between Fair and her supervisor, Helen Mullins. However, the case summary, which was not completed by Fair, shows that the unfounding took place on December 4. Fair stated that both she and Mullins agreed to unfound the case. She added that if she were to receive the same case today, she would indicate it and then still close it out. Fair said the issue was really quite simple: there was no evidence of physical abuse and, except for the taping of the mouth, nothing to suggest that anything was wrong in the home. Finally, even the taping of the mouth was not viewed as severe. Fair also mentioned that she relied heavily on Mullins' experience in unfounding this case because she had only been on the job for four months.

In mid-January, Dorinda and Pedro regained custody of Fleanice from the grandmother, with the assistance of the police. Dorinda and Pedro married on January 22, 1981, and the grandmother never saw Fleanice again.

A Commission investigator interviewed Sergeant Michael Hoke of the Chicago Police Department's Homicide Unit regarding this case. Hoke told us that on February 14, 1981, Dorinda and Lawrence "Pedro" Gray reported to the police that they had been robbed by two men in the alley behind their apartment. Police responded quickly with many men because the Grays claimed that not only were they robbed, but their daughter Fleanice had been kidnapped at the same time.

Hoke said that he worked on the case from the very first day and it was obvious to him that there was something wrong with Gray's story. Hoke's eleven years of experience as a robbery detective told him that they were lying. He said that their stories were just too good and their descriptions were just too accurate. Hoke stated that most robbery victims simply cannot remember details as vividly as the Grays could, particularly since they had been robbed at night and in an alley. Also, never in his experience had anyone ever abducted a child in such a bizarre manner. For the kidnappers to keep the child any longer than a few minutes while they escaped would have been foolish, so the police could have expected to find Fleanice no more than a block or two from the robbery. Hoke added that there was no way the robbers could have used the child to extort more money from the Grays, and keeping her with them for any period of time would only draw attention to them and slow them down.

Hoke said that although he felt the story was fabricated, the police continued to follow up any lead the Grays furnished. At the same time, the police began to work on another angle: that the parents were somehow responsible for Fleanice's disappearance. Police officers learned from their canvass of the area that neighbors felt the parents had abused Fleanice before; even some relatives questioned Pedro Gray's story of the kidnapping. Further questioning of both relatives and neighbors, when compared to stories offered by the Grays, turned up minor inconsistencies.

While Pedro stuck to his story, the mother began to change minor details of hers, which had been exactly the same as her husband's. Hoke told us that a line-up was arranged for the Grays, who picked out one man as one of their assailants. This confirmed some of Hoke's suspicions about the Grays because the man did not even remotely resemble the offender the Grays had described. Hoke speculated that by the time the line-up was conducted, Pedro was beginning to feel that his story had not been believed, so he used the line-up as a desperate way out.

After the line-up, the police brought the Grays in for additional interviews. This time the two were separated because the police felt that the husband was exerting control over his wife. Hoke said that with Pedro in another room, Dorinda broke down and told the police the truth. She told them that on February 12, two days before the police were called, Fleanice wet her bed and Pedro took her to the bathroom, where he beat her. When they returned from the bathroom, the mother noticed that the child's eye was swollen and bruised. On February 14, according to the mother, she got into an argument with Pedro, who told her to take her daughter and leave the house.

The mother did not want to leave, but Fleanice urged her to do so and go to the maternal grandmother's home. The stepfather apparently became incensed that his stepdaughter would insinuate that she would rather live with someone else, so he began to beat her again, hitting her head against a door and opening a cut. Pedro then placed his stepdaughter into a tub of water in the bathroom. When the mother went into the bathroom to get her daughter out, she noticed that she was lying face up and was beginning to sink under the water. According to the mother, she grabbed ahold of Fleanice and tried to pull her out, but in doing so slipped and hit Fleanice's head on the side of the bathtub. Then Fleanice tried to climb out by herself and supposedly hit her own head again.

According to Dorinda, the stepfather tried to revive Fleanice but couldn't. After it was obvious to them both that Fleanice was dead, the stepfather apologized to his wife and said that it had been an accident. She said that he offered to turn himself in to the police but later changed his mind and threatened to kill her if she told police the truth. While both of the Grays cleaned up the bathroom, which was full of blood, the stepfather moved Fleanice's body out of the way and set her on top of a radiator, where the body sustained burns.

The Grays dressed Fleanice and put her into a plastic garbage bag. They carried her from their house and dumped the body in an abandoned building at 6558 South Ingleside. Then they called the police with their story of robbery and abduction.

Hoke told us that after Dorinda Gray completed her story, she offered to take detectives to the exact location where she and her husband had dumped the body. Hoke said that Pedro Gray was in the next room and somehow became aware that his wife was cooperating with police. He also became concerned with the crying

and hysteria of other members of his wife's family, who had congregated in the police station and were easily visible to him. Hoke speculated that Gray must have thought that his only chance was to try to transfer blame for Fleanice's death onto his wife. He offered to give a statement implicating his wife in the beatings; he said that he participated in the cover-up only to prevent Dorinda from being arrested. Hoke said that Pedro Gray simply was not very believable.

DCFS records indicate that two days after Fleanice Gray died, the original report of abuse, which stemmed from the mouth-taping incident, was changed from unfounded to indicated abuse. The record indicates the original unfounding was "in error" and that the mouth-taping should have been indicated. This report also showed that Fleanice had died and that the Grays had been charged in the case.

Commission investigators interviewed CPS Supervisor Helen Mullins about this case and asked her why she approved the unfounding of the case. Mullis replied that there was no evidence of physical abuse on which to base an indicated report, and that she was satisfied that there had been no beatings or injuries inflicted upon Fleanice. She said that the mouth-taping incident certainly was not serious. Mullins added that the case looked like another intrusive relative case, this time in which the maternal grandmother wanted to obtain custody. She added that Fleanice was staying with her grandmother at the time the case was unfounded and that she felt the child was out of danger.

Mullins added that at the time the case had been unfounded, the process of unfounding and indicating cases was relatively new and she had participated in only a few unfoundings. She said there were no guidelines, either written or oral, for unfounding a case. The only guidance she had was the definition of an allegation. Therefore, Mullins had to use her own discretion in determining when to indicate or unfound a case.

A report that Jeanine Smith, CPS Deputy Regional Administrator, had made to DCFS Director Gregory Coler with regard to the Fleanice Gray case is excerpted as follows:

> The first week in January it was brought to my attention through the case review process that workers were unfounding excessive corporal punishment cases with supervisory approval. I do not understand the reasoning other than to state it was existent within the supervisory staff. I immediately instructed supervisors of this error in judgment in at least two supervisors' meetings. The Gray case was unfounded prior to these meetings although the supervisor should have known better, she and several others apparently did not. When I discovered it I took corrective action.

Mullins told us that Smith was utilizing "scare tactics" on workers, particularly supervisors, as a result of irrational pressure exerted by Director Coler in response to cases like the Grays'. Mullins told us that as a direct result of the Gray case, distinct

guidelines were developed for handling cases involving corporal punishment. Mullins told us that until that case occurred, corporal punishment never was defined. When the Gray case surfaced, she and Fair were scapegoated and guidelines were then developed for corporal punishment cases: now, if a child is hit with "an instrument" no matter how lightly, it is to be indicated child abuse. Mullins said that 95% of the parents in the city would be child abusers if this definition were applied to them.

When we asked Mullins if she could shed any light on apparent discrepancies in the summary review of the Gray case, she said that she could not, but she guessed that the summary review was composed under great pressure. Mullins described the atmosphere surrounding the review as one of panic; everyone involved with the case was very scared. She said that Coler and Gordon Johnson, a deputy director in Cook County, wanted a scapegoat, and the final review tends to incriminate both her and Doris Fair. Mullins added that when a case like the Gray case "hits the papers" there is always a tendency to try to find a scapegoat.

We asked specifically why the report from December was unfounded while a report dated two days after Fleanice's death showed that the case was indicated. Mullins said that the new computer system was so back-logged that the original finding had not been entered into the computer by February 16, thereby allowing DCFS staff to change the original report and indicate the case.

We pointed out that it appeared that Fair had insufficient training and experience to handle serious CPS cases. When we asked whether training should not be provided these workers before they are assigned serious cases, Mullins replied that the reality of the situation is that half of her workers are always new. She said she felt that it is "deplorable" that new workers are assigned to "tricky" cases, but that she had no way of determining in advance which cases were going to be tricky. She said that, considering it again, if she were faced with the same situation--with the same backlog and no one else available--she probably would assign Fair to the Gray case again. Mullins said that she had to work with what she had been given.

Mullins' final comments were that there was nothing that DCFS could have done to remove Fleanice from the home to prevent her death. The only thing they possibly could have done that they did not do was try to involve the family in intensive therapy; at the time they had the case, though, there had been no indication that intensive therapy was necessary. She added that no one can force someone to receive counseling if that person does not want to. Nothing in the Gray case suggested that closer monitoring had been necessary or that it would have changed the outcome of the case, Mullins said.

It should be noted that the report prepared by Jeanine Smith recommends that no disciplinary action be taken against Doris Fair due to the fact that she was undergoing training at the time of the Gray case and had "performed duties to the best of her capa-

bilities." Smith also recommended that Helen Mullins receive no more than an "oral warning" and that her actions should be viewed as a "supervisory error." Smith also agreed with Mullins' contention that the facts of this case did not warrant removal of Fleanice from her parents' home.

The Fleanice Gray case was not really complicated. It probably was a case in which the child had been chronically abused. It was yet another situation in which the mother of a child decided to live with, and then marry, a man unsuitable to raise children. DCFS was involved in the case as soon as it appeared likely that abuse would occur chronically; yet, there never was clear-cut evidence that abuse was occurring. The grandmother in this case may have done more harm than good, finally, through her efforts to orchestrate the dissemination of information.

The workers with whom we spoke indicated that morale at DCFS is poor because the Department will not stand behind its workers. Certainly that appears to be the case here. But this case was also flawed for reasons central to the larger problems at DCFS. The supervisor constantly had new workers having to handle sensitive CPS cases. Training was not provided for workers. Caseworkers had to prioritize cases, and this case certainly did not appear to be a priority case. Reprimanding the supervisor in this case for a series of circumstances out of her control appears to have had a negative effect, not a positive one. Changing the child abuse report from "unfounded" to "indicated" as a result of Fleanice's death is an act that we do not fully understand.

Overall, this case illustrates that none of the problems within the system were addressd as the result of Fleanice's death. Instead, workers were instructed to change reports. A summary was developed in which specific caseworker and supervisor blame was assessed. Cook County CPS developed a series of arbitrary rules for the indication of cases in which corporal punishment has occurred, probably further clogging up future CPS work. DCFS continues to respond to crises and criticims by using a short-term approach; the real problems, such as lack of training and expertise and poor communications among professionals, are not addressed.

On Thursday, June 24, 1982, Criminal Court Judge James Schreier found Lawrence "Pedro" Gray guilty of involuntary manslaughter for the February 14, 1981 death of his stepdaughter, Fleanice. Both he and Dorinda Gray were found guilty of obstructing justice and concealing a homicide. During the trial each accused the other of killing Fleanice and then fabricating a story to protect the person responsible.

"Pedro" Gray was sentenced to 14 years in prison by Judge Schreier, who said that the man had displayed "barbaric, uncivilized, and satanic" behavior in beating Fleanice and then dumping her body "like raw sewage" in an abandoned building.

Dorinda Gray was sentenced to five years in prison for the charges she faced.

Fleanice died less than a month after the Grays were married.

E. The Virginia Williams Family

On January 11, 1981, eleven children perished in a fire in an East St. Louis home. Virginia Williams was the mother of the children; she had left them alone and unattended on the evening of January 11 while she and her male companion went out gambling.

Williams was charged with neglect and negotiated a plea agreement that resulted in a sentence of one year's probation. After the final hearing, Williams said, "There's nothing I want to say, except I'm glad I'm not going to have to spend any time in prison."

Ordinarily non-professionals do not consider child neglect to be as serious or severe as child abuse. This case, however, illustrates that the results of child neglect can be worse than those of abuse.

The Department of Children and Family Services first became involved with the Williams family on April 13, 1977, following a report from the East St. Louis Police Department that Virginia Williams' children were being left unsupervised in the home and had been seen begging for food from neighbors. A CPS caseworker on this date established the following service plan goals: establish a child care plan for the children when the mother was absent; assist with housing problems; and provide medical services when needed. Williams refused to accept homemaker services which had been offered by the DCFS workers. The DCFS file contains no indication of how these goals were addressed or whether they ever were met.

On July 12, 1977, the East St. Louis police took temporary custody of all of the Williams children because they again were left unsupervised and were seen begging for food. After their return home, Williams failed to improve, and all of her children were placed in foster care after being left unsupervised on yet another occasion. DCFS custody was terminated when Williams decided to move the entire family to Mississippi. Documentation from the Department of Public Welfare in that state indicates that, in November 1977, Williams refused to have her children innoculated and reportedly often left them without supervision or food.

On February 20, 1979, the Illinois Department of Public Aid notified DCFS that the Williams family had returned to Illinois and had applied for public aid at the East St. Louis office. Mississippi authorities later told DCFS that Williams left the state the day before her children were to be placed in foster care there. DCFS' first contact with Williams upon her return revealed that she was destitute. DCFS workers suggested that she have her children placed voluntarily until she could receive her first public aid check. She refused.

DCFS workers attempted to make ten home visits between February 26, 1979, and June 12, 1979. Eight of these visits were successful; two were not. The family received emergency clothing and furniture, but again Williams refused homemaker services. The DCFS plan was to work with Williams on basic parenting and child care skills. A DCFS summary states that she appeared to be making strides in these areas.

On June 12, 1979, Williams' landlord informed DCFS that the family had moved to Iowa on May 29, 1979. The Iowa Department of Social Services provided services to the family from September, 1979, to August, 1980. Apparently this agency insisted upon mandatory homemaker services and consistently monitored the home through caseworker visitation. Despite these precautions, the agency noted only marginal improvement in child care skills and continued negligence in the children's physical care, household safety, and medical follow-up. The Iowa Department of Social Services placed the eldest child, a daughter, with one of Williams' relatives in Mississippi due to an unexplained conflict between the child and Williams' current boyfriend. According to the Iowa Department of Social Services, "It is possible that Williams left the Waterloo area to avoid what would have been a court referral and removal of her children if these problems persisted."

On August 12, 1980, the family returned from Iowa to East St. Louis. Again the police received complaints that the children were unsupervised and begging for food. On August 26, 1980, Williams was arrested and charged with neglect. DCFS was called and a caseworker responded. While the worker did not view the Williams situation as one of "severe neglect," it did seem serious enough to warrant follow-up services. The case was recorded as "indicated neglect." The major problems identified on the DCFS report were the mother's unemployment; her financial problems; the family's substandard housing; and the mother's poor housekeeping skills. Williams refused to participate in a birth control program but, finally, on October 23, 1980, she agreed to a service plan that called for Headstart programs for three of the children, medical care, clothing, furniture, training in "household functions," and visits from DCFS caseworkers twice a month.

The DCFS list of phone contacts and home visits seems stringent; unlike some cases we have analyzed, visits to the Williams' home seem to have been maintained on a fairly regular, strict schedule.

DCFS records reflect that when a caseworker made a home visit on December 19, 1980, there were approximately 15 children in her house and Williams was not home. An eleven-year-old daughter, Jeannette, was in charge and, according to the worker, seemed to be in control of the situation. The worker noted the following in her report: "Although not the best of circumstances I believe the children to be safe and had not known Mrs. Williams to leave the children home alone in the past. I did plan, however, to discuss the situation wth her." Apparently the worker was referring

to her own experiences with Williams and was disregarding the social history of the mother, which indicated a clear pattern of non-supervision.

The records we have reviewed describe progress toward service delivery for the family. The DCFS records note that no other neglect situations were discovered after August 26, 1980, except for two occasions when Williams was found not to be at home with the children. The final report states that the caseworker, Debbie Moffet, and the supervisor on the case, Vivian Sanders, "were not aware of the mother leaving the children some evenings during the weekend, which became apparent during the fatal fire." Again, apparently this refers to these two workers' personal experiences with the Williams family and disregards both the mother's history of neglect and a case record dated September 4, 1980, when a neighbor commented to DCFS workers that "the mother is almost never home and when she is, doesn't care for them."

The DCFS summary statement, prepared largely because of widespread suggestions that the Department had been remiss in not removing the children from the home prior to the fire, states:

> ...Viewing the case in perspective of the intermittent contact that this agency had had with the family and considering the fact that both in 1979 and 1980 Mrs. Williams had apparently been cooperative in dealing with problems identified by DCFS, it is unreasonable to conclude that DCFS should have petitioned the Juvenile Court for removal of the children in the course of our contact in 1980.

The DCFS documentation written after the fire states that there had been a great deal of improvement in the family situation. This documentation indicates that the mother had shown progress in parenting, child care, and housekeeping skills, that the children were attending school satisfactorily, that the children were healthy and well-fed, that DCFS had received no complaints from community or police, and that the mother was cooperating with her DCFS caseworker. The recommendations included in this report include the notation that DCFS not begin a full-scale investigation because Williams had followed the service plan. This paragraph also appears near the conclusion of the reports, which are signed by Gordon Johnson, Deputy Director for Program Operations:

> It is also my feeling that the worker Debby Moffett and Vivian Sanders acted properly in not requesting court intervention. The Juvenile Court Act requires a finding of imminent danger to the children in order for the court to remove children from their parents at the point of a shelter care hearing. A similar legal pre-condition is required for either law enforcement officers [or] DCFS to take temporary custody. The Williams' case does not qualify as one in imminent danger to the children. Therefore, the Service Plan to keep the children in the home can be supported.

A comparison of the case summary with prior case notes points out at least one discrepancy. In the case summary, Johnson states that a visit scheduled for December 19, 1980 was an unannounced visit. This was the visit at which 15 children were discovered in the home and Williams was absent. This is contradicted by a portion of a document titled "Running Record" submitted by the caseworker. The "Running Record" contains a reference to December 18, 1980, and reads as follows: "I told Mrs. Williams about the Christmas basket being requested and that I would bring it over the next afternoon to give it and gifts to the children." Obviously, the next day's visit was not unannounced, and the caseworker should have known that the mother's absence was a sign that she was not following her service plan to provide adequate supervision for her children. If the mother could not even be home when the caseworker was expected to visit, who could logically assume that she was home on other occasions?

On January 11, 1981, Virginia Williams was 28 years old. Her 12 children ranged in age from eight months to 13 years, 11 of whom perished in the fire. (The 13-year-old was in foster care in Mississippi.)

Sergeant Gregory Cox of the East St. Louis Police Department told us that he had numerous encounters with Williams, including two arrests for child neglect. Cox told us that twice the children were placed in foster care because of the neglect. He added that the mother appeared to have no interest in her children. He described her as a compulsive gambler who borrowed money from friends to gamble, and that Williams was known to have gambled away money that she had borrowed at a 25% or even 100% interest rate, promising to pay back "a dollar for a dollar." Cox told us that Williams was known to gamble away her entire public aid check and that the children went without food as a result.

Cox said that the fire started from a space heater located on the first floor of an old two-story house. All of the bedrooms were on the second floor and all of the children were trapped either in the bedrooms or on the stairwell. Cox said that if the children had not died in the fire, fumes from the clogged space heater would have killed them anyway.

Cox said that one good thing had come from the Williams incident: prior to the fire, the police did not trust DCFS workers and the workers did not trust the police. They were reluctant to share information. Now, however, Cox said that the Williams' tragedy has provided a bridge for them to resolve their suspicions and difficulties. They realize the different functions of the other agency and have begun to cooperate so that each one can do the best job. The police have admitted their shortcomings, as have DCFS workers.

In September, 1981, Commission investigators interviewed Virginia Williams at her home in East St. Louis. Sgt. Cox accompanied them to her home, where she agreed to be interviewed.

Williams told us she was born and raised in Mississippi. By 1976 she had given birth to seven of her children. She said that she was receiving an insufficient amount of money from the state, so she began gambling. State welfare authorities found out about the gambling and threatened action against her and her children. On the advice of her brother, who lived in East St. Louis, she moved to Illinois in 1976. As soon as she arrived she applied for and was granted public aid in the amount of $500 per month, a substantial increase over what she had been receiving in Mississippi.

Williams told us that she remembered her first contact with DCFS as occurring sometime in 1977. She told us that the East St. Louis police had received a call from someone alleging that she had left her children home alone; the children were taken into custody and Williams had to go to court. Williams claimed that she had been visiting friends or relatives in Mississippi when this call came in and that she had left the children in the care of a high school girl, who, she said, had left them alone. Williams added that the judge told her when she appeared at the hearing that she should move back to Mississippi because she had relatives there who could help her with her finances and with her children.

Williams did move back to Mississippi in 1977 and stayed there until 1979. Then, Williams said, the man who had fathered several of her younger children, Will Arthur Jones (who is married with five children of his own), came to Mississippi and moved the entire Williams family to his home in Waterloo, Iowa. In Iowa, Williams again applied for public assistance and was granted $804 per month. By this time she had twelve children. Williams told us that the Iowa Department of Children and Family Services provided homemaker services and was interested in the health and well-being of all of the children. When we asked how the Iowa authorities became involved with her family, she responded that Illinois DCFS notified the Iowa authorities of her whereabouts and past association with DCFS. She added that the Iowa authorities had become concerned with the welfare of the children after one of her children lost vision in one eye following an accident.

Next, Williams moved her children back to Illinois, around October of 1980. When she first arrived, she found it necessary to live with others, so she and her twelve children moved in with friends who had five or six children of their own. Williams said that because the home was so overcrowded, the police were called and her children were placed until she could find adequate housing for them. What she found was a house provided by a friend of Will Arthur Jones.

Investigators asked Williams about the homemaker services that had been provided by Iowa authorities, since she had refused similar services in Illinois. Williams responded that she never knew what the Illinois caseworkers were talking about when they referred to homemaker services; she did not know what the term meant or implied. So she refused the services because she did

not know what they were, she said. She added that had she known what they consisted of, she gladly would have accepted them.

Williams described the events that led to her discovery of her children's deaths. She left home about two o'clock in the afternoon with her friend Jones and spent some time in St. Louis visiting friends and playing cards. They returned to East St. Louis sometime that night, whereupon they went to a friend's home to play more cards. She said that Jones would periodically leave and drive by her house to "check on the children," though he never went in. After his last such trip, he returned to his friend's home about three o'clock in the morning where Williams was still playing cards. Williams said that he was incoherent when he walked in the door but eventually was able to say, "All of the children have been burned up."

Williams told us that she had someone drive her to her home, where she saw firemen trying to put out the fire. That was all that she remembered; she told us that someone informed her later that she fainted at the scene of the fire. She added that she had been told that the firemen had done nothing to save the children and that it had taken them a very long time to respond to the initial call.

Williams was adamant that she had done nothing wrong. She said that the 11-year-old who took care of the rest of the children was quite capable of disciplining the children, cooking, and managing the household. Williams said that had she herself been in the home when the fire occurred, undoubtedly she also would have been killed.

On February 11, 1982, Judge Kenneth Juen discharged Williams from probation during a brief court hearing, saying, "The mere fact you are no longer under the supervision of this court doesn't mean you can slip back in[to] your old ways." He warned her that she probably would lose all rights to her new child if she ever were charged with neglect again.

Williams was pregnant at the time of the fire, and she gave birth to a son during the time she was on probation. Williams gave birth to yet another son during the late summer of 1982. DCFS had been monitoring this case during this entire period.

On September 22, 1982, a nurse from the Visiting Nurses Association called on Williams at her home to check on Williams' 14-month-old son (she was unaware that there were actually two infants in the home). There was no response to her knock on the door, so the nurse waited outside in the hope that someone would return soon. After about 45 minutes, Williams returned to the home, and invited the nurse in.

Once inside the house, the nurse observed that an electric space heater was plugged in and that the burners on the kitchen range were on. She stated that the house was extremely hot and uncomfortable. When Williams fetched her two infants for the

nurse's examination, the nurse noted that they both were perspiring heavily and appeared to be experiencing great discomfort because of the extreme heat.

The nurse notified DCFS of the incident the next day, and the two infants have been in foster care since an abbreviated shelter care hearing was held September 24, 1982. At a rehearing on DCFS' request for shelter care, held October 15, 1982, Williams and her boyfriend both testified that the children were not left alone, and that the boyfriend was tending them. (Apparently, the contention is that the boyfriend was at home during Williams' absence and the nurse's visit but did not want to be seen so remained hidden.) Despite this testimony, St. Clair County Juvenile Court Judge Milton Wharton ruled there was still probable cause that the two boys had been left unattended.

At the October 15 hearing, Williams said she will "never forget" her 11 unattended children who died in the 1981 fire. "God has blessed me with two more sons and I won't do nothing to hurt them," she told Judge Wharton. Williams' lawyer, Marion Goldenhersh, said in court that the complaint was filed because of "overreaction and oversuspicion about this lady."

At a full hearing held on October 27, 1982, Judge Wharton entered a finding of neglect, then ordered the two boys made wards of the court. DCFS is to make a social study for the court before a disposition hearing set for November 30 (subsequent to the time this report is being written). The visiting nurse testified at the October 27 hearing that she and Williams were in the house about an hour before she ever saw the boyfriend, who appeared at the front door.

Criminal charges of child neglect (Ill. Rev. Stat. Ch. 23, ¶2361) are also pending against Williams.

There appear to be few questions about this case. The mother clearly neglected her children and moved from state to state when threatened by child welfare authorities. For whatever reasons, she refused services in Illinois. For supposed religious reasons, she refused to participate in birth control programs. Of her 14 children, 11 are dead, one remains in foster care in Mississippi, and two are in the custody of DCFS.

What is most notable about this case is its implication of the seriousness of neglect, as well as the ability of a person to elude and avoid the authorities. If the mother had been a severe child abuser, perhaps more of an effort to treat her would have been made by state authorities; perhaps the police would have been called in more often. But generally even child protection professionals labor under the illusion that neglect can have a long-term effect on children but cannot be immediately damaging to them. This case proves otherwise.

F. Peter

Peter's case came to our attention during a routine interview of Assistant Cook County Medical Examiner Robert H. Kirschner. He told us that Peter had died of salt poisoning at Loyola Medical Center in June, 1980, and that he may have been abused. He added that authorities were not pursuing the case. Commission investigators then conducted interviews and reviewed records, to construct the following chronology of events leading to Peter's death.

Peter was born several weeks prematurely on July 28, 1977, at St. Therese's Hospital in Waukegan, and was transferred to Evanston Hospital a few days later. Peter developed meningitis and, later, hydrocephalus, an abnormal increase in the amount of fluid in the cranium which, if untreated, causes enlargement of the head and destruction of the brain. Peter was operated on by a surgeon in the Pediatrics Department.

The surgery involved insertion of a small synthetic tube, a "shunt," into Peter's cranium. This shunt drained excess fluid into Peter's abdomen.

Peter's surgery was performed on August 2, 1977; he stayed at Evanston Hospital until October 27, 1977. The operating surgeon could not recall ever seeing the parents visit Peter, but attributed this to the considerable distance between Antioch (where they lived at that time) and Evanston. When Peter was discharged, his parents were advised to bring him back for an examination in one month. They failed to do so.

According to the surgeon, Peter's examination would have included checking the shunt to ensure that it was functioning properly and that Peter had not outgrown it. He told us that because of the hydrocephalic condition, Peter would develop slowly during his first six to nine months but would develop normally after that. On his release from the hospital, every indication was that Peter would be able to lead a relatively normal life.

Peter's family doctor told us that the parents had brought Peter in on November 9 and December 8, 1977. He said that these had been routine office visits to check Peter's height, weight, and general condition. He had not checked the shunt because he was a general practitioner, not a specialist; he felt that the doctor who had implanted the shunt or a similar specialist should check it for effectiveness. Peter had an appointment for January 27, 1978, which was not kept, and another for February 2, 1978, which was. That was the last time he saw Peter or his family.

Officials at the Lake County Health Department told us that between September, 1977 and June, 1979, a public health nurse made regular home and telephone contacts with Peter's parents. The hospital had routinely forwarded Peter's records to the department because he was premature, anticipating the need for medical follow-up. All of the Department's records indicate that the parents were providing Peter with proper diet and care. The Depart-

ment's role in the case, however, was quite limited and ended when Peter's family moved to Villa Park (in DuPage County).

On October 10, 1979, DCFS received a telephone report concerning the alleged neglect of two-year-old Peter and his one-year-old sister, Paula. Paula was a normal, healthy child and the caller's only remarks about her were that she seemed extremely overweight for a child her age and that she probably was not receiving proper medical attention (shots, etc.). The caller told DCFS that Peter was unable to walk or talk, receiving no medical care, fed only strained baby food, and confined to his bedroom at all times.

We interviewed the caller (whose identity cannot be revealed) to find out why he had filed a report on Peter's parents. He told us that although he was not extremely close to the parents, he felt that they were ashamed of Peter. Whenever Peter's name would come up in conversation, they always responded that they did not feel like talking about him.

The source described the parent's backgrounds. When he made the report to DCFS, the mother was about 21 and the father was about 29. Allegedly, the father physically abused his wife; they had even separated briefly because of these beatings. The source listed several allegations about Peter's father, perhaps the most significant of which concerned his abnormally secretive nature. Never allowing his wife to go anywhere, he did all of the family's grocery shopping and even refused to let her answer the door when he was not home. Supposedly, the father's parents had abused him when he was a child, and he eventually spent time in the Juvenile Division of the Department of Corrections. Finally, the source told us that the father had a very bad attitude about Peter, and had said he wished Peter had been a girl.

DCFS caseworker Mary Ellen McIntyre had taken the source's initial call and was assigned the case by her supervisor. She went to the home the day after the call, but found no one at home until a week later on October 17, 1979, when she interviewed Peter's parents.

McIntyre told us that Peter's parents were both quite hostile toward her, and refused to let her enter the home until she threatened to call the police. Once inside, she was able to conduct a "cursory" examination of the children. She remembered nothing unusual about either child. Peter's mother showed McIntyre his shunt and a copy of his special diet, and explained the complexities of Peter's medical condition. The mother told McIntyre that they had just moved to Villa Park, and had not yet had a chance to find a local doctor. She also stated that Peter needed no special medical attention unless he became "extremely" sick. McIntyre left the telephone number of the local public health facility at the apartment. After leaving the home, McIntyre called the reporting source and told him to call DCFS again if anything unusual developed. She then designated the case "unfounded" and closed it.

We learned later that Paula had been seen at the Villa Park Medical Center on three separate occasions for routine purposes, but that Peter had not been brought there at all.

At 6:00 p.m. on June 9, 1980--almost eight months after the DCFS visit to Peter's home--paramedics took Peter to Elmhurst Memorial Hospital. Peter was in a coma, suffering from, among other things, a non-functioning shunt, head trauma, and hypernatremia (salt poisoning). Because Loyola Medical Center in Maywood was better equipped to handle such a case, Peter was transferred there in critical condition. Before the transfer, however, the police were called in to fill out an initial report. On June 11, 1980, at 2:30 a.m.--less than a day and a half after he was brought to Elmhurst Memorial--Peter died. He was not quite three years old.

Loyola Medical Center notified the Cook County Medical Examiner's office of Peter's death. Assistant Cook County Medical Examiner Robert H. Kirschner performed an autopsy on the morning of Peter's death. A portion of his post-mortem report follows:

> This 35 month old white male was brought to the Hospital in a comatose state. The parents related a history of a fall from his crib. The child was admitted to the hospital but died approximately 24 hours later. At autopsy, there is minimal evidence of trauma to the head.
>
> There are, however, old and recent fractures of the limbs characteristic of child abuse. The injuries of the legs are such that the child probably would not be able to stand, due to the pain associated with the fractures. The parents' story is inconsistent with the multiple, repetitive injuries suffered by this child. The recent head injuries were either directly inflicted or occurred as a direct consequence of the other injuries to the body.
>
> The etiology of the hypernatremia and hyperchloridemia is obscure. The greatly elevated levels of these electrolytes suggests that this child may have been fed large amounts of table salt. Salt Toxicity would potentiate seizure activity and cerebral coma.
>
> MANNER OF DEATH: HOMICIDE

An attached radiological report done at Cook County Hospital as a consultation lists three "impressions" of the radiologist. The first is simply "battered child."

It should be noted that this post-mortem report was not prepared until a number of tests were completed several months later. Until all of these tests were completed, the cause of death officially was "undetermined." (Kirschner told us that his report was also delayed because he had trouble getting information from the involved hospitals and others.) Immediately after completing the autopsy, however, Dr. Kirschner did suspect homicide and con-

tacted Detective Andrew D. Subject of the Villa Park Police Department. The DuPage County State's Attorney's Office also became aware of this case at that time, although (for reasons to be explained later) their investigation of Peter's death did not begin until January, 1981.

On the day of Peter's death, then, Detective Subject and Detective Lieutenant Dennis Miller questioned both parents after giving them Miranda warnings.

The parents told the police their version of what had happened. On June 9, 1980, at approximately 4:00 p.m., the mother fed Peter and, as was her normal practice, put him back in his crib. Shortly thereafter, she heard a "thump" and went to Peter's room, where she found him on the floor "in a dazed condition." She said that Peter was not crying and she noted no physical signs of injury, so she put him back in the crib and left the room. Five minutes later, she went back to check on him and found him vomiting, clenching his teeth, and rolling his eyes back into his head.

At about this time (4:45 p.m.), the father arrived home from work and decided to drive Peter to Elmhurst Memorial Hospital. Because of Peter's obviously worsening condition, he stopped en route and called paramedics, who transported Peter to the hospital.

The parents said they remembered two or possibly three previous occasions when Peter had fallen from his crib. They said that one side of Peter's crib malfunctioned from time to time, and they assumed that this is what happened the afternoon Peter had to be taken to the hospital.

Both parents denied ever physically abusing or otherwise harshly punishing Peter. They stated that their only punishment for him was slapping his hands, which seemed to be effective. They also said they rarely went out socially but when they did, their only babysitters were the mother's parents, who lived in another DuPage County suburb.

To learn more about the extent of Peter's injuries, we consulted Dr. Kirschner and another, outside medical authority. Dr. Kirschner gave us copies of all reports that he had completed concerning Peter's death. He told us that the immediate cause of death was salt poisoning, and that if there had been no other signs of abuse, he would have classified the cause of death as "uncertain." However, the multiple fractures and bruises that Peter had sustained were a clear sign of abuse.

Dr. Kirschner said that Peter had four separate fractures--his right arm and both of his legs had been broken. Each fracture was at a different stage of healing, indicating that each had occurred separately. Also, at least five bruises had been detected on Peter's legs and feet. Like the fractures, the bruises were old and in the process of healing when Peter died.

Neither the fractures nor the bruises could be attributed to a recent fall from a crib, as Peter's parents had suggested. Also, Dr. Kirschner found no "visible signs of injury" to Peter's head. This contradicted the parents' explanation of Peter's comatose state: that he had fallen from his crib and hit his head.

Over 30 grams of salt were found in Peter's blood. We asked Dr. Kirschner if there were any way that the salt could have been eaten by accident or through an improper diet. He responded that it was possible that the parents could have mixed the salt with the child's food, but they would have had to be aware that they were giving him so much salt that he would be poisoned.

Apparently, there is no way Peter could have ingested so much salt on his own. For one thing, if Peter had eaten 30 grams of salt at once, he would have vomited it before it reached his bloodstream. Moreover, Dr. Kirschner told us that Peter's fractures would have kept him in constant pain, rendering him incapable of standing on his own, let alone walking to the table salt.

Dr. Kirschner felt that the injuries were typical child abuse symptoms; in most child abuse cases, he explained, the parents do not attempt to kill their child but try to inflict extreme punishment for real or imagined acts. He concluded by stating he was willing to give his opinions "with reasonable medical certainty" as testimony.

The independent medical expert we consulted was Rute Medenis, M.D., Associate Professor of Pediatrics at the University of Illinois Medical Center. We furnished Dr. Medenis with Dr. Kirschner's reports and subpoenaed medical records from all of the hospitals that we knew had treated Peter: St. Therese's Hospital, Evanston Hospital, Elmhurst Memorial Hospital, and Loyola Medical Center. After reading the reports, Dr. Medenis commented: "That kid must have been a punching bag for somebody."

Dr. Medenis agreed with Dr. Kirschner that Peter must have been in constant pain from the fractures of his limbs. She said that it would have been impossible for anyone to have stood up with a fracture like Peter's--located both above and below the knee. She also explained that bleeding in Peter's head had occurred on both sides, which is consistent with the effects of salt poisoning and inconsistent with a blow to the head or fall from a crib, which would have produced bleeding in one area only.

Dr. Medenis told us that she has inserted shunts into children's heads and that it is essential that they be checked periodically to see if the child has outgrown the shunt, in which case it would have been ineffective in draining off fluids near the brain. Peter clearly had outgrown his shunt, she said.

Dr. Medenis said that this case was a "classic" child abuse case and that it was obvious from the evidence that Peter had been abused until he died. She said that the case was typical insofar as abusive parents often will choose one child in the family to

abuse and leave the others alone. Frequently the child chosen is "different" in some way, or is not "normal." She argued that, at the very least, Peter's parents' inattention to his medical condition indicated child neglect. Dr. Medenis also showed us a chart of average height and weight for a child of Peter's age. Peter was grossly underweight at the time of his death, even taking into consideration his medical problems.

Dr. Medenis said that there are several medical conditions which can cause salt to accumulate in the body, including a specific type of head injury in which the brain will shut off the normal flow of instructions to other parts of the body that eliminate excess salt. If this were the case, the body would be unable to eliminate the salt, causing coma or cardiac arrest. However, nothing in any of the medical records even suggested that Peter had this or any other condition that could have been a "natural" cause of salt retention. Dr. Medenis said that there was one indisputable fact concerning the presence of this amount of salt in Peter's body, regardless of whether Peter had collected the salt by force or by accident: he would have had to be deathly ill for at least three days before he was brought to the hospital, and it was more likely that he would have been extremely sick for about seven days before his death, because it takes a certain period of time for salt to accumulate in the body. Therefore, Peter would have had to have been vomiting, convulsing, or showing some other signs of extreme illness long before his parents took him to the hospital for treatment.

Because there was some confusion over who was supposed to report Peter's death to DCFS (which we will describe later in this account), DCFS did not learn of the incident until November 7, 1980, five months after Peter died. The DCFS record states that a report could not be initiated at that time "as child was dead five months prior to the report to DCFS." DCFS did open a case, however, apparently for two reasons: (1) follow-up on Peter's sister, Paula, and (2) documentation of the events leading to Peter's death.

After some difficulty in locating the family, the DCFS worker finally found the right address and apartment, and left a note asking the parents to call DCFS. The father did so on November 20, 1980, expressing his surprise at being contacted. He said that he and his wife had spoken with the police and that they thought the matter had been closed. The social worker taking the call noted that the father was quite evasive and obviously did not want to meet with her. The father said that the worker would have to talk to his wife because he worked six days a week from 5:00 a.m. until after 11:00 p.m.; further, his wife "was away" and would not return for a few days. He would not say where she had gone. Finally, they set up an appointment for November 24, 1980, the father claiming that this was the earliest his wife could meet with the social worker.

On this same date, the social worker spoke with a representative of the State's Attorney's Office, who told the DCFS worker

that he thought the case was being investigated and that he would get back to the social worker about the case's status. The worker also contacted the Villa Park police, who initially agreed to send DCFS a copy of the police report but later recanted, stating that the report could be submitted to DCFS only upon receipt of a written request or a subpoena.

A DCFS social worker visited the mother and Paula on November 24, 1980. Her initial observation was that the home was spotless and that the mother and Paula communicated well together. DCFS case records include the mother's version of what occurred on June 10, 1980, the day before Peter's death:

> [The mother] spoke in a quiet tone and began on the afternoon of 6/10/80. [Paula and Peter] were in the kitchen. [The mother] was in the bathroom. When she returned to the kitchen she found the salt shaker had been opened. [The mother] presumed [Paula] had opened it. There was salt all over the table and floor and on [Peter]. She did not see him eating any salt, but just to be safe, she gave him water and some PeptoBismol. He appeared fine. Approximately 1½ hours later, she fed [Peter]. He ate and drank some milk. She then put him in his crib for a nap. A short while later she heard a noise as though he had fallen. She opened the door and found him on the floor, face down, getting to his knees. She stated that the bar on the crib must have given way. She indicated that she thought he hit his head on the dresser. He was whining rather than crying which is the sound that he usually made when upset. [The mother] stated that she held him for awhile and he seemed to be alright. She placed him back into bed and returned to the kitchen to feed [Paula]. She then heard [Peter] vomiting. She went to his room and found him shaking as though he had the chills. She tried to hold him and he didn't want to be held. He continued to vomit violently for about 20 minutes. She laid him on the floor when it seemed he had stopped and changed his clothes and sheets. She returned him to his bed. He tried to pick his head up but didn't seem to have control of his head. He began to vomit again. She again cleaned him up and changed the sheets. This took approximately 30 minutes. [Peter] then began to kick and jerk his body and arms and head. His eyes opened and rolled back. [The mother] stated she didn't know what to do as she had no phone. Her husband came home shortly thereafter and put [Peter] in the car, and proceeded to Elmhurst Hospital. [The mother] stayed at home with [Paula]. On the way to the hospital, [Peter] worsened and began jerking and acted as though he could not breathe. [The father] pulled over and called for an ambulance. [Peter] had stopped breathing but he was still alive when he arrived at Elmhurst Hospital.

The mother was later transported to the hospital by her parents. She remembered being told by a doctor that Peter had had an epileptic seizure and that he needed to have the shunt removed because it had come out of his stomach. She remembered a doctor asking what Peter had eaten recently and she had gone home to bring in his baby foods for testing. The mother remembered doctors dis-

cussing why Peter had died; she recalled that one had thought it was the result of a brain tumor, while another thought that it had been sugar diabetes. Still another mentioned Reye's Syndrome. The report states the mother's belief that "They were never clear about how or why he actually died."

The mother told the social worker that Peter was developmentally delayed but that they had been told to expect that. She said that he never walked on his own; he walked by holding onto things. He had been able to stand alone for only two months before his death. She also told the social worker that the doctors had said that no follow-up care was necessary unless Peter showed signs of illness.

The following two paragraphs are taken verbatim from the DCFS report:

> Social worker asked [the mother] why [Peter] had bruises on his body at the time of death. [She] said he used to kick his high chair and hit his head on the back of his crib. Whenever he wanted attention, he would hit his head and [the mother] would respond by picking him up or at least go to him. Social worker asked if [Peter] had ever had any broken bones and [the mother] claimed to have no knowledge of this.
>
> In the course of the conversation, [the mother] mentioned that a DCFS worker from the Villa Park office had been out about a year ago. She explained that someone called anonymously claiming they were not feeding their children and were not providing medical treatment. She remembered telling the caseworker that she would follow up on immunizations for both chidren and still had not done so. [The mother] was afraid of losing [Paula] because of this.

The mother remembered that the first report had accused her of never allowing the children out of the bedroom, but when the social worker arrived, all of the children were in the living room (one might recall that the worker was allowed in only after she threatened to call the police).

Later the social worker learned, in conversation with DuPage County Assistant State's Attorney Cynthia Lee Wheeler, whose office was investigating the case, that the mother had not mentioned anything about the salt incident to the State's Attorney's investigator. Wheeler wondered if the mother had changed her story based on what she heard at the hospital.

On the DCFS social worker's fourth visit to the home, on January 23, 1981, she finally met the father. He strongly supported his wife's account of the events that led to Peter's death, and was very cooperative with the social worker. Both parents expressed their willingness to cooperate with DCFS in order to ensure Paula's welfare, "short of removing her from the home."

On February 19, 1981, the day on which the story of Peter's death appeared in a local newspaper, the worker made another home visit. Specifically mentioning Peter's fractures, the worker advised both parents that a finding of "indicated child abuse" would be recorded. Neither parent made any comment or asked any questions. The worker learned at this meeting that the mother had agreed with the State's Attorney's Office to undergo a polygraph examination. The father became upset and expressed his distrust of the "system." The mother expressed her intention of cancelling her appointment with the State's Attorney's investigators, but after discussing the matter with the worker, stated that she would think it over.

Following these meetings, the worker wrote a report which included recommendations regarding Paula:

> This social worker has found no indication of any abuse or neglect on [Paula]. Had social worker been involved immediately after [Peter's] death, this might have been a different reaction and another plan might have been recommended. However, coming into the case after a child had been dead for 5 months and seeing the second child well cared for and happy, social worker is not recommending placement at this time. Social worker has talked with Cindy Wheeler, State's Attorney, and they, too, could find no reason to remove [Paula] from the home. Social worker does recommend follow up in the form of supervision at this time as the family is not feeling any need for services.
>
> A finding of abuse on [Peter] was made on February 19, 1981. The case will be held in the Protective Service Unit for follow up on [Paula].

The news story in the local paper highlighted the fact that the DuPage County State's Attorney's Office did not begin investigating Peter's death until January, 1981, even though the Villa Park Police had notified the office of his death shortly after its occurrence. The story further stated that both Elmhurst Hospital and Loyola University Medical Center failed to report the case as suspected abuse or neglect, and DCFS officials did not learn of Peter's death and the circumstances surrounding it until they conducted a routine check of Loyola's records, looking for suspected abuse cases that might not have been reported.

The story said that J. Michael Fitzsimmons, DuPage County State's Attorney, acknowledged his office's knowledge of the death since June, 1980, but said that his investigation was delayed because the child was transferred from a DuPage County hospital to a Cook County hospital. Furthermore, the autopsy was performed by the Cook County Medical Examiner's Office, delaying transferral of records until January, when his office began its investigation, Fitzsimmons said.

Commission investigators spoke with representatives of the DuPage County State's Attorney's Office on an ongoing basis, beginning in April, 1981. Two representatives of the office, Wheeler (mentioned earlier) and Criminal Division Chief Thomas L. Knight, along with other members of the staff, eventually concluded that it would be virtually impossible to convict anyone of poisoning Peter with salt. They felt that Peter's fractures and bruises, as well as his medical neglect, would have been sufficient to remove him from the home had he still been alive and possibly even to seek termination of parental rights. But they believed that the fractures, bruises, and medical neglect would not aid in any prosecution for Peter's death due to salt poisoning. Knight's reasoning was based on case law he interpreted as prohibiting the introduction at trial of evidence of conduct by the accused not relevant to the actual, specific cause of death. (That is, only conduct illustrative of certain modus operandi would be admissible into evidence.)

An investigator also spoke with Cook County Assistant State's Attorneys Kathleen Ryan and Timothy McMahon. Ryan's assessment of the case records was that this would be a tough case to prosecute successfully because of the salt. However, she recommended that the case nevertheless be prosecuted: she commented that the medical evidence from two experts was overwhelming and that the pattern of abuse was chronic. Further, the parents' stories were inconsistent enough to erase doubts in her mind about their culpability.

While we wanted to interview Peter's parents to complete this case study, we were hesitant to do so because of the possibility--however slight--that the DuPage County State's Attorney's Office might reverse itself and prosecute either or both parents for Peter's death or some lesser charge. We sought their advice; in response, we received a letter from Knight stating that his office had no intention of prosecuting the case because of insufficient evidence. In a later conversation, before the parents were interviewed, Knight told us that his office would bring charges against one or both parents, if they confessed. If the confession contained an admission that Peter was force-fed salt, Knight would proceed on murder charges; if the admission concerned only the fractures and bruises, he would pursue charges of aggravated battery.

We discovered that Peter's parents, with Paula, had moved from Villa Park to a Lake County suburb. We arranged to meet with Peter's mother at a Lake County hospital, where her husband was undergoing minor surgery.

We interviewed the mother on December 31, 1981. She told us that she had been very young when she married and became pregnant in her first year of marriage.

During her pregnancy and throughout the marriage, her husband drank excessively and used drugs. Often he was fired or laid off so there was not enough money to go around. When he was working, it was at night. He spent his days off with friends instead of

his wife and children and sometimes spent weeks away from home. Because her husband did not allow her to go out or have any friends, she had no one to talk to about her problems.

Her husband did not want to give Peter any special medical care; the one time she suggested taking him to a group such as one sponsored by Easter Seals, the husband refused.

She admitted that when the family's monetary problems and other marital pressures got to her, she would take her frustration out on Peter. This became acute after Paula was born, and she had a normal, healthy baby with whom to compare Peter. While Paula might cry occasionally, Peter whined and whimpered almost constantly, sometimes all night long.

Near the end of the interview, she admitted to spanking Peter and screaming at him to get him to stop whining. When that did not work, she would grab his arms or legs and twist them as hard as she could. When he started to cry, she realized what she had done but never really understood why she had done it. She agreed to sign a statement that summarized her actions toward Peter, which she did, and said she felt better having finally discussed the matter with someone.

She continued to maintain, however, that Peter must have ingested the salt accidentally.

The mother said that she never told her husband about hurting Peter until after Peter had died and Villa Park police questioned him at work about Peter's injuries. She said that to the best of her knowledge, her husband had never hurt Peter.

The purpose of the Commission in conducting this investigation had been made clear to Peter's mother; she understood that she had not been subpoenaed and that any information she gave us was given voluntarily. She did say that she did not understand why she had hurt her son, and expressed an apparently sincere desire to talk to a professional about it.

At the time this report is being written, the DuPage County State's Attorney's Office has taken no further action on this case. After our interview with the mother, she underwent counseling, which apparently was successful, according to the counselor.

Systemic Problems

During our investigation of Peter's death, we interviewed several professionals who described general systemic problems that go beyond this one case.

DuPage County Assistant State's Attorney Cynthia Lee Wheeler was quite critical of DCFS, charging that at times DCFS staff had withheld files from her office in order to "protect their clients." Wheeler said that DCFS did not cooperate or work with her office on cases at all. Wheeler's analysis of the problem was that DCFS

workers were interested in their individual clients, while staff at the State's Attorney's Office were charged with being responsible for the "public good." Wheeler felt that this basic conflict might always keep the two from cooperating. Wheeler said that the only cases that DCFS reported to her office were "headline grabbers" and cases needing police support and protection.

Thomas L. Knight agreed with Wheeler, and said that in his eleven years of prosecuting cases, he has seen DCFS fight court recommendations and decisions.

DuPage County Assistant State's Attorneys Victoria A. Rossetti and Patrick J. King, Jr., commented on issues dealing with child abuse and neglect prosecutions. Rossetti and King mentioned that their office established its own screening committee to divide calls and categorize cases. County hospitals and local police departments had been calling their office directly rather than attempting to call DCFS. They said that these mandated reporters ignore the law because they feel that they will get no results if they call DCFS. King said the situation was so bad that ASAs even get calls at home.

Rossetti said that the root of the conflict with DCFS was internal conflict within DCFS as a result of trying to both investigate suspected cases and also provide treatment to the abusive families. She added that DCFS is not always uncooperative with her office, but that inconsistency best decribes the DCFS initiative toward the State's Attorney's Office.

King said that DCFS has at times openly refused to provide his office with information on a case. They have told him that a subpoena is necessary to obtain records and other information. Both Rossetti and King mentioned that when DCFS is involved with a case, caseworkers often tell defense attorneys the details of a case, thereby "blowing" the state's case.

Both ASAs recommended that DCFS hire professional investigators with investigative experience to make initial determinations of indicated or unfounded abuse. They said that there is too much conflict for a worker to investigate a case impartially while also considering the welfare of the family and the Departmental philosophy of trying to keep the family intact whenever possible. King added, "I live in fear of calling a DCFS worker for my witness. We just can't use them."

Rossetti and King mentioned some specific cases to augment their argument concerning problems with DCFS; they also added allegations about workers and supervisors performing inappropriate functions. The upshot of their comments was that they perceived several crucial problems with present activities and procedures of the DCFS workers in the immediate area, some of which seem to be tied to Department-wide philosophy and rules, and some of which could be changed at the local level.

Villa Park Police Detective Subject told us that he had no contact with DCFS. He said that he never calls DCFS or reports anything to them because, in the past, DCFS has never responded to his reports. He said that DCFS only had made things worse in cases that he had reported previously.

DCFS caseworker Mary Ellen McIntyre, who made the very first contact with Peter's family nearly eight months before Peter's death, told us about her employment with DCFS. She started in the Lake County office, was transferred to the Villa Park (DuPage County) office in 1979, and only took over her duties as a neglect investigator in July of 1980. She described her transfer from the Lake County to the Villa Park office as "culture shock." She said that the Lake County office is run much better than the Villa Park office, even though the Lake County office receives more calls that need to be investigated. She thought that the population in Lake County was more diverse than that of upper middle-class DuPage County, and therefore more careful to report possible cases.

McIntyre felt that the relationship between DCFS and the courts was also superior in Lake County, partially because of the work done by the DCFS court liaison, and partially because the Lake County State's Attorney's Office was much more aggressive in bringing cases of abuse and neglect to court. McIntyre mentioned the existence of a Lake County Community Residential Network, a type of multidisciplinary team that meets to discuss the very difficult and severe cases. A DCFS supervisor sits on this particular committee. Lake County may also function better, she said, because all DCFS workers are assigned to specific teams, whereas in DuPage County each worker is given a caseload and is expected to handle it alone. In Lake County, the teams meet faithfully every week to staff difficult cases. In DuPage County, the workers are on their own and they receive little, if any, support from supervisors. There is a lack of consistency in DuPage County, she mentioned, adding that each supervisor wants things done his or her own way. Finally, McIntyre said that the police do not have anywhere near the kind of cooperation with DCFS workers in DuPage County that they have in Lake County. McIntyre speculated that because many residents of DuPage County are upper middle-class, they are not likely to report cases of abuse. She felt that many were completely unaware of the existence of DCFS.

During the course of pursuing Peter's case, a Commission investigator visited Loyola University Medical Center to speak with authorities there and to pick up records. We spoke at the time with Sister Ruth Kleitsch, Director of Social Services, and John S. Swartwout, Assistant Hospital Director. We asked Kleitsch why the case had not been reported to DCFS until five months after Peter's death. She admitted that the case should have been reported and regretted that it had not been. She said that she had been on vacation when Peter was brought in and that her staff was not prepared to report the case. She added that because Peter was only in the hospital for a short period (24 hours), the Social Service Department did not have much time to get involved.

She also stated that once a child is pronounced dead, the case is the responsibility of the Medical Examiner. (When we asked Medical Examiner Kirschner why he hadn't reported the case to DCFS, he said he assumed DCFS already knew about the case.) She guessed that in this case, because Peter had been transferred from Elmhurst to Loyola, staff on duty at Loyola must have assumed that the Elmhurst authorities had reported the case.

Both administrators said that they had discussed the case extensively after they discovered that it had not been reported correctly. Loyola has a child protection team that immediately tightened up its procedures so that a similar case could not fall through the cracks in their system, they said.

Several days later, a Commission investigator went to the Memorial Hospital of DuPage County (Elmhurst Memorial Hospital) to pick up records on this case and to speak with Charles Warner, Director of Social Services at the hospital. We asked Warner the same question. He responded that he had not been Director of Social Services when Peter was brought in; he has been director only since October, 1980. He said that he did not know exactly why DCFS never was notified about the case, but guessed it was because the child was transferred to Loyola within 12 hours of admission and was still alive at the time. He added that because Peter was retarded both physically and mentally, the abuse was not as apparent as it might have been with a "normal-sized" child. His main point was that he assumed that Loyola would report to DCFS. He showed us the forms that had to be filled out on any case of suspected abuse or neglect and noted that they were quite lengthy and complicated. He suggested that the short time Peter was in the hospital, coupled with the mechanics of filling out these forms, contributed to their lack of reporting.

As at Loyola, after the problem was discovered, the hospital staff doubled their efforts to discover and report suspected cases of child abuse and neglect. He said that reports have increased dramatically since Peter's case was discovered to have been mishandled.

Thus, in Peter's case, officials at both treating hospitals assumed incorrectly that the other hospital had the responsibility to report; neither bothered to check with the other hospital to see if, indeed, a report had been made. And the Medical Examiner assumed incorrectly that the hospitals had already reported the case.

G. Kurt Geisen

On May 22, 1979, the Crystal Lake Police Department received a report that smoke was coming from an apartment building. Officers responded and found a young boy chained to a bed in the burning apartment. The boy, Kurt Geisen, was taken to a local hospital to be treated for severe burns and smoke inhalation. He died the next day.

Local newspapers ran the story and, because the Department of Children and Family Services had been involved with the case, accused DCFS of negligence. Governor James Thompson's concern over this case led him to order an independent investigation. In addition, the Commission looked at the events, which led to Kurt Geisen's death.

Kurt was born July 11, 1965 and developed a medical condition known as Prader-Willi Syndrome. The two major characteristics of this syndrome are developmental delay (both physical and mental) and a compulsion to overeat to such a degree that the afflicted person's life is endangered. This need to continually eat caused Kurt's mother to restrain him to his bed with a chain when she was at work and Kurt was unsupervised in the home.

On April 30, 1971, DCFS received a child abuse report from a doctor who had examined five-year-old Kurt and noticed slight bruises on the boy's shoulder and head. Kurt's mother told the doctor that her husband had abused the child. DCFS workers were unable to contact anyone in the family until May 13, at which time the boy's mother explained that Kurt's father had hit him after becoming angry at her. She stated that her husband was alcoholic and assured the workers that such an incident would not recur because she had filed for divorce. DCFS records contain case notes and summaries of this incident, but no further action was taken because of the mother's interest in obtaining a divorce and because the father was no longer in the home.

The next contact with DCFS occurred on March 11, 1977, when Richard Taber, a social worker for the Special Education District of McHenry County (SEDOM), which provided schooling and other services for Kurt, called to report that Kurt had been absent from school for two days and had returned with bruises. Taber requested that DCFS not take any action at the time because he planned to speak to the mother about the incident. Taber just wanted to make the report. Apparently DCFS did no follow-up on this incident.

On April 20, 1979, the Crystal Lake Police Department received a call from a neighbor of the Geisen's who said that Kurt was roaming through the apartment complex in which he lived, knocking on doors. The police contacted Kurt's mother, Delores DeGeorge, who told them that because of Kurt's extreme mental retardation and his compulsion to eat, she had been forced to chain him to his bed and that he somehow got out. Mrs. DeGeorge said that she had a difficult time finding qualified babysitters because of the nature of Kurt's disease.

On April 24, 1979, Detective Keith Nygren of the Crystal Lake Police Department called the Lake County Youth Service Bureau and reported that Kurt's mother admitted to chaining Kurt to his bed during unsupervised periods. The Youth Service Bureau, which was handling after-hours DCFS calls at that time, contacted DCFS the next morning with the report.

DCFS worker Ann Indelicato visited the home on April 26. Kurt and his mother were present at the meeting. The mother repeated to the worker essentially what she had told the police. She admitted to keeping Kurt chained up at times even when she was home, and said that she or her daughter maintained supervision of Kurt when he was loose.

Regarding the incident reported to the police on April 20, Mrs. DeGeorge stated that Kurt apparently found the key to his chain which was kept outside of his room, unlocked himself, and left the apartment. The locking mechanism consisted of a chain attached to a collar that fit around Kurt's ankle. The chain was approximately twenty feet long and gave Kurt access to his room, the hallway outside of the room and the bathroom. The collar was just tight enough to keep Kurt from getting loose. During this visit, Kurt showed his bedroom to the caseworker and showed her how he chained himself. The worker made the following notation in the case record: "When questioned about what would happen in case of fire, Mrs. DeGeorge stated that she and her daughter each had a key close by to use."

The caseworker asked Kurt's mother why she did not just lock the refrigerator and kitchen cabinets and was told that this method had been tried but "penalized the family." Also discussed was the possibility of residential placement for Kurt, but this was preliminary only.

On April 27, the caseworker contacted Patricia Fohrman, a SEDOM nurse, in order to develop a better understanding of Prader-Willi Syndrome. Fohrman told her that those who suffer from the syndrome never have the feeling of being full, and can quite literally eat themselves to death. Most of those who have the disease do not live very long and die from complications associated with obesity. The nurse said that the usual way to deal with the problem is to lock the cabinets and refrigerator. Richard Taber of SEDOM also talked to Indelicato on this date. He said that he had been unaware of Kurt's being chained and told the workers that he would help the mother install locks in her kitchen.

DCFS discussed this case at a regular weekly team meeting held April 30. The discussion concerned Kurt's condition and how his mother was handling it. The decision was made to assist SEDOM staff in changing the mother's attitude about the necessity of chaining Kurt, and to work with SEDOM in finding an appropriate residential placement for the boy.

SEDOM records show that Mrs. DeGeorge met with staff members on May 4, 1979, to discuss Kurt's behavior problems both at home and at school. The mother stated that Kurt was chained and unsupervised generally between 4:45 p.m., when she left for work, and 10:15 or 10:30 p.m., when her daughter returned home from a part-time job.

SEDOM staff expressed their concern with the chaining and asked that the mother continue to seek an appropriate babysitter for this period. Staff members indicated that they would talk

to DCFS about a homemaker for that period of the day when Kurt was home alone. The mother requested that SEDOM look into residential placement for her son in light of her increasing difficulty controlling him. Everyone agreed to communicate better so that disciplinary measures for Kurt, both at home and at school, would be more consistent.

Taber sent a copy of the memo explaining this meeting to Indelicato at DCFS, with a brief note regarding the possibility of DCFS providing homemaker services. On May 15, he sent a letter to Kurt's mother to be certain that she had understood what SEDOM staff had decided to do regarding Kurt. In reference to the mother's request that he look into residential care, Taber mentions in the letter that any such care is "very costly." He continues, "I know of two ways that State agencies might eventually agree to help with this high cost, as follows." He then adds the following two paragraphs:

1. For children and teenagers, one way is through the courts and D.C.F.S. with the child made a ward of the State. Often parents ask for help saying they cannot give the child what the child needs. D.C.F.S. has a policy of trying to keep children in the home and D.C.F.S. may offer various kinds of help to try to keep the child in the home. But, if these attempts fail then D.C.F.S. may take action to provide the best available residential placement for the child, such as foster care, children's home, or other residential care.

2. Under the State Department of Mental Health & Developmental Disabilities (DMH-DD), sometimes funds can be made available for those with developmental disabilities. (Kurt is developmentally disabled.) At this time we could not attest that his present educational placement (SEDOM) is inappropriate for him. So we could not ask your local school district to help pay the educational portion of any present residential placement. This would mean that the State DMH-DD would have to agree to fund the cost of any residential placement. The State DMH-DD is very reluctant to fund residential placements.

The gist of the information is that residential placement did not seem to be a likely alternative for Kurt.

A telephone conversation between Taber and Indelicato on May 15, led to the following agreements:

1) The homemaker request was inappropriate for this situation.

2) Mr. Taber agreed to proceed with assisting Ms. DeGeorge in applying for residential placement for Kurt.

3) Mr. Taber agreed to visit a few local residential treatment centers with Ms. DeGeorge.

4) This worker [Indelicato] agreed to search files for a licensed night-care home for Kurt.

5) This worker agreed to contact Public Aid to determine if they could help the mother in payment for residential care.

The plan developed was simple: cooperate with SEDOM in finding residential care; attempt to locate licensed night-care; and revisit Mrs. DeGeorge to further discuss the issue of restraining her son.

On May 30, 1979, after Kurt had died, SEDOM produced an internal document stating the chronological events that led up to Kurt's death. Listed in this account are the various meetings that had been held. The point is strongly made that both the police and DCFS were aware of Kurt's chaining for seven days prior to SEDOM's being contacted. A good deal of the memo concerns itself with efforts by SEDOM staff to try to persuade the mother not to chain Kurt. Most of what we have discussed is reiterated in this internal document. The document states that no one informed anyone at SEDOM of Kurt's death, though a neighbor of the family notified SEDOM's transportation department of the fire and of the fact that Kurt had been badly burned. The document concludes with a statement that SEDOM had done all that it could to provide appropriate supportive help in this case and shared no culpability for Kurt's death.

Commission investigators interviewed most of the key people involved in the Geisen case. Included in these interviews were conversations with three representatives of the Crystal Lake Police Department: Lieutenant James Weidner, Commander of Investigations; Detective Keith Nygren, Juvenile Officer; and Officer Kathy Sheley, also a Juvenile Officer. They commented first on their investigations of child abuse and neglect in general and then addressed the issues of the Geisen case.

The three said that DCFS officials, at a training seminar, had told the police in the area that they did not want police involved in any cases of abuse or neglect. Officer Sheley added that she had heard the same thing personally. They said that the only time DCFS contacted the police was when DCFS needed to be "bailed out" of a situation. The officers agreed that DCFS definitely tries to hold to its policy of preservation of the family within the home at all costs.

The officers had a number of complaints regarding DCFS' operation: they do not understand how DCFS can conduct child abuse and neglect investigations over the phone; they have had problems with getting DCFS to respond when the police take protective custody of a child; and they had an occasion when they picked up a runaway who was also a DCFS ward and the agency workers refused to come and get the child.

Also, the officers were not aware of any correspondence from DCFS regarding either the new reporting laws or the toll-free "hotline" number for reporting.

A Commission investigator spoke with Winnebago County Chief Deputy Coroner Ruth Anderson. Her office was responsible for the inquest into Kurt's death because Kurt died in a hospital in Rockford, which is in Winnebago County. Anderson said that in the five years that she had been with the coroner's office, there had been only two deaths resulting from possible child abuse or neglect. She described cooperation with local law enforcement bodies as excellent. She described portions of the autopsy procedure. And she described one of the major functions of her office: determining the facts surrounding any death and presenting information to the coroner's jury. She said that it was this jury that would classify a death as accidental, suicide, homicide, or other.

She told us that the jury is composed of six people; this jury is responsible for determining the cause of death but can also make recommendations. In the Geisen case, the coroner's jury found that Kurt died from severe burns and smoke inhalation. The death was ruled accidental but "parties" to the death were cited as negligent. Anderson told us that the parties referred to were Kurt's mother and sister. The State Fire Marshal's report indicated that no accelerant had been used in the fire and that the probable cause of fire was either matches or a defective toy.

The McHenry County Grand Jury returned to the McHenry County Circuit Court a report of their deliberations into the Geisen case on June 8, 1979. The report contains a "No True Bill" and states that "there is no probable cause for an indictment to be issued regarding possible criminal violations." The following five paragraphs are taken verbatim from the text of the Grand Jury's report:

> We want to reprimand the Department of Children and Family Services for their lack of follow-through and their negligence in this case. We feel, in this case, that the child should never have been chained to his bed and left alone. Further, that once the authorities knew of this boy's chaining, the boy should have been placed in protective custody until the matter was resolved as to how this boy was going to live the rest of his life.
>
> We want to reprimand the Department of Children and Family Services for their inaction and for the decisions they made in handling this boy's life.
>
> We also want to reprimand the Department of Children and Family Services for their lack of assistance to the mother. They should have gone back into the home to check and see if the boy was being neglected or left alone.
>
> We don't want another "Kurt incident."

We do not condone the methods used by Mrs. DeGeorge in chaining Kurt and leaving him unattended when she had said she would not do so. We want to reprimand Mrs. DeGeorge for her negligence in leaving her son alone.

A Commission investigator discussed the Geisen case with Ann Indelicato. Included was discussion of the reprimands from the Grand Jury and a complete discussion of the activities that occurred prior to the fatal fire.

At the time of our interview, Indelicato was the DCFS intake coordinator for DCFS-McHenry County. She had served with DCFS for five years at the time of the interview. Before that she had been a school teacher and worker for Public Aid. Indelicato told us that her primary function was investigation of alleged child abuse and neglect cases in McHenry County. She said that she had a number of "desk cases" that required more monitoring. She added that normally intake workers conduct the initial investigations; if a case is opened, the case is transferred to another worker. Indelicato said that the Lake Villa Office, to which she was attached, did not have a CPS unit as such. As an intake worker, she functioned much as a CPS worker in Cook County might.

At the time of our interview, Indelicato said that the Lake County Youth Services Bureau had provided after-hours answering services for DCFS until January 1, 1980. Their contract expired and the after-hours calls service had been picked up by the Antioch Answering Service. Indelicato said that their operators have received training in handling calls and that they determine when they receive a call if it is serious enough to be referred immediately to an intake worker on-call, or if it should wait until the next business day. She also mentioned that the Youth Services Bureau had used the same procedure when handling their calls before 1980. Calls are now handled by the "hotline" in Springfield.

Indelicato also discussed the details of the Geisen case. She admitted that DCFS was the primary agency responsible for handling Kurt's welfare, but she felt that asking SEDOM for assistance in this case was adequate. SEDOM had been involved with Kurt for some time. Furthermore, she charged that SEDOM staff had known about Kurt's chaining for at least a year before DCFS was called in to deal with the problem.

Indelicato consulted her case notes, which indicated that she was to attempt to locate night-care for Kurt and to contact the Department of Public Aid concerning funding for possible residential placement. She told us that she did make an attempt to find night-care for Kurt but was unsuccessful and that she did not contact the Department of Public Aid because she had previously tried to get assistance from the Department on another case and was unsuccessful. She told us that she felt that trying in Kurt's case would do no good.

We had a chance to exmaine Indelicato's case notes and discovered that her attempts to find night-care and her rationale

for not contacting the Department of Public Aid are not reflected therein.

Indelicato addressed problems with the Department of Mental Health/Developmental Disabilities. She told us that it is very difficult for a parent with a developmentally disabled child (like Kurt) to receive assistance from the Department; she said that a parent can apply personally for an individual care grant but will be placed on a long waiting list. Indelicato claimed that DMH/DD does not in fact have emergency placements available in spite of DMH's statements to the contrary. Indelicato was very critical of DMH/DD's operations. She said that it is difficult to get ahold of any one person involved with emergency placements at DMH/DD and that is very hard to have a child placed as an emergency because of the red tape involved.

Indelicato told us that although she had not seen either of two reports that DCFS had issued about the Geisen incident, she had heard that the Department supported the way the case was handled. Regarding the Grand Jury reprimands, Indelicato said that the chaining that Kurt went through was not abusive but had been done for protective purposes only. She mentioned that the mother had told her that the chaining occurred for short periods of time only. Based on the information she had at the time, she did not think that the case warranted protective custody. She added that if the case were so serious that the child should have been removed from the home, the police should have been the ones to do so, particularly since they had known about the chaining for four days before they reported it. She said that she did not think that she had failed to follow up with the mother because DCFS was mandated to utilize existing agencies and services and because SEDOM had stated its interest in helping the mother apply for residential placement for Kurt. She said that she does not call the police every time she investigates a case of abuse or neglect, but she does call them when necessary and claims to enjoy an excellent relationship with them.

Indelicato's final comments were more general. She added to her criticisms of the court system in mentioning that during the past five years in McHenry County there had been only one instance in which parental rights were terminated by the courts. She described that situation as a very clear message that it is difficult if not impossible to attempt such a termination in that county. DCFS is left with two alternatives, she said: return the child to the home or attempt to use court-ordered services. She said that one does not get much cooperation from parents who are ordered by the court to have a homemaker or to attend counseling. She added that in her opinion, juvenile matters in general are at the bottom of the list of priorities in the courts.

Later, we interviewed Diane Breske, Indelicato's supervisor in the Lake Villa Office. Breske addressed the Geisen case directly as well as some of the more general issues we have alluded to frequently in this report.

Breske stated that workers in the Lake Villa Office are not allowed to accept the voluntary placement of children. She reasoned that if placement-type services were really needed, the courts should be involved. Breske complained that the courts do not take abuse and neglect cases as seriously as criminal cases, as evidenced by the assignment of the newest and least-trained judges and assistant state's attorneys to juvenile matters. Breske said that it takes time for a judge to learn the nuances of handling juvenile cases. She said that everyone had been fortunate in Lake County because the same judges had been handling juvenile matters for a few years. But she added that, in her experience, the only people who remain in juvenile court are those who are personally committed to children.

We asked Breske about the relationship between DCFS and law enforcement agencies. She admitted that complaints from police about lack of contact when DCFS makes an investigation are true. She said that DCFS workers will contact the police when investigating a "major" case but will not do so otherwise because many of the small police departments with which workers must deal are "little gossip mills." Most of the departments to which she referred are small and are located in small communities where "everyone knows everyone else." Breske felt that the police do not respect the privacy and confidentiality of some information. She added that police tend to get "caught up" in cases, particularly incest cases, and consequently approach these cases from a different perspective than does DCFS.

Overall, though, Breske said that DCFS enjoys a good relationship with youth officers from various police departments. She did single out the Crystal Lake Police Department as one department with which her workers had had problems in the past. Breske suggested that the younger youth officers are easier for her workers to get along with than officers who have been working in the Juvenile Division for a number of years.

Breske admitted that her workers did have the power to take protective custody of a child, but she added that the Lake Villa Office had instituted a policy of not doing so if the police were not present. The only exception might be her workers taking protective custody of a child while he is in school. Breske said that there were two reasons for this policy: first, police officers are better equipped and trained to handle protective custody duties than are caseworkers; and second, she felt that some police departments felt that the new law was eroding police powers. As a result, she wanted to be certain that the police were involved in these matters whenever possible.

Breske predicted that the new reporting law would result in an increased number of investigations. She said that the degree to which caseloads increase will depend on the ability of central registry staff to screen out the calls that do not require response or immediate response. Breske added that one benefit of the new law would be the allowance for DCFS workers to take 60 days to complete an investigation (as opposed to the 30 days mandated by

the old law). She allowed that it should not take 60 days to complete an investigation, but often 30 days is not sufficient because the caseworkers must depend on a number of other people to provide information and records, and these other people might not respond as quickly as they should. The second benefit Breske saw to the new reporting law was the advantage that the Department would have to close a case if it had been presented to the court and had been denied for court services and if the family had refused to cooperate with DCFS. She said that this would enable DCFS to close out cases that otherwise would clog the system.

At the time of our interview with Breske, she said that DCFS was not providing training in investigative techniques. She said that intake workers in her office, who would all be called CPS workers after July 1, 1980, no longer fool themselves into thinking they are anything other than investigators, because that is what the intake position has evolved into. Breske said that she has provided in-service training and that many of her workers have picked up techniques of investigation from police officers but that the area of investigation and training to conduct investigations remained a serious deficiency in the Department.

Breske talked about the Geisen incident. She repeated that Indelicato had determined that protective custody was not in order in Kurt's case because, although Kurt was mentally retarded, he still could understand and communicate. Further, to remove him from the home could have been very traumatic for him, Breske said, because he did enjoy a good relationship with his sister and mother, who were trying their best to provide care for him. The chaining was not abusive but was for Kurt's own welfare. Breske told us that it was her impression that the mother was very cooperative and had agreed not to chain Kurt during the unsupervised period in the overlap between her job and her daughter's. Finally, SEDOM had agreed to help the mother find an appropriate residential placement for Kurt if still deemed necessary.

Breske told us that she had not seen documentation, but had been told that SEDOM staff had been aware that Kurt was being chained for more than a year prior to DCFS involvement in the case.

Breske admitted to our investigator that, normally, the DCFS intake worker would have conducted another home visit to see if the mother were in fact obtaining proper supervision for Kurt. Breske said that in this case, the intake worker had important personal business that kept her out of the office for awhile and that she did not consider the case to be a particularly "hot" one, so she left the case with another intake worker for follow-up during her absence.

Breske echoed what Indelicato had told us concerning DMH/DD's lack of emergency placements. Breske said that if a caseworker calls DMH/DD, staff there will give the worker the names of specific residential placements to call and the worker would have to place the calls himself. It was her impression that parents have had better luck dealing directly with DMH/DD than her workers had had.

We asked Breske about use of an individual care grant for Kurt's residential placement. She responded that she was unsure whether DMH/DD had the money for such a grant at the time. She said that the DMH/DD staff did not keep it a secret that the Department had run out of money for placement of children with psychiatric problems but was unsure of the funding status for children who were developmentally disabled.

We discovered that both Breske and Indelicato received written reprimands from DCFS Director Coler for their handling of the Geisen case. Breske was extremely angry at getting a reprimand because she felt at the time and still feels now that the case had been handled properly. She told us that she had learned that the letter had not been written by Coler and was replete with inaccuracies. She challenged the statements in the letter of reprimand through the Departmental grievance procedure, and the matter finally was settled by the letter being removed from her permanent personnel file. Breske told us that Indelicato was challenging her own letter of reprimand and that the matter had not been resolved.

Breske told us that she understood why Coler had to issue a reprimand. She described him as a political person bound to certain political realities who really had no choice in the matter. She added that if she were in his position, she would have done the same thing. Breske was upset that information in the letters had been obtained by the press and publicized, making it difficult for her to continue in her job, knowing that others were aware of the specifics of the letter. These comments led to Breske's evaluation that the Department does not support its employees. Breske felt that she would have been suspended from her job if her supervisor and the supervisor above him had not supported her position. She claimed that everyone present at the Grand Jury hearing except for Indelicato and herself was represented by an attorney. This statement concluded Breske's information and opinion regarding Departmental involvement in the Geisen case.

A Commission investigator spoke with several representatives of the Special Education District of McHenry County (SEDOM). Again, we elicited general responses to the problem of child abuse and neglect and then addressed the Geisen case specifically.

Dr. James Albert, Superintendent for SEDOM, provided many of the answers to our questions. Joining him in the interview were the following staff: Richard Woosnam, psychologist; Susan Fugleberg, social worker; Kathy Usborn, social worker; Patricia Fohrman, nurse; and Timothy Foran, social worker.

All of the SEDOM staff agreed that DCFS employs a "bandaid" approach to child abuse and neglect cases. They said that DCFS utilizes stock responses to almost all cases: homemakers and advocates. They added that DCFS rarely addresses the problems that lead to the genesis of abuse and neglect in the home. Instead, they concentrate on the immedate needs of a parent or child. SEDOM staff observed that many of the parents who neglect or abuse their

children simply do not know how to parent properly and probably could benefit from proper training and counseling.

The SEDOM staff complained that many caseworkers are improperly trained or prepared to handle cases of child abuse and neglect. SEDOM staff indicated that none of them would want to work for DCFS, where the pay is poor and morale is exceedingly low. As we have noted elsewhere, turnover was extremely high among DCFS caseworkers, according to SEDOM staff. SEDOM staff also referred to the DCFS philosophy of preservation of the home at all costs. Holding a child's welfare in a position of secondary importance can cause problems with workers trained to be concerned about children and their problems.

SEDOM staff criticized DCFS caseworkers for conducting shallow investigations into abuse/neglect allegations and for taking events and stories of occurrences at face value. They cited several cases in which the investigative effort was just too simplistic and in which the child suffered as a result. SEDOM staff told us that caseworkers are not trained to gather evidence or to adequately evaluate the truth of charges. The information that they develop often cannot be introduced into a court of law.

We also discussed the Geisen case in particular. Much of the chronology reflected in SEDOM documents that we have presented here was repeated to us. Dr. Albert also responded to several questions about SEDOM's handling of the case. He said that no member of the SEDOM staff had been aware of Kurt's chaining until they received a call from Ann Indelicato, and the purpose of that call was not to tell SEDOM about the chaining but to inquire about the nature of Prader-Willi Syndrome. As a result of the conversation, however, the chaining incidents came to light.

According to Albert, full responsibility for the resolution of the chaining incidents lay with DCFS. Albert felt that even if the boy had not been chained during unsupervised periods, he still was being neglected because of the seriousness of his condition. In effect, he was saying that there should have been no unsupervised periods. Albert said that SEDOM staff spoke both with the mother and with DCFS staff in order to try to find an answer to the problem but could go no further. Albert said that, under the law, if the school district could not accomodate Kurt, it had the responsibiltiy to place Kurt in a private residential facility and pay the cost. But, he added, Kurt's condition was such that the programs offered by SEDOM were appropriate; thus, Kurt could not be referred nor could the school district pay for residential placement.

Dr. Albert mentioned the DCFS investigation of the incident that was handled by James Gottreich. Albert said that the investigation was not the result of DCFS interest in Kurt's death but rather had been the result of Albert's interest in making clear that SEDOM was not in any way culpable for Kurt's death. He told us that someone from the Lake Villa DCFS office and another DCFS official had made statements to the press implying wrongdoing or

lack of action by SEDOM. As a result, Albert tried to reach DCFS Director Coler but none of his calls was returned. Finally, Albert told whoever answered the phone in Director Coler's office that if he didn't hear from Coler, he was going to issue a statement to the press. Albert said that Coler returned his call fifteen minutes later and the next morning Gottreich appeared at SEDOM offices. Gottreich spent the day with SEDOM staff, who asked him for more information on the disposition of cases involving children whom SEDOM was servicing. Gottreich agreed to provide the information, Albert said, but never did.

None of the SEDOM staff went into any more detail regarding the investigation into Kurt Geisen's death.

The final document that the Commission obtained is a draft report from the Illinois Developmental Disabilities Advocacy Authority (IDDAA) on the events leading up to Kurt Geisen's death. The report was prepared at the request of Governor Thompson and was to be presented directly to him. We spoke briefly in 1980 with then-Executive Director Stephen Schnorf of IDDAA, who emphasized to us that the report was only a draft and that no findings or recommendations had yet been prepared. He did indicate to us that one of the findings was to be that SEDOM had been in error because SEDOM staff did know about Kurt's chaining long before DCFS involvement.

The report mentions that it had been prepared as the result of Governor Thompson's interest in having an appropriate agency conduct an "independent investigation" into the circumstances surrounding Kurt Geisen's death. The review team that IDDAA assembled consisted of the following IDDAA staff, plus Susan Sitter, a Legal Advocacy Service attorney: Stephen B. Schnorf; Gary R. South, Director of Advocacy Services; Marijo Ransaw-Robinson, Advocacy Service Coordinator; and George Ackron, Advocate. The report's introduction mentions that approximately one week after Kurt's death, two members of the review team interviewed Mrs. DeGeorge. She was cooperative and willing to discuss the circumstances of her son's being chained. In effect, she explained the conditions of the syndrome with which Kurt had been afflicted. Mrs. DeGeorge told the review team members that Kurt was chained at night while other family members were asleep and at all times when there was no one home to watch him. She added that the chaining had been going on for a long time and that, before he was chained by his ankle to his bed, he had been restrained by his bedroom door being chained partially shut so that he couldn't get out. She said that SEDOM, DCFS, and the Crystal Lake Police became aware of the chaining on April 24, 1979; she was unaware if the agencies knew anything about the chaining before that date.

The mother described DCFS involvement as unenthusiastic. She mentioned that a DCFS caseworker had visited the home after DCFS learned of the chaining, but she had made no attempt to recontact Mrs. DeGeorge, nor did Mrs. DeGeorge feel that DCFS was going to take any action at all in relation to her or her son's problem.

The review team then examined documents from both DCFS and SEDOM. All relevant entries are summarized in a chronology of events beginning October 6, 1972. The review team was careful to differentiate between DCFS and SEDOM records when presenting the chronology of events. Included is a notation from 1972 that Kurt had been getting up at night to steal food from the kitchen and that the mother was trying to find a way to fasten a padlock to the refrigerator door. Notations from both DCFS and SEDOM from March, 1977, reflect contact between a SEDOM nurse and DCFS workers regarding Kurt's coming to school with bruises and scratches, including the nurse's request that DCFS not become active at that time. There were several references to Kurt being bruised upon arrival at school, and no reports were made to DCFS. This happened at least four times in 1977 alone. The notations continue into 1978.

The most significant notations, which indicate that SEDOM staff knew that Kurt was being chained at night, come from a SEDOM staff conference dated October 30, 1978. This conference was attended by seven SEDOM workers and Mrs. DeGeorge. No report was made to DCFS and the record indicates the following: "How handle overeating? Chains to bed at night...." The next reports date from April, 1979, when both DCFS and SEDOM became involved in the chaining problem after the Crystal Lake Police Department was called, as we have mentioned.

It seems fairly clear that both DCFS and SEDOM did not act as quickly or as appropriately as they should have. Documentation seems to make it clear that SEDOM staff failed to report Kurt's bruises on at least six occasions. SEDOM staff also apparently had been aware prior to Crystal Lake Police Department involvement that Kurt was being chained in his home, and no report was made to DCFS. DCFS, for its part, was not very aggressive in handling the case. At the very least, more caseworker contact could have occurred, or counseling could have been arranged for Mrs. DeGeorge so that she could learn alternative methods of handling her son. Residential placement did appear to be an impossibility because SEDOM was fulfilling Kurt's needs and because the mother was perfectly willing to care for him in the home. DCFS lacked resources to provide the support that Mrs. DeGeorge should have had during any unsupervised periods.

There are two possible conclusions to our analysis of this case. The first is that this was a very non-routine type of case, a case that DCFS is not likely to encounter very often. Perhaps DCFS should develop an internal method to deal with cases like this. Staffing these cases--either at a regional or state level--might provide solutions to extremely rare and hard-to-solve cases such as this one.

The second conclusion, which follows from the first, is that it might be unnecessarily bureaucratic or cumbersome to develop a system to handle non-routine cases, either regionally or statewide, because there are so few such cases. An internal policy or substructure within DCFS to handle such a small number of cases

might be a waste. This was a very unusual case, but the reasons that DCFS involvement failed have been reflected in many other cases presented in this report. DCFS simply did not have adequate resources to provide support for Kurt's mother. Not only were homemaker and advocate services not available, neither was night care or even emergency placement for Kurt. Related to the problem of lack of resources is the inability of DCFS staff to coordinate efforts with DMH/DD staff. We do not really know how much anyone examined the issue of residential care--but we do not know primarily because DCFS staff did not follow through in its attempts to find residential care for Kurt, based on previous failures by DCFS to secure such placement with DMH/DD.

In no way was this case typical and in no way was Kurt Geisen's death really a typical abuse or neglect-related death. A number of unfortunate circumstances combined that resulted in Kurt's death. Hopefully the way Kurt's problem was handled can be instructive to DCFS and other child care agencies in the future.

H. Alan Madden

When Alan Madden died on January 11, 1981, his death attracted national media attention and outcry. As a result of his death, both his mother and her live-in boyfriend were charged with murder, and several DCFS employees were disciplined by DCFS Director Gregory Coler. Coler ordered a complete independent investigation into the incidents leading up to the five-year-old Alan's death, and the entire case file on Alan and his family was scrutinized. Alan's death has resulted in speculation concerning how to fill the gaps in the child protective system now operative in Illinois.

Apparently, DCFS first became involved with Alan's mother, Pamela Madden, in February, 1975, when Alan's sister Tina was brought to the Knox County Sheriff's Department by a relative of her father. Tina had severe bruises and marks on her lower back and buttocks, and relatives reported that they had seen Pamela Madden verbally and physically abuse her daughter on several occasions.

A DCFS worker met with the Maddens, who said that although they used spanking as a primary mode of discipline, the abuse incident was isolated. The worker noted that the Maddens had unrealistic expectations of Tina, lacked parenting skills, and were inconsistent in their disciplinary measures. He encouraged the couple to attend parenting sessions, and developed a service plan which was to include bi-weekly conferences with the worker and an attempt to find the Maddens a babysitter or other appropriate help in caring for Tina.

DCFS case notes reflect that the Maddens attended the recommended parenting classes only five out of eight sessions, but were active participants when they did attend. The notes also state that the Maddens had moved from Alton to Galesburg since the initial DCFS contact, which had provided them with increased social

contact, and that they had begun to display more realistic expectations of Tina. No further allegations of abuse were received, so DCFS closed the case on September 17, 1975.

DCFS' next contact with the family came in January of 1976. On January 30, the Galesburg DCFS office received a call from a neighbor alleging that the Madden children were being abused. The neighbor said their father, Gerald Madden, had been sent to prison two weeks earlier and that Tina and Alan, aged two years and several months, respectively, had not been seen for five weeks and were probably being neglected.

DCFS accepted the case for service to begin February 20, and assigned it to caseworker Vernon Weiss. Coincidentally, it seems, on that date DCFS received a call from the Knox County Sheriff's Department requesting that a worker come to the jail to discuss child care arrangements for Pamela Madden's children. Pamela had been arrested and charged with several criminal offenses, including forgery. Tina and Alan were placed in temporary foster care that same day.

DCFS records concerning the events which took place during this period are unclear. Court records, however, show that the children's father had been incarcerated at Vandalia State Penitentiary since approximately September 1975, and that Pamela Madden had shown an interest in having her children put up for adoption, not merely placed in foster care, during her jail sentence. She allegedly told caseworker Judith Ludwig that she felt her children had been through enough, and that she no longer wanted the responsibility of raising them; she felt that she had taken on too much too early in her life. There is, however, no written documentation regarding Ludwig's conversation with Madden.

Adoptive surrenders were taken in front of Judge William Richardson on February 23, 1976. The document Mrs. Madden signed is entitled "Final and Irrevocable Surrender to an Agency for Purposes of Adoption of a Born Child." Underscored within the document is the following clause: "That I understand I cannot under any circumstances, after signing this surrender, change my mind or revoke or cancel this surrender, or obtain or recover custody or any other rights over such child." Separate surrenders are filed for each of the two children, and both are accompanied by signed documents from Judge Richardson.

Caseworker notes indicate that DCFS planned to secure adoptive rights to the children and place them in permanent homes. An alternative plan provided for foster placement if the father would not surrender parental rights, to last until one of the parents was able to provide for the children. It is made clear, however, that adoption was the preferable course of action.

The next document in the Madden case file is dated June 2, 1976 and is addressed to William King, Assistant Guardianship Administrator in Peoria, from Judith Ludwig. It informs King that the Madden children had been returned to their father on May 28

and were residing with him in the Galesburg home of his sister and her family. The memo mentions that the mother had surrendered her rights "and thus has terminated her rights to the children," and also reveals that the Maddens had initiated divorce proceedings. Although Ludwig apparently thought the children were being adequately cared for, the question remained as to how and when custody could be officially transferred back to Mr. Madden.

It appears that a good deal of DCFS internal communication is missing from the case file, as conversations and actions are referred to for which there is no documentation in the file. This paucity provides at best a cloudy picture of the events leading up to Alan's death.

Case notes do indicate, however, that Gerald Madden obtained custody of his children through a final divorce action against his wife on May 28, 1976, and that at this time he was attempting to find employment, although caseworkers felt his plans were unrealistic. Case notes do not reflect the supervision which DCFS supposedly maintained over the children throughout 1976. This is not to say that supervision was not maintained; there are simply no records documenting any such service during that time.

The next DCFS contact reflected in the case notes occurred during February and March of 1977, at which time Ludwig and her supervisor Jerry D. Scobee visited the Madden home. At issue was concern over the care of both of the Madden children, particularly in the areas of medical neglect, nutritional neglect, social isolation, bruises on the children, lack of financial support, and exposure of the children to homosexual activities. During the visit, however, Madden denied that his children were being harmed in any of these ways, and that he was doing the best he could. The workers apparently broached the subjects of possible DCFS-provided day-care and adoption, but Madden appeared reluctant and asked for time to think over the services offered. Ludwig contacted Madden several times in the next few weeks, but was not able to get him to agree to any departmental suggestions. In the case notes, Ludwig writes that the case would be closed until DCFS heard from Madden regarding the offered services or through another referral. Postscripted at the bottom of the form is a notation that both children appeared to be pale and both were in diapers. Nothing more was done to substantiate or investigate the above allegations, nor did the notation concerning the children's condition affect Ludwig's informal closing of the case.

Early in 1977 DCFS received reports that Madden was neglecting his children. His sister called to report that Madden and the children had moved from her home and added that he had been neglectful. Other allegations were logged in through 1977, up until August 12, which said Madden had neglected the children, was disciplining them inappropriately, and that he did not provide them with enough food. He denied all the allegations.

On August 12, 1977, Madden visited the Department's Galesburg office to tell workers he was completing a locksmithing correspondence course and to ask if they could provide him with any in-

formation concerning small business loans. A worker named Joan Kelly spoke with Madden on this date as Ludwig was out of the office. She told him she would look for such information and also told him DCFS would be able to provide day care for the children. Madden was apparently not receptive to her suggestions. The worker expressed concern over the medical condition of the children, and she asked Madden to provide her with a breakdown of his monthly expenses, which were as follows: out of the $200 he received monthly from the Illinois Department of Public Aid, $150 went toward rent, $10 for gasoline for his truck, and $40 for food. In spite of this low monthly allocation for food, DCFS workers did not initiate any further inquiry into Madden's financial situation or into the medical condition of his children. Madden said his children were fine.

On August 15, 1977, Joanne Johnson of Galesburg contacted Joan Kelly, who assigned the case to Debra Alstedt. Johnson said that during her frequent visits from Madden and his children, she had seen Madden mistreating Tina and Alan. She said she had seen both children with black eyes, and Alan with stitches on his forehead.

On August 19, Madden visited the Galesburg DCFS office with both children. He told caseworker Kelly that his locksmithing diploma was on its way and that he believed he had a job pending delivering pizzas. He requested care for his children during his proposed working hours. Although Madden's schedule was somewhat difficult to accomodate, Kelly finally located a DCFS-approved home at which the children could stay while Madden was at work. On the day he was to begin working, August 22, Madden was told he could bring his children to the home of Mrs. Barbara Price of Galesburg, and Tina and Alan arrived there at 4:45 that afternoon.

Later that same afternoon, Mrs. Price's daughter Betty brought both children to the Galesburg DCFS office. The Prices had discovered that Alan was bruised and had difficulty moving without pain. Both children had bruised backs and thighs. Alan also had swollen and reddened feet, visible scars from areas previously stitched, severe diaper rash, and an infected laceration on the back of his head. The Prices brought the children to DCFS immediately so that they would not be accused of having inflicted these injuries upon the children.

Kelly contacted the Galesburg Area Administrator, Ronald Noorman, who advised her to contact the police and take Alan to a hospital for emergency room treatment. Kelly took Alan to Cottage Hospital, while Galesburg police officer Barrigan went to bring in Mr. Madden.

Alan was examined in the hospital's emergency room by a Dr. Hoffman, who remarked that he had seen the boy there before. Meanwhile, Betty Price returned home and brought Tina to the hospital for an examination, also. The doctor noted that Tina's condition was less serious, but that she did have a bruised leg, insects

in her scalp, and a severe rash. He completed a suspected child abuse report and both children were admitted.

Officer Barrigan brought Madden to the hospital. Madden said he did not know how the children had been injured, but hinted that either his sister or his girlfriend was responsible. Barrigan had found Madden at home. Supposedly the person who had promised him the delivery job had not been at work, so Madden had simply gone home.

Attached to the DCFS case record are copies of the referral from the Prices, the report filed with the State Central Registry, and Dr. Hoffman's report.

On August 23, Kelly called Assistant State's Attorney John Pepmeyer of the Knox County State's Attorney's Office, who agreed to file a petition for temporary custody of the Madden children, and a hearing was scheduled for 3:30 that afternoon.

At noon, however, Cottage Hospital called Kelly to inform her Madden was at the hospital demanding the release of the children. When Kelly arrived at the hospital, Madden, apparently very upset, told her he had been "set up" with the abuse allegations. Kelly and police officers present told Madden he would be able to present his side of the story at the afternoon hearing. At this time, pictures of the children's bruises were taken.

At the hearing, Kelly testified, and the pictures taken were shown as evidence. Judge William K. Richardson granted DCFS temporary custody and the next hearing was set for September 13. Tina and Alan were placed in foster care the next day; Madden was notified of the placement and was encouraged to visit the children before the next hearing.

Madden did visit his children twice in early September, with a DCFS worker supervising. On October 14, 1977, Judith Ludwig met with Madden and his attorney to discuss the possibility of returning the children to their father. Ludwig suggested counseling for Madden and provided him with the name and phone number of a suitable facility. A schedule of visits with the children was also developed, but Madden failed to make the first visit and also failed to call to cancel it. Another appointment was later made for October 18, but Madden again failed to appear.

No other information is contained in the case file between October 18, 1977 and January 30, 1978, except that DCFS had received several phone calls before the 18th from Pamela Madden, who had been notified of an October 12 custody hearing, to which she did not respond. There is no record of the status of the children in foster care and no list of visits DCFS workers may have made with the children.

Ludwig's January 30, 1978 case notes reflect a phone call she received from Pamela Madden from her home in Aurora, Colorado. Pamela expressed interest in regaining custody of her children,

claiming she had enrolled in child care classes and had been taking care of the son of the man she lived with, James Crain, with whom she had discussed marriage. She had also discussed with her attorney the possibility of moving the children to Colorado.

Ludwig told Mrs. Madden that this would be difficult since she would have to have several successful visits with the children to regain custody. The possibilities of Mrs. Madden's moving back to Illinois and of placing the children in foster care in Colorado were mentioned. Ludwig suggested Madden contact the Knox County State's Attorney's Office and her own attorney for answers to her many questions about having given up her rights to the children. Ludwig agreed to come up with suggestions on how Madden might best recontact Tina and Alan, and set up a weekly time at which Pamela could speak with Ludwig on the telephone.

During early 1978, Ludwig attempted to contact Gerald Madden, who had not been seen since the October 12, 1977, court hearing. On February 1, 1978, Ludwig spoke with a relative of Madden's, Charles Kruger, who told her Madden had moved from his apartment on the afternoon of October 12, and that he had heard Madden had moved to California. Kruger expressed an interest in attending the next court hearing in place of Gerald, but Ludwig told him the judge would have to decide about that. She told Kruger both of the children's parents should have shown a more active interest in them if they had wished to retain custody.

During March and April of 1978, hearings continued concerning the children. On March 16, an attorney representing Pamela Madden was present in court. On April 12, neither Pamela Madden nor her attorney was present in court and Judge Richardson continued the case to October 17, 1978. The judge ordered DCFS to initiate a thorough home study of Pamela Madden and to present the results of the study to the court in October.

On June 22, 1978, DCFS made formal application to the Colorado Department of Social Services requesting a home evaluation of Pamela Madden, who lived in Denver at the time, to determine her ability to care for her children. The Galesburg DCFS office was to be the recipient of the evaluation.

Social service agencies are able to request such studies as the result of states entering into legal, contractual agreements known as Interstate Compacts that provide jurisdictional reach beyond state boundaries. Illinois and most other states have entered into such an agreement for social service and child protective purposes.

We determined that all of the evaluative forms from the Colorado authorities were sent to DCFS on December 6, 1978. The cover sheet states that "approval is not granted" for return of the children to Pamela Madden's care.

Portions of a long letter to Ludwig from Nancy Feldman, Intake Worker for the Denver Department of Social Services, are revelatory

and particularly significant in light of the final decision to return the children to Pamela Madden's care:

> Ms. Berg [Pamela Madden] recalls the last time she and her children (Alan and Tina Madden) lived together was in February of 1976. At that time she went to prison and the children went into foster care. Alan was six months old then. Ms. Berg feels she and Alan never really knew one another as she and Tina did. When she was released from prison, Alan and Tina were living with their father, Gary [sic] Madden. Ms. Berg lived nearby and was able to see the children, but did not spend time with them. Alan and Tina were eventually removed from Mr. Madden's home in August of 1977.
>
> Ms. Berg now feels she is able to care for Alan and Tina. She feels she is the most suitable person to take care of the children and, as their mother, has a right to the children. She doesn't know what to expect from Alan, but states she expects Tina won't be much different from two years ago. She doesn't foresee any problems with regards to adjustments in their lives. They would just have "a good old time together like we used to." These expectations appear quite unrealistic.
>
> Ms. Berg is presently pregnant which adds another dimension.
>
> Ms. Berg feels Alan won't remember who she (Pam) is, but doesn't expect any problems from him. She also does not anticipate any problems between the newborn child, Alan and Tina. It would appear Alan, Tina, and Ms. Berg will have to make considerable adjustments in their lives without a newborn child, and with the newborn, the adjustments become magnified. Again, Ms. Berg's expectations don't appear realistic.
>
> Ms. Berg stated that she is presently living on her savings. When asked about supporting herself, as well as three children, she stated she would get a job, when the baby was six months old or so. In the meantime, she plans on applying for assistance. In terms of employment, Ms. Berg would prefer a night job so she could be with the children during the day. She hadn't thought about day care, but states it is a possibility.
>
> The unborn child is out-of-wedlock. When speaking about him/her, Ms. Berg's affect appeared wrong. She would speak about "unloading" the baby in the beginning of October, and did not appear to be looking forward to the baby being in her life. She would speak the words, but her affect did not agree.
>
> This worker respectfully recommends the children not be placed in the home of Ms. Pamela Berg. It is this worker's opinion that Ms. Berg will have enough to deal with upon the arrival of her unborn child. The arrival and newness of Alan and Tina may just add to the confusion. Alan and Tina are her natural children, however, Ms. Berg herself admits she and Alan never knew one another. These children have known only instability, neglect and abuse in their short lives. Ms. Berg, as well as

> Alan and Tina would have to make considerable adjustments and this worker does not feel these have been looked at realistically by Ms. Berg. She denies all charges of past abuse and does not show evidence of making changes in her life. In addition, this worker did not feel Ms. Berg was honest during the interview as she appeared quite manipulative. In addition, three children may be a great financial burden on her after only needing to care for herself.

The case had been heard again in court on October 17, 1978. Neither Gerald nor Pamela Madden had appeared. Judge Richardson had set another hearing for November 9, 1978, for a status report. Following the October hearing, caseworker Ludwig met with ASA John Pepmeyer and Judge Keith Sanderson, for an "informal hearing" to discuss the status of the Madden case. Judge Sanderson recommended having a hearing in two or three weeks, with notice furnished to everyone involved in the case. ASA Pepmeyer was to have prepared a petition to present to the court requesting that DCFS be given consent to arrange adoption. Ludwig felt at the time that DCFS probably would be granted adoptive rights to the children. Her case notes go on to clarify ASA Pepmeyer's preparations for the hearing to indicate that while he was to have a petition ready, it might not be presented at the next hearing; the next hearing would be for presentation of a status report first, with all parties and their attorneys notified.

Commission investigators determined from their document review that Ludwig filed an annual report on the Madden children with the Knox County Circuit Court. This report, written before the October hearing, reflects that Ludwig expected Pamela Madden to be present at the hearing and expected to be able to present the information from the Colorado agency then, also. She says both she and the Colorado agency shared concern about the possibility of the children being returned to Mrs. Madden in light of her past history of abuse, but that the court would probably order the children returned to the mother unless the Colorado agency recommended otherwise. Ludwig again mentions the necessity of visitation prior to returning the children to Mrs. Madden and the possibility of adoption. Ludwig apparently expected the court to place a great deal of significance on Mrs. Madden's failure to appear at previous hearings even though she was available, and she reiterates that much of the outcome of the proceedings depended upon the Colorado report.

On November 3, 1978, Pamela Madden again contacted Ludwig to ask about her children. Ludwig informed her of the next court hearing, but told her that her rights had been terminated because she had not been present at any of the hearings. Madden responded that she would not fight the court's decision. Ludwig told her that the children were doing fine in foster care and would be moved along to adoptive care. Madden finally added that she had given birth to a girl, Nicole, on October 22.

Again, Commission staff were unable to find any documents describing the care of the children in their foster home, nor did we discover any notes or reports that indicated foster care was being monitored.

In our document review, we did come across an annual report covering the period August 1, 1978 to August 1, 1979, prepared by caseworker Dorothy Mason and submitted to the Knox County Circuit Court on August 30, 1979. Her comments follow:

> Nothing has been done through the court since the Interstate Report was received from Colorado in February, 1978. Colorado would not approve placement with natural mother. However, a Court Hearing was never held to present that information.
>
> I would still like to see these children placed for adoption. DCFS staff have repeatedly requested a Hearing on this matter since February, 1979, in the interest of a permanent plan for these children.

Pamela Madden apparently regained interest in having her children returned to her, and after several hearings, Judge Richardson on May 27, 1980 determined that Mrs. Madden's parental rights should not be terminated and that DCFS should arrange for home visits between Madden and her children. Had the children not been eventually returned to their mother, they would not have endured further abuse and Alan would not have been killed. The judge's decision follows in full:

> It is the conclusion of the Court that the parental rights of Pamela Madden Berg should not be terminated.
>
> The Court would feel compelled to reach this decision because of the sorry state of the record, if for no other reason. The Court does not exculpate itself for its responsibility for this faulty record.
>
> A Petition was filed in both cases on August 23, 1977 alleging abuse--an allegation applicable to the Respondent Gerald Madden, and not to Pamela Madden Berg, whose address was listed as unknown. Pamela was served with copies of these Petitions on September 20. On September 22, 1977, after securing leave of Court, Amended Petitions were filed alleging that the children were living in an environment injurious to their welfare. There is no proof of notice in the file of this hearing, which was held on October 12, 1977. The father, Gerald Madden, was present, and the Court found that he had punished the children in an abusive manner and that as to him, the children were neglected. Pamela Berg was not present. She stated Mr. Pepmeyer told her it was not necessary for her to appear. Mr. Pepmeyer denies he told her this, but did testify that in his conversation with her prior to the October 12th hearing, such conversation concerned itself with Gerald's conduct, and he did decide to call her as a witness. In the light of this, the Court feels that Mrs. Berg may have been under a misunderstanding as to there being any reason for her to appear, nor any realization that there would be a finding as to her that the children were neglected.
>
> Subsequent status reports were scheduled, and although actual notice may have been given, the Court file does not reflect proofs of notice of the hearings.

> On November 9, 1978, with neither Respondent, parent, nor the Guardian ad Litem present, the causes were continued to Dec. 7, 1978 and people instructed by Judge Sanderson to give notice of their intent to ask for adoption rights. Such a Petition was not filed until November 13, 1979. This review of the Court proceedings would make it appear that the termination of Pamela Berg's parental rights would be based on a record which would not stand close scrutiny. The Court agrees with the Guardian ad Litem that the finding of neglect very well may not be a valid order as to Pamela.
>
> Assuming it should be considered a valid order, the Court cannot concur that Pamela has shown a lack of interest in her children. In February of 1978 she notified the Department of her intention to secure custody of her children. She employed counsel for this purpose, and if he failed to exercise proper diligence, Pamela should not be penalized. In July of 1978 she called from Colorado advising of her change of address and asking about a home study. On November 3, 1978 she made a phone call inquiring about the children. It is not contradicted that she maintained medical insurance on the children. She was never told where the children were located. She was not granted permission to visit her children. It was testified that visitation would have been granted if requested. Ms. Mason further testified that she would not initiate any suggestion for visitation, nor did she now think it would be in the best interest of the children.
>
> While Mrs. Berg has been ineffectual and spasmodic in her efforts to maintain a degree of interest in her children, neither has she received any guidance or help in doing so. In the case of In re Overton, Ill. App. Brd. 1014 at p. 1019, the Court states "In regard to Colene's visitation, we note that while Colene's case worker did not expressly refuse Colene's right to visit her children, he did not encourage her to visit the children. It is apparent from the case record that the case worker felt it was in the best interests of the children that Colene should not visit them and that his feeling was communicated to Colene". The same attitude exists in the instant case.
>
> It would appear from this opinion in the Second District that the Appellate Court puts the onus on the Department to encourage visitations and other efforts to reestablish parent-child relationship.
>
> The petition accordingly is denied, and the Department is instructed to initiate a program, commencing with visitations, which ultimately will culminate, if all goes well, in return of the custody of the children to Pamela Berg. Please prepare an Order. I would suggest a conference among the three of you and Ms. Mason to spell out the program of visitations.

Although the Knox County State's Attorney, on behalf of DCFS, had cited both Pamela Madden's 1976 surrender of parental rights and the results of the Colorado home study in his brief filed in

this matter, the judge in his decision inexplicably failed to address these two factors. In addition to this brief, two others had been filed in this matter--one by Pamela Madden's attorney and one by the Guardian Ad Litem. As explained in our chapter on legal issues, the Guardian Ad Litem represents the best interest of the child(ren) in proceedings such as this. In its brief, the Guardian argued that Madden's parental rights should not be terminated, and that steps should be taken to place custody of Alan and Tina with the mother. However, it was stated in this latter brief that termination of Pamela Madden's parental rights would have been recommended if their foster parents were ready to adopt Alan and Tina.

After Judge Richardson issued his decision, Pamela Madden moved from Galesburg to Quincy, Illinois. Dorothy Mason wrote an inter-office memorandum to the Team Leader of the Quincy Field Office on June 30, 1980, enclosing a copy of Judge Richardson's decision. She mentions that the Departmental plan developed in Galesburg was to initiate a series of overnight visits between the children and their mother to begin in August, 1980. Mason requests in her memo that someone from the Quincy office be with the family during these visits and provide the Galesburg office with a written summary of the contacts, including "observations relating to appropriate space and care of children, and also, adjustments by children into mother's home." Mason also requests "courtesy supervision of this family" because she still was required to make status reports to the court in Galesburg.

A memo in response to Mason's request dated July 18, 1980, and written by Amy Anderson, Supervisor of the Quincy Field Office, indicates that she visited Pamela Madden on July 15. She mentions in the memo that Madden expected her children to move in with her by August 22 and that she had last seen her children in Galesburg on July 11. The first planned visit to Quincy was scheduled for August 7. The memo also notes that Madden had rented a six-room house "with plenty of beds" and that "Pam plans to take Tina and Alan to stores and parks during their visits."

Another memo, also to Mason and from Anderson, is dated August 12, 1980: it is a formal response to Mason's memo of June 30, 1980. The memo mentions that Madden had planned at that time on marrying again. Her intended husband was "Dean Fanucchi," her landlord, but she planned on delaying the wedding for about a year so that the children could get used to him. Anderson felt that there was plenty of sleeping room at the home. She closes her memo by stating that the next visitation would occur on August 15 and that if the children were placed with their mother, her office would maintain courtesy supervision. The following paragraph is the only substantive indication of conversation with Pamela Madden concerning her interaction with the children:

> Ms. Berg said the three children got along pretty well but there were some discipline problems since the children were not used to being with their mother. They commented that they would go back to their foster home if they didn't get what they wanted. Ms. Berg discussed the discipline problem with me but stated

> she understood it would take time for everyone to adjust. She said she would not use physical punishment on her children except for a light spanking, if necessary. The three children seemed to get along well and be happy. Tina tried to act like the mother of the whole group. Ms. Berg expects to have the most problems adjusting with Alan since he was so young when they were separated.

The next record of DCFS involvement with the Madden family reflects events occurring around October 17, 1980, after the children had been returned to Pamela Madden. On October 17, the Quincy Police Department received an anonymous call alleging that Alan Madden had a bruised face. The police called DCFS, and Quincy Office caseworker Mary Butler was assigned the case for follow-up. She made several unsuccessful attempts to contact Pamela Madden, and finally called the Quincy Police Department to tell them she had been unable to reach the woman. Butler was unaware at this time that there was any open case on the family, the mother, or the children.

On October 19, 1980, Jack Cosgrove of the Quincy Police Department visited the Madden home and viewed the bruises that Alan had sustained. His mother explained that Tina was very rough with him and had pushed him off the jungle gym at school about two weeks earlier. The children confirmed the story and Cosgrove told the mother that he would still be contacting DCFS about the matter.

The Commission obtained the official Quincy Police Department record of this contact. The report reads that CPS worker Kathleen Cherington, who had originally taken the October 17 abuse report call from the police, had requested the police visit the Madden home over the weekend because DCFS workers had been unable to get a response during their visits to the home. The rest of the report repeats that Mrs. Madden explained to the police officer the incident at school as well as her entire history with DCFS, going back to the father's neglect of the children and the support she was receiving at the time from Child Welfare (CW) worker Mary Carroll. She even mentioned the custody problem that was to be resolved in court. The report concludes with this sentence: "I feel this situation should be closely monitored because we may have an abusive parent here, it might be wise to check with the school and the doctor also the other D.C.F.S. office where Pam came from."

On October 20, 1980, Cherington called the police, who gave her basic background information on the family and promised to send her the police report within the week. On the same date, Cherington received a telephone call from Richard Baldwin, the principal of the school both Madden children attended. He asked that Cherington come to the school to have a look at Alan Madden, who had just returned to school, after about a week of absences, with bruises around his eyes. Cherington spoke with Alan in Baldwin's office. Alan told her that his sister beat him, which Tina admitted. Tina also told Cherington that she had knocked Alan off the jungle gym, although there is no record of the incident in school records.

The same day, Cherington visited the Madden home. Pamela Madden told her that when Alan fell off of the jungle gym she called a Dr. Lovell at the Family Practice Center and followed his instructions to put ice on Alan's head and watch for signs of concussion. Cherington told us that the mother explained her DCFS Galesburg history to her also and the two discussed appropriate forms of discipline.

We were able to examine Cherington's case summary as requested by her superiors in DCFS after Alan Madden died. The following two statements are taken from her summary of the October 20, 1980 contact:

> Alan stated that Tina beats on him and that was how he received the bruises on his stomach and back. He could not explain how he received the bruises on his arm and the topside of his hands.
>
> We discussed methods of handling this aggressiveness and various forms of discipline. She stated that the bruises on Alan's arms and hands were due to "rough house" play in which she would pick up Alan by his arms and throw him onto the bed.

On October 22, 1980, Cherington visited Dr. Lovell, who told her that he had been satisfied with Mrs. Madden's version of how the injuries to Alan had occurred. He also regarded Mrs. Madden as a very responsible mother, based on her following his instructions in caring for Nicole, the youngest child. Cherington also learned during her visits to the school and the doctor that Alan had not been treated immediately after he fell off of the jungle gym, that no formal allegation of abuse was filed by the school principal, and that the name listed on the bottom of the school registration card in the box marked "relative" was the name "Jim Crain."

On November 5, 1980, Baldwin called Cherington again to tell her that Tina reported that her "dad" had kicked her in the stomach. Alan agreed that this had happened. When Mary Carroll called Pamela Madden, she told her that Tina admitted making up the story in order to get out of school because she did not feel well. On the same date, Mrs. Madden called Cherington to repeat the same story, and also to complain that Tina had been waking up at night screaming, "Daddy hurt me." Mrs. Madden claimed that Tina had done the same thing when they lived in Galesburg. During this conversation, Cherington asked if she could meet Dean Fanucchi, Mrs. Madden's supposed fiance. An appointment to that effect was set for November 7.

On November 6, Mrs. Madden called caseworker Carroll to tell her that Tina had chicken pox; the following day, the appointment to meet Mrs. Madden's fiance was cancelled because of Tina's illness. Cherington called back on November 10, but was unable to reschedule the meeting.

On November 12, Cherington learned from Dorothy Mason of the Galesburg DCFS office that the Quincy office had received only

one report of neglect regarding Tina prior to Alan's birth. Mason indicated that a court review date to determine guardianship had not yet been set.

Cherington visited the Madden household on November 13, 1980, and noted in her records an improvement in the relationship between Tina and Alan. The following day, Cherington contacted Alan and Tina's former foster parent, who confirmed Tina's aggressive attitude toward her brother.

On November 24, 1980, Cherington spoke again with Dorothy Mason and learned more about the Madden's case history in Galesburg. Cherington learned of the two neglect findings concerning Tina, the removal of the children from Gerald Madden, placement of the children in foster care, and Pamela Madden's surrender of parental rights. We determined through our review of DCFS records that reference to adoptive surrenders is made in Cherington's case notes but not in her summary of the case requested by her superiors after Alan Madden was found dead.

Supposedly, Cherington called Pamela Madden on December 11, 1980, and discussed the children's behavior. Madden said that the children were making a good adjustment to both her and to Quincy and that she had not had to spank them even once. This entry by Cherington is not in her case notes but does appear in the final summary.

On December 17, Cherington called Madden to see if Tina might like to participate in a community event. She was happy to accept but told Cherington that the family would be away for more than a week on "Dean's farm" during the holidays.

The next DCFS contact with the Maddens ocurred on January 11, 1981, when Martha Butler received a call from James Rost of the Quincy Police Department reporting that Alan Madden was dead.

On January 11, 1981, a flurry of activity occurred. Tina and Nicole Madden were placed in emergency foster care. Pamela Madden was arrested for the death of her son Alan, as was a "friend" of hers, James Crain. DCFS officials began a series of telephone calls to the SCR and to each other to determine what to do about the case. Alan Madden's body was taken to the coroner's office for an autopsy.

The following account, recorded by James Rost, is in actuality a very small portion of the Quincy Police Department's official records on the case, and it presents one perspective of all of the immediate events occurring just prior to Alan Madden's death:

> In talking with Pam about the things that happened to Allan [sic] prior to his death, she told me the following:
>
> Pam said that Jim [James Crain] came over Saturday (01-10-81) around 1400 hours. She said that he was in and out of the

house after this. Pam said that the only persons present in the house all day up to Alan's death was her, Jim Crain, Nicole, and Tina. They had no other visitors at all in the home that day.

Pam said that Alan got out of bed Thursday without asking, and she questioned him as to why he got up without asking permission from her. Pam said that Alan told her that he wanted to play with his sister, and Pam said that she knew he was lying, and not telling her the truth why he got up. Pam said that she asked Alan again why he got up, and this time Alan did not answer her question at all.

Pam said that she was real mad at Alan for lying to her about the question ("Why did you get out of bed?"), so she punished him for this. I asked what the punishment was, and she said that she put him in his bed and made him stay there. Pam said that this was at 2100 hours on Thursday evening (01-08-81), and he was made to stay there until Saturday 01-10-81 when she had Tina get him up at 1900 hours. Pam said that during this time he was being punished he was not permitted to eat or drink anything, and had to stay in bed all the time. She did let him up only to go to the bathroom. Alan was also kept out of school all of the week of 01-05-81 through 01-09-81 because she did not want the teachers at Washington School to see his badly bruised right eye.

Pam said that when she entered the living room and bedroom area (same area) that WKRP (a television program) was just starting. She told Tina to go get Alan out of his bed, and for him to come to her. Tina at first yelled real loud "Alan come here." Pam said that Jim got onto Tina for yelling and told Tina "Tina, your mom could have done that. What she wants you to do is go get him." Tina then went to get Alan.

Pam said that when Tina and Alan came into the livingroom that Alan came up to her and stood in front of her. She (Pam) was sitting on the couch. Pam said that Alan asked her what she wanted, and Pam said that she again asked Alan why he did not answer her question on Thursday, and Alan said "I didn't get up or dressed". Pam said that she hit Alan after he said this, and told him that he was lying, and she wanted the truth. She asked him several times over and over to answer her question, and when Alan stammered around trying to answer, she would each time hit Alan with her hand. Pam said that she would ask the question of Alan and then hit him, ask the question of Alan, and then hit, etc; etc; etc;. Pam said that she repeatedly struck Alan after each time she asked the question.

I asked Pam how long she did this to Alan, and she said that this lasted for about 15 minutes. While she hit on Alan, Tina was made to stay on the end of the couch, and see all of this taking place. She thinks it bothered Tina to see her brother getting hit.

When this question and hitting on Alan was taking place Pam said that she made Alan stand directly in front of her, and she was sitting on the couch. Jim was on the mattress watching, and hearing what was taking place, and Tina was on the couch next to Pam. Nicole was said to have been in bed asleep.

Pam also said that the hitting she did was mostly on his rump area, and the more she asked the question, the more she got carried away, and hit harder. I asked Pam what answers Alan gave each time she asked the question of why he got out of bed, and she said that Alan did not give her any true or full answers, he would just stutter saying things like "well, uh, I, uha," and things like this. Pam said that she could not accept the answers and kept it up, until about 2000 hours which was a hour after she started.

Pam said that she wore herself out hitting on Alan, and Jim took over for her. She went in and got Nicole out of bed, and sat back on the couch with Tina.

Pam said that she also told Alan "I'm getting mad, and I'm going to give you a good one if you don't answer me". I asked Pam again where she hit Alan with her hand, and she said I started hitting him on the rump, but after that 'where it hit; it hit".

Pam said that when Jim first started on Alan, that he just got up off the mattress, and hit Alan with his hand. Jim, after hitting him the first time said "Why don't you answer your Mother?", and before Alan could say anything, Jim started hitting him some more. Pam said that Jim kept hitting, and hitting Alan, and she did not know how many times at first.

Pam said that Alan was crying, and screaming real loud, and it started to get to her. She said that she did watch for awhile, and it got to the point where she could not handle it so she started sewing on some socks that needed mending. Tina said that the socks she was sewing belonged to Tina. Pam also said that she was doing this sewing on the couch in front of where Jim Crain was beating her son, and that the two girls were still present.

I asked Pam if she believed the beating that Alan was getting from her could have caused death or great bodily harm to Alan, and she said that she believed it could have at the time she was hitting him.

I asked Pam if she believed that Jim was doing great bodily harm to her son when she sat and watched Jim Crain beat Alan, and Pam said that she believed he was.

I asked Pam how she could sit and sew socks while her son was being beaten in front of her. She said she did this to block out the beating Jim was giving Alan, and that she could not stand to watch it.

I asked Pam where Jim was hitting on Alan and she said that he was getting hit all over, where the hits would land is where he got it. I asked Pam if Jim used anything other than his hand such as clubs, or sticks, and she said that she thinks he just used his hand, but she did not watch all of it.

Pam said that she did look up, now and then, to see Jim beating on Alan, and she heard Jim yelling and asking questions of Alan all the time it was going on.

Pam also said that Jim would kneel down on the floor, and with both hands holding Alan in the air would drop Alan with force onto and across his raised right knee. Pam demonstrated this. The victim was said to have been facing towards the floor each time that Jim brought him down across his knee.

Pam said that the beating of Alan was over about 2200 hours, which meant the victim was beaten for about three hours. When it was over Pam said that Alan was still alive, but he had a lot of bruises on him, that showed up. She said that this bothered her because if the DCFS seen the bruises or if it was reported to them that they would come and take the kids away from her.

Pam said that Jim took Alan to his bedroom, and she did not know if Alan walked or Jim carried him. Jim came back out of Alan's bedroom and had put Alan in his bed. Pam said that after Jim came into the living room after this she asked him if she should put Alan in cold water. This was to get rid of the bruises, and change the body temperature. Jim told Pam "it's up to you to do what you think is best; I could have hit him too hard", and "too many times".

Pam went into the bathroom and ran cold water into the tub. She yelled at Alan to come to her, but got no answer. Pam said that Jim then came in with Alan in his arms. Pam said that she did not remember who undressed Alan, but both of them was in the bathroom.

Pam said that they put Alan into the tub of water, and he was in the tub for about ten minutes. Jim was the one that took Alan out of the tub, and held him up while Pam put a yellowish-gold colored blanket around Alan. Pam said that she put a towel over Alan's head.

Pam said that she took Alan into the living room and laid Alan down on the floor next to the register so the warm air would blow on him.

Pam said that Alan would not talk to her, only stared at her. She also said that the ends of Alan's fingers were a bluish color, and his eyes were white-like. Pam said Alan laid by the heat register for about five minutes, and she then took him (carried) to his bed again.

Pam said that Alan was naked so she put some clothes on him. Pam said that she took Alan into the living room and laid him on the floor. She and Jim tried to get a temperature reading from Alan with a thermometer but could not get a reading. She then thought the thermometer was not working right.

Pam said that she and Jim watched wrestling on T.V. and it was over about 0100 hours (01-11-81). Pam said that they checked on Alan between 0100 and 0115 hours, and she knew that Alan was dying at the time. She took an electric blanket and wrapped it around Alan and turned it on. She said that she told Jim that she knew Alan was dying, and that she could not stand to watch it happen so she was going to lay down.

Pam said that she told Jim to set the alarm to go off in one hour, and that he was to wake her up when Alan was dead. Pam said that she did lay down and go to sleep until Jim woke her up at about 0200 hour (01-11-81).

Pam went to where Alan was, and got down on the floor by him. She said that she gave Alan mouth to mouth resuscitation and CPR, but it did no good. She then took a stethascope that she had to get a heart beat, but could not get one. Pam said that she looked up at Jim and said "My god I think he's dead".

Pam said that she told Jim to call an ambulance because we need some help. She said that Jim did and the police and ambulance came.

Pam said that the police brought her and Jim in then for questioning.

After I got through questioning Pam I went into the interrogation room where Sgt. Griffin and DeVoss were talking with Jim Crain.

I asked Jim if he still understood what his Rights were and he said yes. I then told him who I was, and wanted to ask him something. Griffin and DeVoss were still present.

I told Jim that he was under arrest for the murder of Alan Edward Madden age 5, and asked him if he understood the charges. He stated yes. I then asked Crain if he knew he was hitting the victim, Alan Madden, that the hitting could have induced great bodily harm, and likely death. Crain looked at me for a moment, and stated "Yes, I did". I left and lodged Pam in the County jail in lieu of bond for the charge of murder.

In order to balance this narrative presented by Pamela Madden, we will now present selections from the interrogation of James Crain. These statements were recorded by detective Michael DeVoss.

Crain was interviewed on January 11, 1981, and was told that Madden had told the police of her involvement in Alan's death and had implicated Crain in the beatings. Crain responded, "I'll tell the truth; what do you want to know?" When DeVoss asked Crain

about the reasons for the beatings, Crain claimed that Alan was being punished by Madden and that he had been in bed all day as part of the punishment. He said that the reason Alan was being punished was that he had not answered a question directed to him by his mother. Crain said that the question that Alan could not answer was, "What was the question I asked you yesterday?" Crain said that periodically throughout the evening he would go back to where Alan's bed was and ask him the question, to which Alan could only mumble a reply. Crain admitted to police that he did not even know what the original question had been. He said that every time that Alan was unable to answer the question, he hit him. The police asked Crain to demonstrate the kind of blows he used; he backhanded Alan with an open hand held slightly curled. He demonstrated the blows to the police on a wall in police headquarters.

After each blow, Crain would return to the living room to continue to watch television. Crain said that with each blow, Alan would normally not fall down. When he did, Crain would pick him back up. Crain told police that he thought he was using "reasonably soft blows" and that he did not use anything other than his hand on Alan. Crain claimed that at no time during the beating did he get angry, although he told police he felt that Alan giggled during the beating and did not understand that he meant business. Crain claimed that he was hitting Alan so that he would answer the question; if he answered the question, then he could come to the living room and watch wrestling on television with the rest of the family. When asked if Crain did not feel that being kept in bed for not answering a question was a bit extreme, he acknowledged that it was somewhat extreme.

The police told Crain that Alan had sustained a broken rib. Crain denied breaking a rib and hypothesized that it had been broken before the beating. Crain told police that he had had a cracked rib and that it hurt more after the event than when it actually cracks. Crain claimed that he never heard a bone snap or crack during the beating and he never heard Alan scream in sudden pain.

The police asked Crain if he knew that Alan had been constrained to his bed since January 8 at 5:00 p.m. and that he had not been fed. Crain claimed that he knew nothing about it; he had only noticed that, when he stopped at the house for lunch on Friday the 9th, Alan did not eat with the rest of the family. Crain said that it was not uncommon for Alan to spend a lot of time in bed because he liked to sleep. Crain did mention that when he came over for lunch, Alan never ate with the rest of the family.

Crain was asked about bruises. Crain said that Alan had fallen in the bathtub two or three weeks earlier and that no doctor was called because neither he nor Madden felt the injury was serious. When pressed, he admitted another reason no doctor was called was that they were afraid of a DCFS investigation.

At this point in the interview, officers were called from the room and the interview was momentarily halted. DeVoss was advised that Madden had told other officers that Crain had picked up Alan and driven him down over his bent knee in a "board breaking" motion. Crain was again advised of his Miranda rights and questioned about this. Crain denied that he had punished Alan in that way and said that he had only picked Alan up twice during the beating, both times by his arms, in order to deliver a stern warning to him.

Crain was informed that the statements he had given contradicted previous statements, to which he issued a denial. Finally, when police officers asked him why Alan would be punished so severely while two other children in the same household would hardly be punished at all, he said that Madden had told him that Alan reminded her of her ex-husband.

Both Madden and Crain were charged with murder.

Meanwhile, Martha Butler responded to James Rost's call to come to the Quincy Police Department station to place Tina and Nicole in foster care. Butler found a suitable foster placement, picked up the girls and dropped them off, and returned to the station to talk to Detective Rost, who was busy interrogating the suspects. At about 10:30 that morning, Butler called her supervisor, Timothy Morrell, but he was not in. She left a message. He called her back about 12:45 p.m. and Butler called the State Central Registry to report the incident about 1:00 p.m.

That afternoon, Butler received a call from an SCR official in Springfield. Butler's summary of this contact is interesting:

> He indicated that Bill Ryan had been advised about the Berg situation. Bill Ryan was requesting a chronological summary of the Department's involvement with this case. He wanted the information Monday, 1-12-81. [He] asked me how it was going today. I stated I had not heard much more about the situation. He indicated that East St. Louis had taken the heat off of us. I stated, "What do you mean?" He stated that eleven children had died in a fire there and U.P.I. and A.P. had picked up on that and had left us alone.

Soon thereafter, Butler learned that Sergeant Theda Jansen of the Quincy Police Department had visited Tina Madden in foster care to ask her questions about the death of her brother.

The Commission obtained Sgt. Jansen's report of her conversation with Tina Madden, portions of which will follow. The foster mother reported to her that Tina's second question to her, after asking what she should call her, was, "Do you hit kids here?" Before going to bed, Tina instructed her two-year-old sister Nicole not to wet her bed. The children then went to sleep. Earlier, during dinner, the foster parent said that Tina had blurted out, with no questions directed to her, the statement, "My daddy hitted and hitted my brother and then he throwed him up and he landed on his knee."

Sgt. Jansen spoke with Tina after she had slept through the rest of that night. She asked Tina if she could describe how her brother had gotten hurt (Jansen could not ascertain if Tina knew that her brother was dead, but she did not tell her). Tina replied that her "daddy" had kept hitting him in the stomach. When asked if he had used a flat hand, as demonstrated by Jansen, Tina said that it had been a fist. Tina made a fist to show Jansen what had happened. She also said that "her daddy" had thrown Alan onto his knee. Jansen did not understand this description at first and asked if Alan was on his knees. Tina said that he was thrown onto his daddy's knee and that blood came out of his mouth.

Sgt. Jansen asked Tina if Alan had been kept in bed for a long time, and she said that he had. She added that he had had nothing to eat but that she had given him a drink of water, with her mother's permission. When Jansen asked her why she did not take Alan something to eat, she replied that she did not want to get hit. Jansen asked if her mother had hit Alan. At first, Tina did not reply, but eventually she said that her mother told Alan to stick his feet out of the bed and hit him on the feet. When asked what she hit him with, Tina mentioned a stick with tape wrapped around it. Then Tina said that her mother told her to give her the telephone. She did, and her mother hit Alan with the telephone mouthpiece on the feet and then on the head.

Sgt. Jansen asked Tina if she knew why Alan was being hit. She replied that it was because he would not answer the question. When asked which question she meant, she said it was something about why he had gotten out of bed. She said that he had answered the question; he had gotten out of bed to play with his sister.

Sgt. Jansen examined a deep scab on Tina's back where she said her mother had kicked her. Then she adds this account:

> Tina told me that Daddy and Mama had put Alan in the bathtub. She said that his eyes were wide open and that Daddy had splashed water into his face but that he did not blink. She said that Alan had rolled over in the water and that when they raised him up that his eyes were still open and that he had not blinked. I asked if this was after Daddy had hit Alan and she said "yes." She said that they took him out of the tub and put him in a blanket and put him by the heat.

The next day, the foster parent decided to tell Tina that Alan had died. Her own husband had just died, and she explained to Tina that before a person dies, he goes into a coma and then doesn't hurt anymore. She said that her husband would look after Alan in heaven:

> Tina looked up at her and asked, "Does Grandpa hit kids?" She was assured that Grandpa does not hit kids and that people do not get hit in Heaven.

Detective Gregory L. Scott wrote the Quincy Police Department report on the autopsy, performed by Dr. Zakiah S. Ali, a pathologist, and assisted by Coroner Wayne Johnson and Laboratory Technician Thomas Luctenburg. Before the autopsy began, Detective Scott counted the bruises and abrasions on Alan's body and stopped counting when he reached 170.

The autopsy revealed that all of Alan's major organs, with the exception of the heart and lungs, had suffered extensive hemorrhaging. The doctor found that 400 cc. of blood lay in the abdominal cavity; he explained that a child Alan's size should have about 500 cc. of blood in his entire body.

Scott told the doctor that Madden mentioned that some of the bruising had occurred as a result of her attempts to perform cardiopulminary resuscitation on Alan. Dr. Ali stated that there was no sign that CPR had been used on Alan and that there always will be some sign on both the heart and sternum if it has been done. Dr. Ali also stated that there was no way that the injuries that Alan had sustained could have been accidental or self-inflicted.

Fourteen pictures were taken during the autopsy and four more were taken after Alan's body had been taken to a funeral home. The photographs reveal massive brain hemorrhage, kidney hemorrhage, colon hemorrhage, and pancreas hemmorrhage both on the inside and the outside. The photographs taken at the funeral home show severe bruising even in extremity areas, such as the feet.

Soon after Alan Madden's death, DCFS Director Gregory Coler instituted disciplinary action against several Departmental employees deemed by an internal DCFS investigation to have failed the case in one or more ways.

Dorothy Mason and Carol St. Amat, both of the Galesburg Office, were accused of failure to transfer the Madden case file. Mason was suspended for two days without pay; St. Amat was suspended for a single day without pay.

Indeed, one of the issues raised by this case is the question of appropriate DCFS jurisdiction responsible for monitoring the Madden family. As we mentioned, caseworker Mason of the Galesburg office had to report to the court concerning the suitability of placement for the children with their natural mother. But she had to rely on Quincy DCFS staff to monitor the home situation, speak with the mother, and supply her with written records. We asked both Carol St. Amat and Joan Kelly, Galesburg caseworkers, if the Madden case file had been transferred to Quincy. They told us that it had not been transferred because they interpreted DCFS rules to state that a case file should not be transferred unless all business is complete from the original DCFS office, and Galesburg still had contact with the family. They told us that as long as critical issues faced the court--such as the father's rights to the children and giving the mother custody of the children--the case file properly belonged in Galesburg. The judge had not rendered a final decision prior to the case being transferred.

According to both St. Amat and Kelly, DCFS policy is that a case should not be transferred until a disposition is reached. They mentioned that the case file could have been transferred if the judge had ordered it to be transferred.

Both St. Amat and Kelly agreed that, in their opinion, there was nothing critical in the case file regarding Pamela Madden's past history or demeanor toward her children, while there was a good deal of important information about the conduct of Gerald Madden. Therefore, the file rightfully belonged in Galesburg, they reasoned.

The Commission reviewed the applicable DCFS rules governing both transfer of cases and transfer of case files; the rules that we reviewed were applicable at the time the Madden case was pending. They may have been amended since then. A portion of the "Policy Governing Transfers" (Rule 6.3.1) follows:

> Areas shall utilize written agreements to delineate service responsibility when more than one Area must be involved in service delivery.
>
> Areas shall also utilize written agreements when total responsibility (service and financial) is being transferred from one Area to another. Such agreements shall be negotiated prior to the transfer and shall specify the proposed date of transfer (by the sending Area) and the acceptance date of transfer (by the receiving Area).
>
> A. When a family exists, the Area in which the family resides (home Area) will be responsible for service and financial planning.
>
> 1. Planning and payment responsibility shall remain together.
>
> 2. The Area in which the family resides has service and financial responsibility for all children from that family who are in purchased resources. In addition to private agency/institution resources this includes all state-operated facilities, licensed Department foster homes, relatives' homes, and independent living arrangements.

DCFS Rule 6.3.2 is titled "Case Record (File) Transfer" and delineates circumstances governing transferral of physical case records. The rule includes a comprehensive list of the responsibilities of different DCFS staff to assure that the proper documentation has been included in all transferred records. The important portions of this rule follow:

> The case record (file) of a child shall remain with the Area providing services, even though the "home" Area retains payment responsibility. Housing and maintenance of the "files" should be agreed to in writing by the appropriate Area administrators (i.e., which Area will submit required forms, etc.).

> When case records (files) are physically transferred, the Area initiating the transfer is responsible for assuring that the record(s) is/are in proper order.

Kathleen Cherington was discharged from the Department, effective February 3, 1981, for: failing to contact the State Central Registry about three separate abuse allegations; failing, in four separate ways, to complete and return the Child Abuse and Neglect Tracking System (CANTS) forms correctly; and failing to initiate an investigation of the October 17, 1980 abuse report within 24 hours. Cherington did not appeal her discharge because she became confused about filing dates.

Martha Butler was suspended for three days for failing to call the State Central Registry regarding the October 17, 1980 incident. When we asked Butler about the disciplinary action taken, she told us that the community was demanding that something be done and that some type of action had to be taken against those heavily involved with the Madden case. However, she did not feel that any of the workers was incompetent in actual duties and mentioned that the State Central Registry procedures of the Quincy office have changed at least a dozen times. She added that workshops to explain the new reporting system have served to only further the confusion about reporting.

When we asked Butler why she was unaware on October 17, 1980, that there was an open case on the Madden family, she responded that the case originally was referred to the Quincy office from the Galesburg Office as a child welfare case and not a case for Child Protective Services. She added that the Child Welfare unit provides "non-protective" services such as family stress consultations, home studies, and adoptions. As Butler understood the case later, the Galesburg workers had requested that a home study be conducted so that the adoption and parental surrender issues could be settled in court in Galesburg. Toward that end, Child Welfare (CW) assigned caseworker Mary Carroll to coordinate services to the family. Butler added: "There has always been interaction between CPS and the CW units at the Quincy office and later in the scenario Cathy Cherington who was assigned the case in CPS, did in fact communicate with Mary Carroll who had the case in the Child Welfare Service Unit."

Furthermore, as Butler's supervisor Timothy Morrell and Kathleen Cherington pointed out, the bulk of information in the Madden file pertains to Gerald Madden, the father, with very few references to Pamela Madden, the mother. They said that the case could not have been handled much differently and that Pamela Madden could not, based on case history, have been considered a potentially abusive parent.

Timothy Morrell was discharged from the Department effective February 11, 1981; he appealed his discharge to the Civil Service Commission, which examined the specific charges against him (basically the same charges as applied to Cherington) and ruled in October, 1981, that some charges had a basis in fact and responsi-

bility and others did not. It ruled that Morrell should have been suspended for 60 days without pay and reinstated him with the Department with the stipulation that he receive seven months' back pay.

No disciplinary action was taken against Quincy DCFS caseworker Amy Anderson. Nevertheless, she resigned in protest against the firings of Cherington and Morrell.

Originally, William Sheppard, once Field Service Supervisor in Springfield and responsible for the Quincy office, was suspended for 30 days pending dismissal. Director Coler changed his mind in this case and levied the penalty of eight days without pay and demotion to Regional Planner in the Springfield Office.

Ralph L. Hannebutt, DCFS Regional Director, was reassigned to a nonsensitive job in the Springfield office. Investigators' reports showed that Hannebutt had spent less than 13 hours in Quincy during the entire previous year; Sheppard, the Field Services Supervisor, had spent less than 80 hours in the Quincy region during that same time period.

Commission staff were able to scrutinize the results of the "Special Investigation Report: Alan Madden," conducted by the Department between January 16-19, 1981. The investigative team issued a 23-page report that included findings, conclusions, and recommendations based on more than 60 interviews, six telephone interviews, and document review from DCFS records. The report states that the findings and recommendations are the results of a concensus of opinion of the team members: "This concensus was developed in several group meetings at which important issues were identified, findings presented and recommendations formulated with the approval of a majority of the team members. Issues, findings and recommendations with statewide applicability are identified in the report when appropriate." Twelve issues are identified in the report, most with appropriate applicable recommendations suggested. We will review each of the twelve briefly.

1. The report identifies weaknesses in the condition of case records. It criticizes the Galesburg records for lacking formality and for the absence or inaccuracy of dates on entries. Both the Quincy and Galesburg records are criticized for missing information, and the investigatory team viewed these problems as symptomatic of a general lack of "proper supervisory review and evaluation of employee performance." The team recommends that workers be required to develop adequate social histories on clients and keep their records current, and that supervisors be required to review case files on at least a quarterly basis to assure compliance with Departmental regulations and state law.

2. The next issue identified is inadequate representation by the State's Attorney's Office, particularly for failing to prepare adequately for court hearings, failing to notify the judge of Pamela Madden's signed surrenders which resulted in her improper inclusion in the 1977 petition and the 1978 hearing, and failure to take significant action in pursuing termination of parental rights for almost a year after DCFS requested such action. The team recommends that a) consents to adoption be irrevocable after 12 months without exception; b) abandonment be better-defined and grounds for termination of parental rights be made much looser; c) a finding of abandonment contain no clause stating that diligent efforts must be made by an authorized agency; and d) a DCFS attorney be appointed as liaison with the court and the State's Attorney's Office for the Springfield region. (The reader should refer to our chapter on legal issues for more information on these recommendations.)

3. The third issue the team addresses is that, "Inappropriate court hearings were conducted, and the presiding judge failed to acknowledge the surrenders signed by Pam Madden, and failed to issue a Court Order." The report notes that there was no evidence to suggest that Pamela Madden's surrenders were ever voided, and claims that her subsequent involvement in matters concerning Tina and Alan was inappropriate. The team considered its second issue recommendations to be pertinent to this issue, as well, but also expressed the hope that judges would more closely review court records in the future and suggested that DCFS assign trained attorneys to work as court liaisons in every region in the state.

4. The team said that there was inadequate follow-up by the Child Welfare Services caseworker. The report sites her failure to obtain custody for DCFS before the children were placed in foster care in February, 1976, and notes that the case file contains no record of any services provided Gerald Madden when he regained custody of the children in May, 1976. Recommendations include instructing all DCFS regions to comply with the case transfer provisions of the Child Welfare Manual, and periodic review of cases by supervisory staff to correct staff mismanagement.

5. "Failure to report abuse allegations to the State Central Register and to complete required CANTS forms in a timely manner," are criticisms leveled in the fifth issue. The team found that both the October 17 abuse allegation and the report of Alan's death were called in too late and that not once in DCFS's involvement with the Maddens was any reporter referred to the 800 number by the workers. The review team alleged that the CANTS form submitted on October 20, 1980 contained factual inaccuracies and that the worker failed to provide aliases for Pamela Madden, thus limiting SCR cross-referencing possibilities. Also, the team criticized the amount of time lapsed between filling out of CANTS forms by workers, the dates they were signed by supervisors, and the dates they finally were submitted. The Quincy Office's overdue report record was very poor, according to the team, as were the records of two of the workers associated with the case. Recommendations emphasize timeliness, accuracy, and completeness of CANTS reports and increased use of the 800 hotline number.

6. According to the review team, "The lack of adequate management policies and direct supervision of staff activities had hindered

effective administration of the Quincy office and the execution of staff responsibilities." Cited in this allegation were the small amount of time some administrators and supervisors spent in Quincy, the lack of a formal mechanism for communication between the CPS and the Child Welfare workers assigned to the Madden case, and the lack of maintenance of basic caseload statistics needed to make adequate judgments concerning case assignment and staff performance. Recommendations include disciplinary action against individuals previously identified, formalizing office procedures for sharing information between caseworkers of two different divisions, and that "requirements for maintenance of basic management statistics should be formulated at the regional level and disseminated to all field office supervisors."

7. Issue seven mentions a lack of coordination of community resources and expertise in identifying, treating, and preventing child abuse and neglect, and suggests that there is a need for greater public awareness in Quincy. The team also decided that the procedure followed by the staff at the Washington school "may have thwarted the intent of the law...." The team recommends that all mandated reporters be made aware of their responsibilities; that law enforcement agencies conduct criminal investigations when appropriate, jointly with DCFS in some cases; that the Quincy DCFS office reach out to the community for professional expertise and volunteer help; and that funding be provided to the Quincy office to develop additional CPS treatment services.

8. The team's eighth area of criticism alleges that both DCFS and the community devote too little time to management and treatment of child abuse and neglect. The team continues that "it is apparent that the worker is given far too much discretion during the intake phase," and it criticizes workers' being allowed to screen calls and determine which should be referred to the SCR. Also criticized is the worker's handling of the Madden case with respect to the doctor's opinion that Pam Madden's explanations of Alan's injuries were plausible. The report claims the worker should have obtained a second opinion from a doctor who did not already know the family, especially in light of the severity and suspicious character of Alan's injuries. The team recommends that supervisors play a larger role in case management decisions and that the Springfield region assist the Quincy office in developing community and contractual resources. It also advises DCFS to study the option of having staff personally escort the possible abuse victim to examination by a doctor unknown to the child in order to ensure an impartial assessment. Also, the team recommends that the medical community receive further education about child abuse and its responsibility to report, and that all CPS workers be required to participate in CPS training no matter when they were hired.

9. The ninth issue is that neither the DCFS Quincy field office nor the community properly utilized the toll-free hotline number to report allegations of abuse or neglect. The team claims that neither the head of the local Probation Office nor the teachers at the local elementary school were aware of the hotline number.

The teachers were not aware of their status as mandated reporters, and the principal was not aware of the 800 number, either. Both he and the local DPA superintendent preferred to report locally, regardless. Recommendations include educating the general public through an intensified publicity program and that DCFS study the feasibility of call-forwarding local reports to the SCR.

10. Issue ten is that structure and staffing of the DCFS office have an impact on service delivery and case monitoring. This issue seems obvious, and very little discussion is devoted to it. Recommendations include separating intake functions from case management duties, hiring experienced nurses and investigators to assist on cases, and, again, supervisors maintaining caseload information on each worker in the office.

11. The eleventh issue is that "Follow-up procedures related to client services and case management are not well developed." The key recommendation regarding this problem is that the Division of Policy and Plans, with the input and approval of other Department units, develop policy for provision of services to families during such transition and adjustment periods as Pamela and the three Madden children underwent. The services recommended are to be composed of homemakers, day care, counseling, and parent education. The recommendation adds that the service could be developed as a written service plan, with a stipulation that failure by a parent to follow the outlined plan could result in removal of the children from the home.

12. The twelfth and final issue is stated thus: "The community reaction to or image of DCFS may have a detrimental effect on the Department's ability to investigate, treat and prevent child abuse and neglect." The discussion notes the negative reactions by community members following Alan Madden's death and also chastises Quincy DCFS office staff for failing to explain the Department's functions, purposes, goals, and procedures to the general community. The only recommendation is that the Department attempt to strengthen its image through education. Presentations to local civic groups are suggested as the primary forum for this educational effort.

The DCFS investigative report was prepared very quickly. We have presented what some of the principal figures in the Madden case had to say about the report and the disciplinary action that resulted from it. Undoubtedly, the report's authors realized that such a brief investigation could not identify all of the problems pointed up by the Madden case, but they appear to have presented those issues that seemed most pressing at the time the investigation was performed.

Quincy Police Department records, which are voluminous, provide some very interesting information not reflected in DCFS records or anywhere else. This information serves two purposes: it provides answers to questions that previously had remained unanswered, and it may help to explain some of the events leading up to Alan Madden's death.

Berg is Pamela Madden's maiden name. Quincy police officers were able to interview relatives of Pamela (Berg) Madden who came to Quincy for Alan's funeral. They, as well as neighbors and friends of Pamela Madden, told police that Tina had been badly bruised on several occasions when she was still a child. Friends of Madden told police that they had seen her force Alan to try to do pushups as a punishment when he was only four years old. Two neighbors mentioned that they had seen him trying to leave home, pushing a box with his belongings in it, because of the way his mother treated him. One relative mentioned that Alan reminded his mother of her first husband, Gerald Madden, and that displeased her.

Police also learned that both Crain and Madden were in the habit of using aliases. All of the water bills at Madden's residence in Quincy were paid by her, using the name "Nicole St. James." She may have used similar aliases for other purposes as well. The mysterious Dean Fanucchi, Madden's fiance with whom the DCFS caseworkers wanted to meet to discuss the children, turned out to be James Crain.

None of Alan Madden's relatives came forward to take responsibility for his funeral. He was buried in a donated casket in a donated burial plot with police officers acting as pallbearers. Hours after James Crain was released on $300,000 bond, his home was firebombed and he left town.

Pamela Madden's murder trial was held in Cook County because the widespread publicity about Alan Madden's death in Quincy could have been prejudicial. On May 8, Pamela Madden was convicted of involuntary manslaughter. She was sentenced to ten years in prison for the killing of her son, Alan.

James Crain was tried for murder in Springfield in July 1981, but the proceedings ended in a mistrial. Ultimately, the trial was held in Adams County Circuit Court, with most of the testimony being offered in December, 1981.

Pamela Madden testified for the prosecution, saying that while she had used some corporal punishment on Alan, Crain, a martial arts enthusiast, had used a karate maneuver she called a "knee drop" on the boy. She said this consisted of Crain's repeatedly slamming Alan's face down over his knee. "It was like breaking a board over his knee," she said, according to a December 16, 1981 Chicago Tribune article. According to the article, Crain in turn blamed Madden for beating Alan to death and claimed he had only hit the boy a couple of times. But, according to the Tribune, Madden said Crain told her late the night of the beating, "My God, I didn't mean to hit him that hard. I didn't mean to kill him."

Crain had not testified at Madden's trial, invoking his constitutional protection against self-incrimination, and she had not implicated him in the beatings at her trial. She changed her story for Crain's trial, however, saying she had had to lie in order to protect herself but that she now felt the truth had to come out.

On December 15, 1981, James Crain was found guilty of involuntary manslaughter for the killing of Alan Madden.

On January 20, 1982, Crain was sentenced to ten years in prison and $10,000 in fines for his role in the beating death of Alan Madden. Circuit Court Judge Edward Dittmeyer levied the maximum penalty for involuntary manslaughter against Crain, telling the defendant the case was "the most heinous and brutal" he had seen in his 35 years in the legal profession.

Crain pleaded for a five-year sentence, telling the judge that five years would be "plenty to pay for the mistakes I've made." Among those mistakes, he said, was being involved with Madden and not knowing what to do to prevent child abuse. Crain claimed that he had called DCFS to report Madden as an abusive parent. Crain also said: "I didn't kill him, and I wish it was me instead of him. The reason Alan is dead is because I didn't know what to do. She had me fooled. Pamela hit that kid with a stick many times. This was just one of those times."

Immediately after the sentencing, Crain was rearrested and charged with 63 counts of theft and public aid fraud. Madden was charged the same day with welfare fraud.

It is difficult to categorize the Madden case as typical or atypical. In many child abuse cases that result in the death of a child, the parent(s) have a prior history of abuse and/or neglect with a social services agency. It is true that Pamela Madden had no formal history of abuse or neglect with DCFS. Instead, she was receiving child welfare services in order for DCFS to assess her fitness to have her children returned permanently to her care. CPS only became involved following the October 17, 1980 allegation of possible abuse of Alan.

Police reports suggest that perhaps both Alan and Tina had been physically abused quite a bit more than ever was discovered. The severity of abuse finally inflicted upon Alan Madden was what made this case appear so heinous.

The case also suggests that the child protective system failed miserably in the Madden case. DCFS and the State's Attorney's Office in Galesburg appear to have experienced breakdowns in their functions, allowing Alan and Tina to be returned to a mother who had signed irrevocable surrenders on the children. Some of the findings of the DCFS investigative team appear to be correct, while others are questionable. Hopefully, we have presented a balanced view of this case, showing the realities of how the case was handled as opposed to the investigative team's blunt suggestions concerning caseworkers' and supervisors' doing a better job in filing forms and calling the registry.

I. Conclusion

A study of 112 cases of child homicide in New York City spanning a two-year period in the late 1960's, entitled "The Murdered Child and His Killers," by David Kaplun and Robert Reich, presents

information on the assailants, the victims, the status of involvement by both law enforcement and social service systems, and a broad discussion of pertinent issues. We will quote portions of the article that are directly relevant to child abuse-related death:

> Over two-thirds of the assailants in the cases we studied were parents or paramours. The most frequently named assailant was the mother, a finding that agrees with results of a study on child abuse. The mother usually acted alone but sometimes acted with her paramour. The biological father was the killer in only 10% of the murders, and minor siblings or other children were almost never implicated.
>
> In addition to child maltreatment and marital discord, all but 9.2% of the families we studied showed evidence of other behaviors prior to the assault that would be considered socially or psychiatrically deviant.
>
> In one-fifth of the cases, the victim or sibling had been placed in an institution or foster home because of parental problems. In five of the nine cases in which the victim himself had been in such care, the killing occurred either in the foster home or during a trial discharge to the parents.

The article provides information consistent wtih our case findings. In addition, the article discusses the problem of continuing jeopardy for other children in the home and the interaction of psychiatric, social service, and law enforcement involvement:

> After a child has been murdered there are generally surviving siblings or subsequently born children. In 79% of these cases we studied in which the children remained in parental custody following the homicide, there was evidence of possible jeopardy, and in 32%, continued neglect or abuse was a matter of record. The case of Mr. and Mrs. B illustrated such jeopardy. In a similar case no charge was pressed against the father, a violent criminal who used narcotics, after one death because the evidence was deemed insufficient for court purposes. In this case a younger child later died under suspicious circumstances, and another sustained a subdural hematoma and multiple fractures. In the latter instance the hospital physician refused to file a child-abuse complaint although he was aware of earlier injuries because he was impressed with the mother's gentle manner and did not know about either her own past episodes of ungovernable violence or the husband's history.
>
> When penal and correctional institutions were excluded, we found that before the murders 61% of the public welfare families were known to social or mental health agencies and that 47% were known to such agencies afterward. In both periods, the contact with psychiatric, counseling, and guidance agencies was negligible.
>
> Law enforcement activity, as shown by review of 60 of the public welfare cases, was meager and minimal. In 20 cases, no suspect was arrested. Of 25 cases in which postarrest information was available, 17 suspects went to trial. Virtually all alleged assailants were given short sentences on reduced charges in return for guilty pleas, and one case was dismissed because the witness to the killing was a 10-year-old sibling whose testimony was deemed inadmissable on the ground of age. Only in one case--a highly publicized one in which the father had drowned his child--was there a conviction for first-degree murder. Psychiatric evaluation was used only in the cases of four women who were sent to state hospitals.

Part of the discussion above centers on counseling and psychiatric help offered to assailants and alleged assailants because the authors had a vested interest in considering psychiatric options. But the information also makes it clear that the cases we examined, in which little counseling was offered or was available, and the sentences in those cases, both follow patterns discovered in this New York study. The authors offer the following in the discussion portion of their article; the six questions are intended to identify abusive home situations. The final paragraph from the article presents an interesting view of the abusive household that is still disputed, though most opinions agree that violence in the home is not confined to one child but is endemic among most or all of the household members:

> Only rarely are the violence-prone adults associated with these homicides recognized by their community agencies as needing psychiatric attention, and they do not seek such attention on their own. What, then, are the prospects for early identification of children in potential jeopardy? Such identification cannot be made with certainty. But bearing in mind that the great majority of the cases came from poverty-saturated areas and that most were known to the public welfare agency, it would seem that professionals who serve young mothers with out-of-wedlock children in such areas should identify cases in which some of the following six questions have affirmative answers:
>
> 1. Does an adult in the home have a history of assaultiveness toward children or adults, of involvement with crime, drugs or alcohol, or of episodes of impulsive rage?
>
> 2. Is there an unwanted pregnancy, with a neglected or abused child already in the home?
>
> 3. Where there is a legal or consensual marriage, is it marked by discord and physical violence?
>
> 4. Is casual promiscuity or prostitution the mother's way of life?
>
> 5. When children are seriously ill or badly injured, has there been failure or delay in seeking or using available medical care?
>
> 6. Are relationships with neighbors or relatives characterized by mutual hostility or avoidance?

CONTINUED

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> Our study throws into question the widely held belief that the abused child is the family scapegoat, battered by his parents while his siblings are unharmed. We have repeatedly seen the contrary. Our study also does not tend to support the belief that severely abusing parents are receptive to counseling or psychotherapy: the extreme, long-standing psychopathology, the host of coexisting problems, and the paucity of insight and motivation all tend to point against this view for most cases.

Commission staff examined an article entitled "Most Murders of Children Caused by Family Abuse" by Louise S. Miller and Carolyn Rebecca Block in a recent issue of the Compiler, a newsletter published by the Criminal Justice Information Systems Division of the Illinois Law Enforcement Commission. All of the data presented are extremely pertinent to our investigation. The authors state that data in the study come from "police-level" assessments of child deaths, which they explain as follows:

> These data are police-level; that is, they represent the investigating police officer's assessment of the incident. If the police consider an incident to be a murder, the incident is counted as a murder on the SHR, whether or not the suspect is later cleared of murder in court. Thus, these data do not reflect the number of people convicted of murdering children. Rather, they reflect the number of children that the police consider to be murder victims.

While this typology can cause some problems (the police may have been over-zealous in certain cases in classifying them as murders), the data are useful and probably accurate because, as we have seen, so few people are ever convicted of murder of children. Some are judged insane at the time of the killing, some plea-bargain for a lesser sentence, and some cases never come to court.

The article states that the leading cause of murder of children four years old and younger in Illinois from 1976-1980 was abuse by a family member. Of the total of 151 murders reported in the article, 62% were murdered by a parent, step-parent, or other family member. One hundred of the children were murdered in Chicago; the remainder were killed in other parts of the state. However, the article points out that the relationships of victims to offenders was consistent statewide, as were the circumstances surrounding the murders.

During the course of our investigation, our scrutiny of the national media as well as of local sources led us to some of the most extreme cases of child abuse that one can imagine. In Illinois, the Virginia Williams and Alan Madden cases attracted national attention and were both examples of tragic misdeeds, in one case through clear neglect and in another through willful beating. Child abuse resulting in the death of a child runs a continuum, from the parent who generally ignores the nutritional and other needs of a child until the child dies, to parents who deliberately set out to murder their children. Most cases lie somewhere between these two extremes.

Richard J. Gelles, in an article entitled "Violence Toward Children in the United States," (in Bourne and Newberger's Critical Perspectives on Child Abuse), claims to present the first study of parent-to-child violence based on a true cross-section of American families. He states that his data must be the most accurate such data concerning American child abuse yet presented.

Regarding child abuse resulting in death, Gelles estimates that anywhere from 365-700 children are killed each year in this country as a result of child abuse. Gelles also mentions that the data that he presents indicates that violence against children almost always represents a pattern of abuse rather than a series of isolated events. The only times that violent episodes were one-time affairs were in the atypical abusive situations, such as when a parent uses a knife or a gun on his child.

We obtained other data from the "Annual Statistical Report: National Analysis of Official Child Neglect and Abuse Reporting, 1978," published by the American Humane Association in conjunction with the Denver Research Institute of the University of Denver. This report closely parallels Gelles' in terms of the dates of abuse report compilations: the report was issued in November, 1979. This report presents information about 66,248 children who had been abused in this country. The report states that 331 of these children (half of 1%) died as a result of abuse, but adds this caveat: "This, of course, does not include those children who died after the report was completed and therefore must be considered as a conservative estimate of the total number of fatalities." Of the cases of child abuse death that the Commission reviewed, perhaps half of the children had died at the time the report was initially prepared. Furthermore, this data does not pretend to be all-inclusive of child abuse incidents throughout the entire United States for the previous year. This is a partial listing of data available to these researchers. Therefore, if 331 deaths is considered conservative, and is based on partial data, the total number of child abuse-related deaths must be far higher.

Closer to home, documentation given us by the Department of Children and Family Services for FY 79 (also comparable to the other dates being used herein) indicates a total of 57 deaths statewide as a result of child abuse. There had been a total of 24,807 abuse reports, but the reader must keep in mind that some of these reports were multiples on the same child. Only 14% of the deaths were reported by coroners, while hospitals accounted for 37% and law enforcement officials for 23%. Eighty-one percent of the children who had been killed had been under the age of three. The mother alone was implicated in 61.4% of these death cases, while the father alone was implicated in only 7% of the cases. (See the beginning of this chapter for death statistics in later years.)

Finally, while few cases of child abuse and neglect ending in death can ever really be called "typical," certain patterns among such cases are obvious. The question remains as to whether consideration of these patterns can actually lead to identifica-

tion of possibly abusive or neglectful parents and prevention of the needless deaths of children.

Chapter 6

CASE STUDIES: INTRAFAMILIAL CHILD SEXUAL ABUSE (INCEST)

This section of our report will deal with actual cases of incest, its treatment, and its effects on the victims. A great deal of attention has been focused recently on incest, partially because it appears to be much more pervasive than anyone thought even a few years ago. Research and self-help groups such as Parents Anonymous have uncovered cases of sexual assault in a large percentage of our female population, so much so that almost any figures are contradicted by data from more recent studies. The more the phenomenon of family sexual abuse is studied, the more pervasive intrafamilial child sexual abuse is shown to be. It is the hidden crime; the secret assault.

Staff research has turned up a tremendous number of definitions of incest, ranging from simplistic definitions to more complicated definitions that take into account many factors. For instance, Sandra Butler provides the following definition of incestuous assault in her book Conspiracy of Silence: The Trauma of Incest: "Any manual, oral or genital sexual contact or other explicit sexual behavior that an adult family member imposes on a child, who is unable to alter or understand the adult's behavior because of his or her powerlessness in the family and early stage of psychological development."

Researchers agree that incest is a more serious form of sexual abuse than sexual abuse that is non-family related. The after-effects are more lasting and far-reaching in incestuous situations, primarily because a parental or family bond of trust has been violated.

The Commission report Child Molestation: The Criminal Justice System provides information concerning the effects that such non-family molestation has on its victims. Another Commission report, The Sexual Exploitation of Children, deals with child pornography and child prostitution. Readers should refer to those reports in order to develop a complete picture of sex crimes against children. This chapter will deal specifically with sexual assaults and relationships between children and members of their own families.

A. Gail

Gail walked into the Chicago Ridge Police Department station on October 23, 1978, and reported that her father had sexually molested her. She told the police that her father had also sexually molested her sisters, but she specifically refused to file charges against her father for fear that such an action would aggravate her mother's heart condition. The police quickly contacted all of the girls in the family (one out of state and three in the home, including Gail) to question them regarding these allegations.

All of the girls responded that on more than one occasion their father had had sexual relations with each of them. None of the girls agreed to file charges against the man.

Based on Gail's initial allegations and confirmation from the other girls, the police took protective custody of all of the girls still in the home and took them to a girlfriend's house until DCFS could take custody. Police also reported the matter to DCFS and questioned the father about the allegations.

Soon thereafter, when DCFS became involved with the case, Gail's two sisters returned home at their own request. The two girls were twelve and seventeen at the time; Gail was fifteen. Gail refused to return home and was instead placed in foster care while DCFS referred the case to CAUSES (referred to earlier in this report) for treatment.

The DCFS worker we interviewed who had handled the case confirmed that none of the girls would sign a complaint against their father. The decision to refer Gail to CAUSES was made jointly by a DCFS caseworker and her supervisor. She explained that CAUSES' basic philosophy is that sexual abuse cannot be treated successfully unless the family is intact; the primary goal of therapy, she said, is reunification of the victim with other members of the family.

DCFS records of the initial investigation state that the father came to CPS offices to discuss the allegations. The following account comes directly from the case history:

> Mr._____ openly admitted having sexually abused all three girls. He stated that Gail was the only one of his daughters whom he had "penetrated" and that he had started having sexual intercourse with her when she was 13 years old. He said that he had had sex with Gail on many occasions, most recently, about one week prior to the interview.
>
> He stated that he had only "showed" Violet sex once during the summer but when she said that it hurt, he stopped. He said that he had at one time, had a sexual relationship with Carol, but the last incident took place over a year ago and ended due to Carol's insisting that they stop having relations.
>
> Mr._____ told us that in the beginning with the girls, he thought that he would be "teaching them about sex" but the whole thing got out of hand when he actually penetrated Gail.

He said that his wife had severe medical problems and that he had had practically no sexual relationship with his wife for the previous five years. All of the incidents with his daughters had occurred when the wife was hospitalized; she never knew about them until Gail went to the police.

The father said that he wanted to receive help and even volunteered to move out of the home. He wanted the family to remain

together, but if the children had to be placed, he would allow it.

A DCFS caseworker first visited Gail on October 26, 1978. Gail was very open about the incestuous relationship with her father; she told the worker that it had begun when she was twelve. She said that her father bribed her at first by saying that she couldn't see her friends unless she had sex with him. Gail also said that her father had left her alone at times, but resumed the relationship whenever the mother was hospitalized.

Gail said that a friend of hers had given her the courage to first talk to a priest and then go to the police. She had ambivalent feelings about her father and did not want to get him into trouble, but she also did not want to continue her sexual relationship with him. She still loved him and was afraid that he would have to go to jail.

DCFS workers interviewed the mother on October 30, 1978. She expressed guilt about the poor relationship she had with her husband and anger at Gail because she had gone to the police. She would have preferred that Gail had come to her with the problem so that it could have been dealt with within the family. The mother agreed to counseling and expressed the wish that all three daughters remain in the home with her. She felt she could adequately protect them now that she knew what was going on.

DCFS workers also interviewed the eldest daughter. The father had left her alone for more than a year after the initial assault, ever since she told him that their sexual relationship upset her. The eldest daughter was very angry with Gail for going to the police; she too was afraid that her mother would die from the added stress. The eldest daughter simply could not understand why Gail had gone to the police.

The youngest daughter also was angry with her sister for going to the authorities. She told DCFS that her father had tried to have sex with her once, but that he stopped when she said that it hurt.

The first CAUSES assessment is dated January 25, 1979, and covers the period from initial referral to December 31, 1979. The report states that the mother ran the household with an iron hand in spite of her illness. The mother was viewed as being completely dominant. Gail is described as follows: "She seems consistently to be on the 'bottom of the hierarchy' at home, although she is described by everyone in the family as 'daddy's girl.'"

The family had described itself as being happy, but CAUSES workers felt that there was a good deal of hostility within the family. The report states that the parents engaged in "one-upmanship" and that the mother "set the children up" by pitting them against one another. The report states that the first objective was to get Gail to return to the home, but it also notes that she

was very resistant to returning, partially because of her father and partially because of the reactions of her sisters. The following comes directly from the CAUSES report:

> During the course of the interviews with the father, he steadfastly stated that he had had sex with his daughters and he knew that it was wrong, but that he was trying to "instruct" them as to what to do when confronted by the sexual demands of their peers; i.e., how to kick, bite and scratch when confronted by a man. He was unable to admit to his untenable position of "instructing them in the art of defense against sex" while not allowing them to fight him back.

The report acknowledges that although the family had been resistant to counseling, the potential for change "still seems moderately good."

CAUSES also submitted a report sometime in 1979 (an undated report) that contains a summary of progress to date on Gail and her family. The summary states that the very day Gail was returned to the home (February 2, 1979), she reported to the police that she was molested again by her father. The police again assumed temporary custody, and the father left the home.

We were told that the two workers involved with the case from CAUSES were Clifford Rot and Debra Sachs. After several counseling sessions with them, Gail was returned home. When the second sexual assault allegation surfaced, CAUSES staff requested permission to remain active on the case, but the request was denied by the DCFS liaison with CAUSES. The case was taken to court. The DCFS caseworker told us that the contract between DCFS and CAUSES for work on Gail's case was officially terminated upon entry of the case to the court system.

The court ordered the father to leave the home and gave DCFS custody of Gail. Although the father was not charged with a criminal offense, a protective order was issued to assure his staying out of the home. Gail was then placed in temporary foster care.

The caseworker told us that when she interviewed members of the family, Gail's mother and sisters were very upset with Gail because she had reported her father's activities to the police. No one wanted to discuss the incest, and they blamed Gail for forcing the father out of the home and out of a position to provide for them. The two other daughters told the caseworker that they forgave their father for what he had done. The caseworker discerned a feeling of competition between the mother and Gail as a possible source of her extreme irritation with Gail.

The caseworker told us that counseling was provided by the Special Services Section of the Cook County Probation Department after CAUSES' involvement in the case was terminated. Counselors from the Department worked with the family twice a month and more intensively with Gail alone.

The next document we reviewed is a social investigation done by DCFS. It refers to the February 2, 1979 allegation. After the police assumed temporary custody, Gail was placed at New Life House in Chicago. The DCFS report states, "During the first weekend of Gail's placement, she seemed to feel rather self-destructive--as witnessed by the fact that in the space of two days she managed to smash her fist into a brick wall, have her foot run over by a car, and fall down the stairs of New Life House during a fire drill. All of these incidents required medical attention."

DCFS reported that a worker visited the mother when she was home alone on April 4, 1979. The first thing the mother told the worker was that she never had believed Gail's allegation against her husband. "When asked why Gail would falsely accuse her father of sexually abusing her, _____ said that Gail was a chronic liar, who was angry at her parents for forbidding her to see a boy of whom they did not approve." The mother also characterized Gail as "the bad seed" who had always been in trouble.

On this same date, the same worker visited Gail. Gail told her that she was very confused about her father--that she both loved and hated him. She was angry at her sisters and mother and expressed no wish to see any of them.

The DCFS worker's impression was that it seemed very unlikely that the family ever could be reunited. As a result, long-term foster care was seen as the most viable plan for Gail.

Commission investigators also interviewed a probation officer with the Special Services Unit of Cook County Juvenile Court in order to gain a greater perspective on this particular case and to determine just how the special unit functions. She told us that the Special Services Unit consists of six social workers and one supervisor. The purpose of the unit is to serve sexually abused children, the majority of whom are female. We were told that creation of the unit was the idea of Assistant State's Attorneys Mary Martin and Catherine Ryan, who had both noted a lack of adequate care for these children by DCFS. The unit provides individual, family, and other group counseling therapy. We were also told that the unit can work on a case only upon court order; when a service plan is developed, the unit worker attempts to have the DCFS caseworker actively involved in case planning. She added that some workers cooperate with the project and others show no interest in it.

We were told that one big problem with the unit's functioning was that the parent/defendant was not compelled by any legal means to cooperate with counseling. She said that in most cases a parent's attorney will advise him to go along with counseling because, if nothing else, it will look good to the judge when the case comes before the court again. She said that, in her own experience, these parents attend the counseling sessions but refuse to get involved. She also said that she would like to see some leverage exerted on parents to either participate or face criminal prosecution.

Sometime in the early morning of August 13, 1979, Gail ran away from her foster home. The foster parents notified DCFS as soon as they discovered that Gail was missing. A few hours after this notification, Clifford Rot of CAUSES called DCFS to report that Gail was in his office. Apparently, she had called Rot when she ran away and he met her at 3:00 a.m. Rot then took Gail to his office where he allegedly fell asleep and Gail sat up all night.

The DCFS worker asked Rot to try and get Gail to return to the foster home, but she refused. Gail's problems at the foster home had precipitated her running away and DCFS was in the process of seeking another placement but had been unsuccessful up to that point.

Rot demanded that Gail be hospitalized immediately, based on the recommendation of Dr. Greenberg. The DCFS worker indicated that the guardianship administrator would not agree to this, especially since CAUSES staff were no longer responsible for planning on Gail's case. Rot reportedly berated the worker for her lack of professionalism and said that Gail should be picked up at the CAUSES office, although he would not "guarantee" that she would be there.

Eventually, Rot dropped Gail off at CPS offices. The CPS workers decided at that point to take her to the Institute for Applied Behavioral and Psychological Research for testing and treatment.

The probation officer and the DCFS caseworker agreed that Rot's continued involvement in the case had undermined DCFS planning and the caseworker's relationship with Gail. The probation officer added that Rot need not have encouraged "her dependence upon him"; further, she noted that Rot failed to notify all of the appropriate parties when he first learned of Gail's runaway: DCFS, the police, and the foster parents.

On October 19, 1979, Gail was again placed in temporary foster care. During this placement, her delinquent and other inappropriate behavior appeared to escalate. Allegedly, she set a fire in a bathroom of a local high school, accused her foster parents of beating her, and hit a policeman following yet another runaway incident. Because of these incidents, Gail was placed in a JSPA group home, the Essex House, in January, 1980. An agreement was made that Dr. Jonathan Lewis, a psychiatrist at the Institute, would continue to see Gail while she stayed at the Essex House.

Unfortunately, problems continued in spite of coordination of efforts by all parties. Essex House staff developed what they defined as a "very clear pattern of behavior" that involved Gail's manipulation of both people and her environment. Gail charged in February, 1980, that she had been sexually harrassed by another girl at Essex. When she discussed the incident with Dr. Lewis, the situation appeared to have been resolved. But when she discussed the incident with another doctor, whom she was visiting

for a routine physical examination, she became hysterical and convinced him that she had indeed been assaulted. The doctor decided that she should be admitted to a hospital for observation and that the other girl should be charged. The director of Essex House confronted the doctor and Gail and tried to persuade him that there was no truth to Gail's allegations. Gail's response was to call the police.

The police found no substance to Gail's allegations and refused to recommend removal of either girl from the Essex House facility. Gail's response was to run from the home and stay out all night.

Case records indicate a series of problems with Gail thereafter, including attempts to persuade Dr. Lewis to allow her to stay out all night, two unauthorized and unannounced visits with Clifford Rot, and extreme emotional reactions to simple occurrences.

On March 30, 1980, Gail was granted a pass to go to the movies alone. At 9:30 that night, she called in and asked what would happen if she came home late. She was told that she had to be home by 10:30 that night. She did not show up. She appeared at Dr. Lewis' office at 8:30 the next morning, exactly on time for an appointment. She told him an incredible story of having been kidnapped and raped by four men the night before; she claimed that she escaped just in time to get to his office for her appointment. A summary from the Essex House records states, "It should be noted that Gail later admitted she lied about being abducted and raped."

The next incident of note was referred to in interviews that we conducted and in files that we reviewed. In essence, Gail ran away again on the evening of April 1 and called her boyfriend to pick her up at a bar. An hour later, he picked her up and they drove to one of Gail's former foster placements. An hour later, they drove to the boyfriend's house, picked up some money and food, and Gail called Clifford Rot to tell him she was coming over to his apartment. They arrived about midnight; the boyfriend dropped her off. The next morning, the boyfriend called at about 8:00 a.m. to speak with Gail and was told by Rot that Gail was still asleep. When he called again an hour later, he got the same response. Sometime later that day, Rot brought Gail to Dr. Lewis' office. Dr. Lewis called the DCFS caseworker.

The caseworker spoke with Rot and asked why he had not notified DCFS when Gail appeared at his apartment. He refused to answer her questions. A portion of the caseworker's memorandum reporting this incident follows:

> When Gail was placed at Essex House Mr. Rot and I discussed, at length, Gail's running to him. We agreed that he would follow proper procedure by notifying one of the following, preferably in this order:
>
> 1. DCFS
> 2. Police
> 3. Essex House or JSPA

> The involvement of a number of persons in this girl's life, at this point, is giving her double messages. She is placed in a structured setting at Essex House. On the other hand she is taken in by a previous worker with whom she has had a prior relationship. This worker's failure to return her to placement gives tacit approval to her for running away. What I want is clarification regarding Gail's case; clear messages around what should occur if she runs in the future.

After discussion of this issue with her superiors, the caseworker initiated the filing of a supplemental petition in Juvenile Court with respect to the actions of Clifford Rot.

A protective order agreed to by JSPA's director, Rot, a DCFS attorney, an assistant state's attorney, and a guardian ad litem was signed by Judge Arthur N. Hamilton on May 14, 1980. Each of the five paragraphs in the order mentions Rot and enjoins him from acting toward Gail as he had in the past.

The last we heard from the caseworker was that she no longer was monitoring Gail's case. As far as she knew, Gail still was in placement and the father had returned to the home. She said that the extent of his counseling was to speak with a priest twice a month.

The last that we know about Gail comes from a letter from a JSPA social worker to DCFS officials. The letter, dated July 21, 1980, confirms Gail's discharge from JSPA. It mentions that Gail had run away from Essex House on June 23, 1980. Though JSPA workers had made an attempt to locate her, Gail's last contact had occurred when she called Dr. Lewis from a phone booth on the city's south side three weeks before the letter was drafted. The letter mentions that Gail had been seen prostituting herself on the city's north side during the week after her runaway, but she had not been seen since. The social worker notes that Gail had never been away for more than 24 hours before this incident. He refers to her continued psychiatric care for more than a year and her extreme emotional outbursts and concludes that JSPA staff was very concerned about her ability to stay out for so long unharmed.

Apparently, that was the last contact that Gail had with the "system."

Commission investigators spoke with Dr. Lewis about Gail; he told us that he could not discuss her case because of doctor-patient privilege. But he did agree to discuss the role that psychiatrists play as consultants for DCFS. Dr. Lewis told us that he had been under contract to DCFS for seven years, working part-time (20 hours per week). He assessed clients and counseled wards for DCFS. These functions were intended to assist in placement planning. Dr. Lewis added that he was engaged in his own research into the typology and characteristics of child abuse.

Dr. Lewis commented on what he called "myths" perpetuated by DCFS officials through their bureaucracy. The first such myth is that DCFS assumes that children referred to DCFS are "normal" and can be handled even by untrained workers. He mentioned that one of the Department's deputy directors had told him that 90% of the Department's wards are normal, while 10% are disturbed. Dr. Lewis felt that these percentages really should be reversed. He said that by the time he sees children, they have been abused, severely neglected, or orphaned, and then brought into the bureaucratic system of the courts and DCFS. Most of the children he sees are severely disturbed.

The second myth Dr. Lewis challenged is the DCFS assumption that because there is a natural bond between child and parent, placement with the natural parent is best. Dr. Lewis strongly opposed the trend to keep the family together in cases of extreme abuse. He felt that at the time that abuse occurs, parents are actually mentally ill. "Impulsive abusers" should develop the necessary controls to stop their behavior before it becomes dangerous. Other abusers, primarily the sadists he has encountered in his practice, have "personality deficits" that prevent them from feeling guilt.

Dr. Lewis concluded by saying that abused children should not be considered mentally healthy. He has encountered a majority of children who feel extremely guilty as a result of their abuse; some feel that they are "evil" and somehow caused the abuse through their own behavior. These children both love and hate their parents and need treatment to sort out their emotions, as in Gail's case.

Gail's case was complicated because of the personality traits involved, the home situation, the involvement of other girls in the home in sexual abuse, and Gail's multiple placements. Complicating the abuse were the double messages that Gail received from professionals assigned to her case. The ultimate effectiveness of any of the treatment and therapy offered to Gail remains unknown. Our final contact with the Chicago Ridge Police Department revealed that Gail's family had moved out of state, probably to Texas or Kentucky. Nothing further has been heard of Gail.

B. Mary

On June 20, 1980, Mary, a four-year-old child, was taken to Forkosh Memorial Hospital by her mother and grandmother, following complaints of internal pains. After they arrived at the hospital, the mother told hospital personnel that Mary had said she had been sexually molested by her father. Hospital staff then called both DCFS and the police.

Upon examination, doctors could detect no "penetration or trauma." However, the doctor added this observation, as recorded in DCFS case notes: "Because of the age of the child he feels that she is being sexually abused because she is not old enough

to make up the story and because of her persistence." Also, the mother reported that for the previous two months, her husband had been going into Mary's bedroom at night. The following mornings, Mary had trouble urinating.

The mother told the police she had confronted her husband but he denied it every time. The mother refused to sign a complaint against her husband because, as she told a DCFS worker, she "did not know what would become of her" if she were to do so.

A Chicago Police Department investigator spoke with the CPS worker assigned to the case, Michael Frank. The police report states that Frank had interviewed the victim and that "...he felt this family was in need of professional counseling through the Courts, and that his agency was pursuing the case via the Family Court." As a result, he requested that the case be closed by the police, and it was.

On June 30, 1980, Mary's mother took her to Children's Memorial Hospital because of her daughter's complaints that the father had been fondling her. DCFS case notes state that the mother had noticed spots of blood on Mary's underwear. An emergency room doctor confirmed that the spots were indeed blood; his examination showed redness and irritation to the vaginal area but no penetration. Again the police were called; again the mother refused to sign a complaint; again the police closed the case.

On July 7, 1980, Mary's mother took her to Swedish Covenant Hospital, alleging that her husband had sexually molested Mary. The medical examination by two doctors discovered an "old" tear of the hymen. One of the doctors quoted Mary as saying that her father "put his finger in her lower part." This time the mother told doctors that the molestation had been going on for 2½ years. DCFS case notes emphasize the doctors found no new injury and that they did not recommend hospitalization.

Again the police were called; this time they took Mary and her mother to the station for further interviews. All parties involved were concerned about the case because of obvious mental limitations of the mother. Nonetheless, the police arrested the father and charged him with taking indecent liberties with a child. The assistant state's attorney called in to interview family members determined that both parents were so limited intellectually that neither would be credible as a witness in court. In fact, he felt the only credible witness would be the girl, Mary, who was far too young to qualify as a witness. As a result, the charges against the father were dismissed. DCFS case notes state that Mary was considered to be at "high risk" and that protective custody should be taken as soon as possible.

The next day, after a review of the case by the Child Abuse Unit of the Cook County State's Attorney's Office, police took custody of Mary and this time arrested both parents. Mary was placed in temporary custody of DCFS and taken to emergency foster

care. The parents were bailed out of jail and, four days later, the mother was admitted to Read Mental Health Center following a disturbance in the alley behind her home.

This case becomes clearer when we examine a report submitted by CAUSES on July 29, 1980, entitled "CAUSES Diagnostic Assessment/Closing." As it turns out, Michael Frank had no intention at the beginning of the case of referring Mary's case to Juvenile Court. Contrary to what he told the police, he referred the family to CAUSES for treatment, thereby limiting the likelihood of court involvement, since CAUSES generally will not work on cases that have been referred to the court. Frank took the entire family to CAUSES offices for counseling on the first day Mary was released, June 24. The report we examined covers the period from June 24 to July 29, 1980.

The report states that the parents were seen in CAUSES offices on the 24th, the 26th, and on July 1. The report adds, "_____ took Mary on 7-2-80 to a private physician and then to Children's Memorial Hospital with vaginal bleeding which Mary stated occurred by mother scratching her with her fingernail while applying a vaginal cream." The parents were seen in CAUSES offices again on July 2, and July 8, prior to their arrest. The father also had a visit in CAUSES offices with Mary, supervised by Michael Frank, on July 18. The report concludes:

> Mrs. _____ has a long history of mental illness and hospitalization and presents as a paranoid schizophrenic. Mr. _____, who is 14 years her junior, presents as a deeply anxious and depressed man whose apparent inadequate personality is overwhelmed by his wife's illness and his inability to deal with her actions and accusations.
>
> Mary, in her two visits with the child therapist shows evidence of emotional disturbance. It was not possible to establish whether Mr. _____ has sexually abused his child. Her mother's actions, attention to Mary's genitalia and the frequent examinations of them are clearly adding to whatever sexual abuse may have occurred. It may also be that Mary has been caught up in her mother's delusional system....
>
> Court involvement has precluded further CAUSES' intervention and this case is being submitted for closing by this agency unless further services are requested.

Mary was reported doing well in her foster home. She asked social workers when she could go home but did not ask anything about her parents.

The DCFS social investigation makes it clear that the husband is the sole source of support for his wife; Michael Frank indicated she "may" qualify for general assistance or disability if she divorces her husband but that she cannot support herself "unless she receives training." If the wife understood her dilemma, it may explain why she refused to sign a criminal complaint against

her husband and why she said she would not know what to do if she had to live without him.

A crucial section of the social investigation is the "assessment of problem" section, which follows:

> The major problem in Mary's case is determining how traumatized Mary was by the sexual abuse by her father and by the manual penetration of her by her mother. Because of the emotional instability of both parents, determining how frequently the child was abused is impossible. Are the parents capable of providing appropriate care for their daughter if they are in therapy? The history of the parents' marital relationship and their individual emotional make-up raises serious doubts about their competency as parents.

This assessment also indicates that the mother's instability and the unlikely prospect that she can make significant strides toward learning how to parent Mary properly. The father is assessed as impaired, but the final evaluation is reserved until a more complete study can be done. Frank indicates that he will attempt to place Mary with a relative until the father's condition can be assessed.

An August 21, 1980 memorandum from a Chicago Police Department youth officer assigned to the Abuse/Neglect Unit to the Commander of the Youth Division deals specifically with Mary's case. This particular officer was assigned as liaison to Juvenile Court.

The memo reports that after DCFS assumed protective custody of Mary on July 7, Michael Frank again returned Mary to her home, just as he had done in June. The youth officer brought his action to the attention of Assistant State's Attorney Catherine Ryan, who ordered a petition to be filed on Mary. Ryan also approved a warrant for Mary's father's arrest on the charge of contributing to the sexual delinquency of a child. What happened next, as detailed below from the youth officer's memorandum, is very important to an understanding of how Frank handled this case:

> Assistant State's Attorney Catherine Ryan informed DCFS on 8 July 80 that her office was filing on Mary. Michael Franks [sic], the DCFS caseworker, came into her office on 8 August 80. R/O was asked by Catherine Ryan to participate in the interview. Michael Franks requested that Catherine Ryan not file on the child. He stated that he was actively involved with the family and court action would interfere in his relationship. He related that he was also aware of two prior reports of sexual abuse which were reported to the Chicago Police Department (20 June 80 and 30 June 80). He further stated he also believes the mother, _____, is also sexually abusing Mary. He was asked to clarify this statement. Michael Franks stated he was at CAUSES, Illinois Masonic Medical Center, when the mother demonstrated how she applies her [own] medicated cream to the child's vaginal area. He interpreted her actions to convey sexual overtones. Mother is under psychiatric treatment and exhibits unusual behavior when she does not take her

> medication. She has been known not to take her medication; Michael Franks was aware of this. When he was informed that warrants would be sought both on the father (Contributing to the Sexual Delinquency) and the mother (Neglect), he became quite upset. At this time he stated that he never had any intentions of bringing this matter to Juvenile Court for either criminal or civil charges. He stated he was working with the family and had them in counseling with CAUSES a private agency that DCFS contracts with. Its Executive Director is Dr. Nahman Greenberg, M.D. CAUSES will only work with an intact family. Michael Franks knew if the child was removed from the parents, DCFS could no longer contract the services of CAUSES. When he was asked what protection was being provided for the child, he could not answer. He then admitted that he had gone to the police station on 7 July 80, took the child and waited until the father was released. At this time, he returned the child to the home.

On September 2, 1980, Michael Frank transferred Mary's case to the North Area Office. We should note that the DCFS social investigation states erroneously that DCFS "filed a petition in Juvenile Court on July 8, 1980." In fact, Michael Frank took custody of Mary on July 7 and then returned Mary to her home. The State's Attorney's Office, not DCFS, filed a petition in Juvenile Court.

Commission investigators conducted interviews to determine how this case had been handled by different parties and to give us insight where documents failed to provide it.

We spoke with a Forkosh Memorial Hospital nurse and her supervisor. The nurse had been in charge of the floor when Mary was brought in on June 20, 1980. Perhaps because cases of child abuse are extremely uncommon at Forkosh, the nurse remembered the case extremely well. Hospital staff had arranged a room to allow Mary's mother to stay with her, but the mother refused. This particular nurse had been on duty when Mary was admitted and again when Michael Frank first came to the hospital. Her biggest problem with Frank was his decision that Mary should go home, made after interviewing her mother over the phone. She protested to him that Mary should not go home because of the nature of the charges against the father and because of the mother's unstable condition. Frank responded that the parents had agreed to attend counseling sessions at CAUSES and that unless the parents did not show up for counseling, Mary was going home.

We also spoke with three Chicago Police Department detectives who had been involved with Mary's case. One of the first officers involved recalled Frank's telling him the case would be referred to court. As a result, the officer requested that the case be cleared by the Chicago Police Department. The same officer also spoke with Dr. Greenberg of CAUSES. Greenberg had assured him that CAUSES was handling the case in cooperation with both DCFS and Juvenile Court, even though no court referral had been made.

Our investigators also spoke with Assistant State's Attorney Edward Stern, assigned to Felony Review when Mary was brought in on July 7 with her third abuse allegation in three weeks. He told us that there was very little physical evidence to support the child's claims. The mother did appear to him to be mentally unstable. He added that she could not have testified: she could not even tell him her name or address (DCFS case notes reflect that she could not remember her own telephone number and that she carried her address written on a slip of paper for reference).

Stern was under the impression, though, that Mary would be removed from her home even though he could not approve charges against the father. He spoke with DCFS workers on the phone who assured him that a caseworker would be sent out immediately. He recalled telling the workers of his concern for Mary because of the mother's unstable condition. Stern also told us that DCFS said that Mary would be removed from the home. Stern had to respond to another case, so he left the station before Frank showed up. He concluded by telling us that he had been deceived or at least misled by DCFS when told that Mary would be removed from the home. He said that had he known she was to be returned home, he would have done something to prevent it.

We interviewed Michael Frank in our offices on December 10, 1980. At the time of the interview, Frank was on "educational leave" with DCFS, working on an advanced degree. He had gone to work part-time as a therapist for CAUSES.

Frank told us that CAUSES is the primary agency to handle sexual abuse cases in Cook County. Frank said that he referred Mary's case to CAUSES because CAUSES was the sole provider of services. He was not aware of other agencies in Cook County that could handle incest cases. Frank also mentioned that a team from CAUSES meets each week at the CPS central offices and reviews copies of reported cases that had been referred to CPS during the previous week. Frank added that CAUSES had the only DCFS contract giving clear and immediate access to information at the intake stage. Through a process of discussion and negotiation, CAUSES and DCFS workers determine which cases to refer to CAUSES and what type of treatment is appropriate.

Frank said that he and a supervisor agreed that CAUSES could provide immediate service for Mary and her family, so no court referral was made. Frank told us that proper procedure would be for a CPS worker to monitor a case for a certain period of time and then to transfer it to another unit within CPS responsible for contracts and grants liaison. Frank did not ever transfer this case as required. He said that because DCFS policy has changed so often over the years regarding how long the original CPS worker is to monitor a case, he decided to monitor Mary's case himself, even after it was referred to a contractual agency, CAUSES.

Frank claimed to have made the decision to keep Mary in her home because of the close relationship Mary had with her parents, the abuse allegations notwithstanding. He added that CAUSES was

to do a family assessment and would be seeing the family regularly as a whole. Frank also planned to attend many of the counseling sessions at CAUSES himself. He did not feel any responsibility to report Mary's case to the State's Attorney's Office because any time there is a second report of abuse, the State's Attorney automatically is notified.

Frank said that he was surprised at the third allegation of abuse. As soon as he heard about it, he planned to take the father to see Dr. Greenberg directly from jail. Had they the opportunity to analyze the case, he and Dr. Greenberg might have decided to take the case to court, he said; they never had that chance because Catherine Ryan brought the case to court on her own.

Frank took the father home from jail as he had planned, and then took the entire family to CAUSES the following day. That same day Ryan summoned him to court to discuss the case. Frank said that the people at the court were all alarmed at his treatment plan, and that they should not have been.

Frank criticized the State's Attorney's Office for having too much discretion concerning when to file a petition on a child and bring the parents to court. He claimed that the Office never contacts or discusses cases with caseworkers before filing petitions. He added that it was "inappropriate" for an assistant state's attorney to initiate court action without first consulting him. Frank said that it was his responsibility to decide when a case should be referred to Juvenile Court; certain agencies may suggest that a child is in danger or needs protective custody, but it is solely a caseworker's decision as to when to take custody, even if the matter is a police-reported incident. Frank admitted that there is a screening committee to which police, prosecutors, and caseworkers can go with cases. The committee meets regularly and cases could be screened there. He still felt, though, that the decision to refer a child to the court should be in the DCFS caseworker's exclusive domain.

As a final comment on his handling of Mary's case, Frank said that if he had it to do over again, he might have considered the "mental health conditions" of the family differently and therefore might have decided to remove Mary from the home.

One of the larger issues raised by this case is the role of different agencies and departments. How social workers interact with the police and representatives of the court can be crucial in determining a child's fate. Frank's attitude that he was the expert who should make all ultimate decisions in Mary's case prevented the victim from being protected and treated for sexual abuse, even though CAUSES' diagnostic examinations done when she was first referred showed that she had been scarred emotionally, if not physically.

We spoke with Catherine Ryan concerning both Mary's case and the procedure for referrals coming to the State's Attorney's attention. Instead of referring serious cases, she said that DCFS

sends over cases involving abandoned children and other "non-serious" cases; DCFS keeps most serious abuse and incest cases, refusing to cooperate with her office; and DCFS routinely ignores its own internal rule.

Ryan said that workers know that nothing will happpen if they circumvent the system and return a child home after the police or another agency has taken protective custody. She added that most DCFS workers appear to feel that they help the victim by not calling the police and by not cooperating with a case when it reaches court.

Ryan said that the relationship between her office and DCFS is poor. She added that DCFS workers are ill-trained and ill-equipped to do the jobs expected of them. Because of a lack of accountability within DCFS, caseworkers felt that they could handle cases in any manner they wished, with no uniformity of approach. Ryan felt that it was incorrect for a DCFS caseworker to be the sole judge of how to handle a case of abuse or incest. All of her comments were congruent with what we discovered from reviewing the details of Mary's case.

Most incest cases are complicated because of unique factors involved; this case was no exception. Still, except for Frank's attitude toward placement of the victim and treatment for the family, the case was handled in a straight-forward fashion. The case does point out, however, how a single worker can interfere with or thwart the purpose of the child protective network that often involves many people. Only when they achieve cooperation will cases be handled with a degree of uniformity that may be necessary for these cases to be resolved properly.

C. Lois and Marcia

One of the more bungled cases that the Commission came across during its investigation was the case of Lois and Marcia, twin sisters. At this writing, in September, 1982, the case still has not been fully resolved. Some of the more obvious facets of it remain at loose ends and only now are being addressed appropriately by the authorities.

A review of DCFS records reveals that the first contact these girls' family had with DCFS occurred in 1975, when DCFS received a report that the children had been left with a 16-year-old baby-sitter in a filthy house while the mother visited France, her native country. The children were placed in foster care until the mother returned home.

In June of 1978, Lois allegedly had been forced to attempt to engage in sexual intercourse with her stepfather. Her mother worked at night and was worried about Lois because she had been sick. She told her daughter to sleep with the stepfather. When the stepfather told her to remove her clothes and attempted intercourse, she told him that it "wasn't right" and to stop, which he did.

Lois was afraid to tell the mother about the incident, she later admitted to police, so the following night the mother again advised her to sleep with the stepfather so that her fever would not worsen and go unnoticed. The stepfather repeated the scene of the previous night and again failed to achieve penetration. Lois asked him to stop again, which he did.

Lois did not tell her mother or go to the police.

Between July 21 and 25, 1978, Lois was approached by the stepfather while she was making his bed. Again he told her to remove her clothes and attempted to have sexual intercourse with her. Again she told him to stop; this time he did, but he forced her to masturbate him. Then he said "it was all over" and told her to go back to her own room to go to bed.

A week later, he called her into his bedroom and told her to get into bed with him. He attempted intercourse again and failed. Again he persuaded Lois to masturbate him. Finally, he tried to coax her to put her mouth on his penis, saying that her mother did it all the time. She refused.

These incidents became known to the police when one of Lois' cousins implicated her in acts of sexual intercourse and oral copulation. The cousin said that Lois told him she had learned about oral copulation from her stepfather. The police brought Lois to the station, where the incidents described above were reported. The police asked her why she never had reported the abuse. She responded that she felt no one would believe her.

The police asked her if she ever attempted to have oral intercourse with her cousin. She admitted that they had removed some of their clothing and had kissed and rubbed their bodies against one another, but she insisted she had never had oral intercourse with him.

Marcia also was called in by the police and questioned separately. She was asked whether her stepfather ever had approached her sexually. After hesitating, she offered the following account. Sometime in April of 1978, she had been asleep in her bedroom after her mother had left for work. The stepfather woke her and told her to come into his room. She refused and tried to go back to sleep. The stepfather then picked her up and carried her into his bedroom. He forced her to remove her clothes and then lay down on top of her. She told him to stop, which he finally did, and he allowed her to return to her own room.

Between July 21 and July 25, 1978, the stepfather called Marcia to his bedroom. He told her to remove her clothes. This time he attempted intercourse but did not succeed. Marcia told police that he had not tried to bother her since but that he had shown signs of hostility, not allowing her to spend time with her friends and making sure she always was in before curfew.

When asked about these incidents, she told police that she had told no one, not even her mother, because she felt ashamed and thought that she would not be believed.

The Bensenville Police Department investigation uncovered the 1975 situation, in which the mother was adjudicated neglectful and placed on two years' probation. The abuse/neglect report had not been easy to find because it had been filed under the mother's previous married name.

After the police heard the two girls' stories, they went to their house to remove the remaining son and daughter from the home. At that moment, the mother returned home. Police told her to meet them at the station. All of the children were segregated in the custody of their grandmother while officers spoke with the mother. She was shocked at the stories and asked to call her husband. Police allowed her to do so, but cautioned her to only tell him where she was and not to say anything about the allegations.

Because the father had been born and raised in France, he spoke very poor English. Police arranged for an officer who was bilingual to interview him. An assistant state's attorney was present for the interview. When the man was asked if either of his stepdaughters ever had sexual contact with him, he replied that they had done so while in France several years ago, but not since that time. He was told of the allegations, all of which he denied.

The police notified a DCFS worker and advised her of charges (two counts of contributing to the sexual delinquency of a child) that had been filed. They also told her that the father could provide bond and be back in the home immediately. As a result, the caseworker decided to place the children in the custody of the grandmother.

Following placement, DCFS referred the family to CAUSES for treatment. Charges against the stepfather were later dismissed because DCFS failed to provide records for the court. CAUSES terminated treatment with the family on September 9, 1979, without notifying the local police, who had made the referral in the first place.

Documents and interviews reflect a series of other incidents involving this family. On January 7, 1979, one of the girls' aunts reported to the Elk Grove Village Police Department that the sexual assaults had continued. The police interviewed the girls again but this time decided that nothing had transpired. When we asked why no report had been made to DCFS, the police admitted that a mistake may have been made in the case; an officer added that he was uncertain whether reporting in the particular instance had been mandatory.

On January 2, 1980, the girls' brother attempted suicide. Police reports do not speculate concerning his reason for trying to hang himself; they do note that the boy was taking Tofranil for chronic bed-wetting, a drug that is also used to treat depressive states. One of the relatives suggested to the police that the stepfather had already sexually assaulted the girls and now he was going after his stepson. Because the boy slipped in and

out of consciousness while hospitalized, he never told the police why he had attempted suicide. DCFS was called in and a caseworker was again assigned to the family. The family was also referred to CAUSES for the second time.

On August 11, 1980, Marcia attempted suicide by swallowing three handfuls of phenobarbital. This attempt came to light only after Marcia told police of another sexual incident with her stepfather. This report proved to be the catalyst for action with this family.

On August 13, 1980, Marcia told Elk Grove Village police the following: on that same day, the stepfather had been asleep in his bedroom and Marcia had been in the living room. The stepfather came into the living room and escorted Marcia by the arm into his bedroom, laid her down on the bed, and removed his clothes. He undressed her and attempted to have intercourse with her. He failed to penetrate and Marcia managed to pull away and run to her own room, where she locked the door.

Marcia told the police that, as in the past, her mother had not been home during the alleged incident. She added that her mother would never believe her and that she had believed neither her nor her sister two years earlier. Marcia told the police she was uncertain whether Lois had been sexually assaulted since the incidents of 1978; the two never talked about it.

The police then called both the stepfather and mother to come to the station. The mother said that she had to work, but the stepfather appeared with the three other children then in the home. When asked about Marcia's alleged suicide attempt, he admitted that it had happened but that he had called his wife at work and she recommended that he just keep Marcia walking around, that it was not too serious.

When questioned about the allegation of sexual assault, the stepfather said that he did not remember. He admitted that he "forgot some things" and also stated that he could very well have molested his daughters while asleep. He added that he had been seeing a psychiatrist for his problems since the sexual assault allegations of 1978. His private therapy had grown to include the entire family following his stepson's suicide attempt earlier that year.

The Elk Grove Village Police Department investigation revealed that when the stepson was hospitalized following his suicide attempt, hospital officials asked the police not to report the incident to DCFS because the family was under the care of Dr. Nahman Greenberg. The police refused the request and did contact DCFS.

Following the alleged incident of August, 1980, DCFS again was contacted. At the first court hearing, CAUSES sent a worker to testify on behalf of the father. The hearing was continued, but later, the case was dismissed because of conflicting statements by Marcia to defense counsel. CAUSES terminated treatment with the family.

On October 19, 1980, Lois attempted suicide, blaming the home situation for her mental state. Interestingly, the Elk Grove Village police have no record of the incident; the State Central Register shows a report filed by the attending hospital; and the local DCFS office shows no report of the incident.

In fact, we discovered an obvious problem with reporting. The Elk Grove Village police have seven reported incidents in their records; the State Central Register shows three incidents; the DCFS official file shows three incidents; and Cook County DCFS Intake records reflect only one.

Following Lois' attempted suicide, the attending doctor took protective custody, and she was eventually placed at Maryville Academy. The stepfather, who by this time was prohibited from living in the home, moved in across the street from the family.

We discovered that, with the exception of the initial allegations made in 1978, CPS workers did not believe that the girls had been sexually assaulted. They felt instead that the girls had fabricated stories to draw attention to themselves and to lash out at their stepfather. When questioned why the abuse allegations had not even been entered into the case record, one DCFS worker claimed that since they had not been proven, they could not be entered into the file.

We spoke with a DCFS worker in charge of this case's contractual services. This person served as a liaison between DCFS and the contractual agencies providing therapy and treatment to any family members. When we reviewed case documentation, we discovered that there was nothing to indicate the extent of treatment for the family, the cost of this treatment to DCFS, what was being or had been achieved, or even what the nature of the problem had been to begin with.

We spoke with this worker's supervisor to determine why there were these problems with the case record. We pointed out the absence of billing sheets from CAUSES. He responded that not having billings in the case record was not unusual. In fact, he said, Dr. Greenberg and other CAUSES therapists accept referrals from DCFS and sometimes do not even bill the Department. He said that sometimes the Department does not have the funds to pay for services, and that other times CAUSES is paid by sources outside of DCFS. He explained that federal grants could pay for treatment of some cases. The supervisor saw no problem with referring cases in this way.

We also questioned this person concerning why the stepfather had been allowed to remain in the home with the children when there had been at least four allegations of sexual abuse within the past three years. He told us that keeping the stepfather in the home undoubtedly was part of the treatment plan developed by Dr. Greenberg. The supervisor said that "incest is not considered to be a bad thing." He added that there was a growing theory in this country that incest has been with us through the centuries and

that sexual relationships within the family may not be bad. We asked the supervisor if he personally subscribed to that theory and he would not answer, although he did say that he kept an open mind. We then asked how he expected anyone in the general public--or the state legislature--to accept this "new theory," and he said that it was about time people "came down off their high-horse morality and accept things as they are."

We asked the supervisor how one could determine the nature of treatment being rendered by CAUSES from the case file, since nothing there showed what was being done with the family. He responded that there was a mutual bond of trust between DCFS and Dr. Greenberg. He added the Department did not require Dr. Greenberg to submit detailed reports on everything he did.

Early in 1981, we asked the new CPS caseworker what had been done in terms of treatment by CAUSES. She told us that one of the CAUSES therapists, Debra Sachs, had participated in the investigations of alleged abuse that were determined to be unfounded. The caseworker could not tell us how effective CAUSES' treatment had been. She told us that a new contractor, Home Intervention Systems (HIS), would take CAUSES' place in treating the family.

When we spoke with the caseworker two months later, she told us that the condition of the family had deteriorated. The entire family had been condemned by the community, adding to the family problems that precipitated the abuse. The caseworker felt that the police had not acted in the best interests of the children. She was one of the workers who felt the 1978 allegations were valid but that the girls had not been assaulted since that time.

We also spoke with the girls' Cook County Juvenile Court probation officer. She told us that the girls met with their CAUSES therapist, Sachs, separately and that there never had been a family meeting or discussion concerning the case with Sachs. The last time that the probation officer had met with Sachs, she determined that Sachs had not seen either girl for more than a month.

Early in 1981, DCFS Director Coler requested that then-CPS head Jeanine Smith prepare a summary of this particular case for his review. The review makes it clear that from September, 1978, to January 4, 1980, DCFS had no contact with the family except through CAUSES; apparently no one at DCFS was aware that CAUSES had withdrawn from the case on September 30, 1979. CAUSES became involved with the family again on January 4 following another sexual abuse allegation. This time the stepfather and mother asked to be referred to Dr. Greenberg for treatment.

The summary states that DCFS workers appear to have taken appropriate action regarding the case; the delegation of the case to CAUSES for treatment was deemed correct. There is no reference to quality or value of CAUSES' reports to DCFS. According to both caseworker and supervisor assigned to the case, "Dr. Greenberg

can be trusted to do what is proper." Included with the summary are medical records that were furnished to the Commission after we were told that we had already received all documentation on the case. We learned of their existence and specifically requested copies of the material.

On June 19, 1981, a Commission investigator spoke with the caseworker assigned to the family following a Juvenile Court hearing. He said that the cost of treatment for Lois would be enormous and he did not know who would be able to pay for it. Also, it was his opinion that the stepfather could very well have been guilty of molestation while still asleep.

We learned through a conversation with Assistant State's Attorney Bruce Paynter that the criminal case against the stepfather had been weakened considerably by a tape recording given to him by the stepfather's defense attorney. The recording, which included statements by Marcia, presented a story at odds with the story she had told the police. Paynter said that he had at first contemplated asking for a dismissal of charges but then requested a continuance to consider whether the case were prosecutable. Later, Paynter did not oppose a motion for dismissal of criminal charges and they were dropped. The protective order against the stepfather remained in effect.

A Commission interview with the girls' grandmother revealed that there had been problems within the home for a long time. She added that nothing had improved in the three years that the family had been receiving treatment from CAUSES.

In June, 1981, we spoke with Marcia. At that time, she was living in the home. She mentioned that she had always gotten along well with her sister but recently, when Lois visited from Maryville Academy, her mother made them stay away from each other. She said that her mother was afraid that Lois might influence her in some negative way.

In June, 1981, Marcia reported that her mother had embarrassed her in front of the mother of one of her girlfriends. Her mother asked the neighbor why she allowed Marcia in her house, and said that sooner or later the neighbor was going to catch Marcia in bed with her husband just as the mother had. The mother said that she had found Marcia performing an act of oral sex on her husband.

When we asked how she got along with her DCFS caseworker, she said that everyone except for the police sided with her mother and stepfather. She added that she had thus far been able to "hold out" and remain in the home, but she was afraid that constant pressure from her mother and stepfather (when he visted) would force her to run away.

Marcia said that she had spoken to Dr. Greenberg only once. She felt that he sided with her mother and stepfather. She said her contact person at CAUSES was Debra Sachs. Sachs never talked about the alleged sexual assaults but would only ask general questions, such as, "How are you feeling?"

We also spoke with Lois while at Maryville Academy; at the same time we spoke with Maryville staff who were working with her. We asked one of the staff if Lois were being forced to visit her mother and denied visitation rights with both her aunt and stepmother, as we had heard from another source. We were told that the treatment plan is handled entirely by DCFS, and it was her understanding that DCFS' goal was to return the child to her parents. Furthermore, the program established for Lois had been developed with that principle in mind. Whether Lois was sent home or placed elsewhere was out of the hands of Maryville staff.

Maryville's Director, Father John Smyth, told us that his staff does make recommendations to DCFS and that in Lois' case he would strongly suggest that the Department not force Lois to return home. Father Smyth said that he had personally examined Lois and had read a psychiatric workup done on her following her suicide attempt. He determined that she had emotional problems with which she was only beginning to cope. At the same time, he had been pleased with the progress that she had made.

We had an opportunity to speak with Lois alone while at Maryville. She told us that she had attempted suicide because her mother had blamed her for what had happened with her stepfather. She added that after the suicide attempt, her mother showed up at the hospital and put on a "big act," impressing all of the hospital personnel with her supposed concern for her daughter.

Lois told us that she was being forced to visit her mother at home and that when she goes home her stepfather is there. Because she is ultimately supposed to be reunited with both mother and stepfather, she has to act as though she can get along with them.

Lois felt as though none of her caseworkers had done anything to help her or her sister or brother. She told us that her caseworker had told her that the privileges she enjoyed at Maryville depended on the progress that she made in getting along with her mother and stepfather. Lois, like Marcia, had only talked once with Dr. Greenberg, and her contact at CAUSES also was Debra Sachs. Lois said that Sachs only asked her general questions, such as, "How are you feeling?" Sachs never discussed the allegations of sexual abuse with Lois, either. According to Lois, Dr. Greenberg saw her mother and stepfather weekly. She did not know what they talked about.

On November 25, 1981, Marcia left her home and went to her grandmother's. She refused to return home and ultimately went to the Schaumburg Police Department to turn herself in on November 29. Schaumburg police took temporary custody after she told them she refused to return home and called an advocate from Illinois Status Offender Services (ISOS). The advocate arranged placement for Marcia in foster care. Somewhat later, Marcia was placed temporarily with her aunt. Only a day or two after the second brief placement, Marcia was placed a third time.

Marcia appeared in Cook County Juvenile Court on December 15, 1981, at which time Assistant State's Attorney Revelle Peritz changed the petition from MINS to a neglect petition so as not to reflect adversely on Marcia. The case was consolidated with petitions on all of the children in the family. At the hearing, the judge decided to continue Marcia's third foster care placement.

In March, 1982, the new DCFS caseworker and her supervisor came to Commission offices to discuss the case. The caseworker told us that she had not been assigned to the case very long, since approximately October, 1981. When we inquired about a service plan for Lois, we were told that staff at Maryville work out a service plan. Then a DCFS caseworker will review the plan and approve or reject it. Apparently the caseworker had approved Lois' plan. We were shown a copy of the original plan, which included a number of goals to be met by Lois. Included among them was reconciliation with the mother. When we pointed out that it was our understanding that Lois had no intention of reconciling with her mother, the caseworker told us that it was just another example of Lois' trying to manipulate those involved with her case.

We also asked about the court order barring the stepfather from the home when Lois was present. Neither the caseworker nor her supervisor had read the court order, nor could they locate it in the case material that they had brought to the interview. They said that all of these court orders are alike, and, in any case, the specific court order didn't matter because Maryville would produce a service plan congruent with the desires of the court. If they did not, at the next court hearing the plan's deficiencies would be obvious.

When we suggested that having Lois return home while a criminal action was pending against her stepfather, and in which Lois might be a witness, was improper, neither the caseworker nor her supervisor felt that this action could be construed as tampering with a witness. The caseworker insisted that, based on her meetings with her, Lois sincerely wanted to return home.

We asked the supervisor if the Maryville placement were considered temporary or permanent. He responded that Maryville is considered a permanent placement. We then wondered why Lois had been sent to a permanent placement, given the service goals for her. The supervisor explained that a placement is defined by the contractual agency, not by DCFS. Maryville called itself a permanent placement, he said, therefore it was a permanent placement. He added that the length of stay in this "permanent placement" would vary from six months to several years.

The supervisor also commented on this particular case. He said that it is not uncommon for girls their age to act as Lois and Marcia had. He added that the two girls had discovered how to use the "system" to achieve their own ends. He mentioned that the Department had to work with poor resources. Psychiatric services in particular have become too expensive, we were told; the

Department had contracted with Maryville partially because it could not afford other services that Lois might need. He added that the Department rarely interferes with the service plan developed by the contractual agency. He said that if too many restrictions were placed on contractors by the Department, soon DCFS would be unable to contract with anyone for any services. The supervisor told us that contractors are given a good deal of latitude in the development and implementation of service plans in order not to antagonize them.

We learned during the interview that there was to be no criminal trial against the stepfather because the case had dragged on too long. The civil hearing to determine custody of the children was the only court action pending.

This supervisor again repeated that the girls were typical of many girls he had encountered in his professional career. Regarding placement of the girls with neighbors or others in the community, he said, "As soon as one of the girls becomes seductive with one of the parents, they'll throw the kid out. And this happens over and over again."

The supervisor reiterated that the service goal for the children was family reunification, beginning with meetings among all children and the parents. Appropriate agency staff would be invited to administrative case review meetings as needed. He made it clear that eventually the father would be brought back into the home permanently.

This interview made it clear that DCFS expects contractual agencies to provide service plans, while contractual agencies claim that DCFS produces such plans for implementation. Surprisingly, neither the caseworker nor her supervisor had taken the time to review the case file. Neither was familiar with facts of the case occurring before their own personal involvement with it.

Neither DCFS staff nor Maryville staff knew what was contained in orders from the Juvenile Court. In spite of this ignorance, treatment plans had been written up and implemented. The initial reason for DCFS involvement in the case was either lost or ignored, partially because no one attempted to review the case file. DCFS staff also chose not to seek additional information available to them. The initial allegations of incest in the family had almost been forgotten. The focus for the case in 1978 should have been protection of the children and prosecution and/or rehabilitation efforts for the stepfather. In 1982, almost all Departmental efforts focus on addressing the two girls' non-delinquent but troublesome behavior and the mother's emotional problems. Yet, the DCFS plan remains as reunification of the entire family.

As the DCFS supervisor left our offices, he mentioned that he would not be surprised if the Department wound up with the two other children from this family. He told us that they probably would be referred one at a time, for one reason or another, and that Lois and Marcia would probably outgrow the system before anything becomes settled.

Commission investigators spoke with officials at Maryville Academy regarding Lois' treatment plan and how it was established. One of them admitted that he was to blame for the controversy concerning who was to be allowed to visit Lois. He said that he had proceeded on the assumption that Lois was to be prepared to return home because DCFS had said that the goal of treatment was family reunification. We told him of the court order specifically removing Lois from her home for her own protection. He responded that he had not been aware of any court order, but, had he known about such an order, he never would have made home visitations part of Lois' service plan.

In March of 1982, we spoke with Juvenile Court Judge James M. Walton, who handled Lois and Marcia's case. Judge Walton told us that even after he issued a finding of neglect in the case, there were a number of unanswered questions remaining in his mind. Judge Walton questioned why the case had taken so long to come to court. He told us that he had made his ruling only after listening to testimony from a young girl who lived next door to Lois and Marcia's family. She too had been sexually assaulted by the stepfather. Judge Walton said that calling a girl to testify concerning events that had occurred four years earlier presented a number of problems to him.

Finally, at a hearing in Cook County Juvenile Court on June 30, 1982, Judge Walton listened to recommendations from DCFS workers that Lois and Marcia be placed in the custody of their maternal aunt, with the stipulation that she lease a three-bedroom apartment. Representatives of Maryville Academy also recommended that the girls be so placed. DCFS recommended that the two younger children be allowed to remain in the home with their mother and stepfather, with the provision that the younger girl not be left alone in the home with the stepfather. This arrangement was to be for a probationary period that would end December 30, 1982, at which time DCFS would present Judge Walton with a progress report.

Judge Walton agreed to the recommendations. As this report is being written, the two older girls are in placement with their aunt. The younger children remain in the home.

D. Additional Pertinent Information

Commission investigators conducted a number of general and specific interviews, both in Illinois and in other states, to determine how the problem of incest is viewed by others and to identify specific treatment programs. This section of the report briefly highlights our findings; it is not meant to be exhaustive.

1. Family Sexual Abuse Program, Fairview Community Hospital, Edina, Minnesota

In February of 1981, an investigator met with Miriam Ingebritson of the Family Sexual Abuse Program. We were particularly interested in speaking with a representative of this program because, like CAUSES, the program was one of the special nationwide demonstration

research projects funded by the National Center on Child Abuse and Neglect (NCCAN). Ingebritson mentioned to us that she has met with the directors of all of these projects on occasion. She added that CAUSES is run significantly differently than her program.

The obvious and most significant difference between the two programs is that the Family Sexual Abuse Program treats families that have been referred to the criminal justice system. Ingebritson felt that the involvement of the system was a significant aid in treatment. She admitted that she has treated clients who have had no involvement with the courts or other parts of the system; she felt that those that were so involved fared better in treatment. One of the advantages to court involvement was that it prevented families from moving away when therapy becomes too intense or emotional for the father or other family members to stand.

Ingebritson said that it is natural to want to get away when a person is required to address behavior that is condemned by society. Even a normal family would have a hard time enduring some of the rigors of intense therapy, and any incestuous family would have less of an advantage than a "normal" family.

Another important reason to require court involvement is that society gives a man double messages if it allows him to commit the crime of incest, which in Minnesota is a felony, and then does nothing to bring him to the attention of legal authorities. It is important for the family to accept the responsibility for understanding that incestuous behavior is a serious breach of societal rule.

We discussed with Ingebritson the problems we had encountered in Illinois between those who feel that human services is a treatment-based ideology, while criminal justice is a punishment-based ideology. She told us that criminal justice is much more than simply punishment, and that the simplistic view that one must choose between punishment on one hand and treatment on the other is ludicrous.

Ingebritson emphasized the necessity for therapists to make it clear to clients that if incestuous behavior is reported during treatment, it will be reported to the appropriate law enforcement authorities. Not doing so, she pointed out, feeds into the pathology of the incestuous family even more, because it allows them to think they are maintaining "their little secret" even as they are being treated because of it.

Ingebritson told us that in 3½ years of operation, her program has been successful in 85% of its cases, and she considered that a conservative estimate. The 85% would refer to those families that completed therapy more than a year previously and had remained incest-free. She hoped that her program could expand from its present 12 months of therapy to 24. The first four months of treatment are intense, with 10-12 hours of therapy per week to begin.

Ingebritson felt that the father should remain out of the home during the first four months. It was her experience that incest does not cease upon discovery, in spite of research to the contrary. Furthermore, she felt a fundamental responsibility to protect the child victim. Third, if anyone should be inconvenienced as a result of incestuous behavior, it should be the offender, certainly not the child. Fourth, she has seen a dramatic change in mothers' behavior when the father is forced to leave the home, allowing the mothers to develop skills and the knowledge that they can indeed survive without their husbands. Finally, a family that really wants to succeed is self-motivated, including the father. She told us that if a father really wanted to stop assaulting his children and salvage his marriage, he should be willing to remain out of the home for as long as it might take to achieve those goals.

Regarding funding, she felt that it was possible to run a cost-effective program without government financing. She felt that the "welfare mentality" of funding all incest treatment programs because they could not otherwise survive was crazy. She thought that programs could charge for their services and that such a move would further remind clients that they live in the real world, a notion all too often lost on incestuous families. Ingebritson described her own program as cost-effective. Her program schedules several families to meet together with a team of four or five therapists as a group. All of the therapists are familiar with the individual problems of the clients. This way, the program does not lose money by having each family come in singly to meet with a single therapist.

Her therapists maintain extensive charts and records on all families referred to the program, not only for internal use, but also in therapy when a man might begin to deny that he ever assaulted his daughter. Then they can show him a chart with a list of arrests and court hearings. Ingebritson said that these records are exhaustively reviewed, both by the sponsoring hospital and also by NCCAN. Her program had also received approval from the Joint Commission on Accreditation of Hospitals.

In summary, Ingebritson emphasized that the one thing that can damage therapy is allowing the therapist to do too much. All involved parties need to know where the therapist's responsibilities begin and end.

2. Child Sexual Abuse Treatment Program, Santa Clara County, California

Commission investigators traveled to California to interview a number of people involved in child protection in that state. One of the interviewees was Henry Giarretto, Ph.D., Director of Treatment and Training for the Child Sexual Abuse Treatment Program (CSATP), considered by many to be an innovator in incest treatment. Giarretto is also the founder of the program.

Giarretto explained that CSATP has three components: professionals (police, probation officers, court personnel, prosecutors); the self-help component (Parents Anonymous, Parents United, and Daughters and Sons United); and volunteers (who, according to Giarretto, can amplify the effects of therapeutic treatment many times over). The support systems came about when he realized early on that therapists could not handle the burden of incestuous family problems alone.

We learned that in 1977 the CSATP became a state demonstration center and that subsequently 30 additional centers modeled after this program were established in California. This in turn led to the program becoming a National Training Center, the first of its kind and the only such program being copied across the country.

Giarretto explained that basically his program takes a troubled family and resocializes its members through the efforts of many people. While no one therapist can do this alone, the therapist is essential to coordinate services honestly and impartially.

Giarretto's program works through the Santa Clara County Probation Department and therefore is criminal justice-oriented. Giarretto feels that the criminal justice system needs to be involved in an incest treatment program because the reality the family is faced with involves the courts. Giarretto was quick to add that no workable system can take an overly punitive stand against incest; reports will not come in and families will not come forward for treatment if that is the case.

To Giarretto, the biggest obstacle to doing a good job in therapy is "getting over professional jealousy," the idea that one person is the only one who can perform a task or get something done. Cooperation is what allows a family to be treated successfully.

Giarretto went through the entire referral process for us so that we could compare how incest cases are handled in Illinois. In San Jose, where his program is located, when a case is reported to the Juvenile Probation Department, the San Jose Police Department Sexual Assault Investigation Unit is notified and a joint investigation is performed. The case is then referred back to a coordinator within the Juvenile Probation Department. The coordinator will then assign the case to a counselor, who is responsible for developing a therapeutic case plan and report back to the police and any other appropriate professionals, such as CPS workers.

Giarretto told us that 90% of the children referred are reunited with their families, with a recidivism rate of less than 1%. Giarretto said that the key to the success of his approach is to begin therapy with the family immediately and not to wait until the disposition of the court case. His counselors also make a point of providing the Santa Clara County Adult Probation Department with information so that judges hearing criminal complaints can know how and what the offender is doing in treatment.

Giarretto added that his program is not diversionary in nature. His therapists provide the courts with information but do not attempt to influence them one way or another. He told us that the problem with diversion programs is that if they fail to work, the time lag between arrest and determination that treatment has failed will destroy any criminal case that might have been prosecutable.

Giarretto also had met with directors of other demonstration centers across the country. Although his approach was quite different from CAUSES', he felt that sooner or later Greenberg would have to "make his peace with the system." Giarretto told us that ten years ago he also wanted to treat families outside of the criminal justice system. He quickly learned that the approach was counterproductive to anyone who really wants to help both victims and offenders.

Finally, Giarretto felt it important for programs such as his to keep their books open for inspection by government. The controlling body and the funding source have to see what is going on, he said, and they have to decide if the program is worthwhile. He added that confidentiality is a "false issue" when it comes to opening up a program's records. It is just a barrier to an honest evaluation. He felt that the only legitimate issue in this realm is maintaining anonymity of clients, which he saw as quite different from the confidentiality question.

Giarretto's program has become the model for the majority of incest treatment programs in this country. Although some professionals continue to suggest that involvement with the criminal justice system can be damaging to a therapeutic relationship, in practicality, very few systems exist in which the criminal justice system is excluded, as it is with CAUSES.

3. Sexual Investigation and Educational Unit, East St. Louis Police Department, East St. Louis, Illinois

In 1980 we interviewed Sergeant John E. Smith and Detective Deborah Guyton of this unit. Not every police jurisdiction has a unit such as this one, so it was interesting to learn how it works. Smith and Guyton agreed that because most child sexual assault occurs in the home, there is a problem with prosecution. Often offenders never are identified; other times the offenders convince the victims not to testify. Smith and Guyton estimated that fewer than one third of all sex offenses committed against children are reported. They added that a DCFS supervisor once told them that the police do not see 99% of the sexual abuse cases seen by DCFS. The officers suggested that incest case reports are not made because these cases frequently fail in court, thus becoming a self-fulfilling prophecy for people adverse to reporting because they consider it futile.

The two officers agreed that DCFS contacts them regarding incest cases only "when the breaking point is near." This places the police at a disadvantage because the families they encounter

are always extremely disturbed. As a result, often the police become the "fall guys" in these cases and are blamed for escalating problems already present within the families.

Neither Smith nor Guyton had ever seen an incest case that they had worked on go to court. They felt that the St. Clair County State's Attorney had a problem prosecuting such cases and estimated they had heard of only three incest cases that had gone to court in the entire county.

Finally, Smith and Guyton handle all cases of sex crime in East St. Louis and also provide educational programs to the community. They mentioned that a good deal of their educational efforts were handled on their own time. Just recently, counselors had been added to their team to work with the victims of sexual assault.

4. Child Sexual Abuse Treatment and Training Center of Illinois, Inc., Bolingbrook, Illinois

Commission investigators spoke on several occasions with Thomas Ryan and Shirley Robinson of the program named above (CSATTC), a group formed in 1976 by Ryan and Sandra Gaylord. The program's precepts are taken from Giarretto's program in California, and it maintains a charter from Giarretto's program. Ryan told us that his program is geared only toward treatment of incest victims and members of their families. When it incorporated in 1979, it received a contract from DCFS to serve 10 families at one time. Soon thereafter, 23 families had been referred by DCFS. At the time of our first interview, in September, 1980, CSATTC was serving 39 families. Ryan told us that he had to put a hold on all DCFS referrals because the Department could not keep up payment.

Ryan told us that his agency had a contract with the Aurora Region of DCFS. For some reason, he had been unable to get a contract to serve any clients from Cook County, in spite of efforts to do so. Ryan had received a few referrals of families living only a few blocks from his office, but across the county line. Because of no contract with Cook County DCFS, the only way these families could receive services from the CSATTC would be for the family to move across the county line or pay for therapy completely out of their own pockets.

Ryan told us that the CSATTC works well with criminal courts but prefers noninvolvement if possible. Ryan explained that he preferred to work in conjunction with the Juvenile Court because of a similarity in goals between the court and his agency. Ryan's program is structured to focus on preventing future situations within the home that could lead to incest recurring. The program works separately with the offender, the victim, and the wife. Eventually the three are brought together for group sessions. The final step is to bring any additional family members in for counseling.

Of the 39 referrals at the time of the first interview, 17 were involved with criminal court and eight with Juvenile Court, eight had no court involvement, and six were self-referred, paying clients.

Robinson mentioned that sometimes it is difficult to cultivate a good relationship with the State's Attorney of a given county because he is vulnerable to political attack and pressure. Robinson added that a State's Attorney in any county in Illinois except Cook County is under tremendous pressure if he charges a person with incest but the person does not end up in jail. Robinson's comments refer to the five counties in which the CSATTC works: Will, Kane, Kendall, DuPage, and Grundy.

We last spoke with Ryan in July, 1981. Ryan had had a series of meetings with other therapists in the area in order to put together a more comprehensive treatment program, ultimately called HELP, Inc. After three months of being involved with the larger project, Ryan decided to terminate his association with it. He felt that the project had taken too much of his time from the CSATTC.

5. Human Effective Living Programs (HELP), Inc., Chicago, Illinois

We interviewed a number of people regarding the treatment philosophy and effectiveness of this new incest treatment program. Gabrielle (Gaby) Cohen, director of the agency, gave us a copy of a report dated January 12, 1982, that assesses the early history of the agency. The agency was developed to implement a model for joint investigations of child sexual abuse by the Chicago Police Department, DCFS, and HELP, Inc.; to develop, coordinate, and effect procedures for the involvement of criminal and juvenile courts with the treating agency; to develop treatment procedures that are "victim-sensitive"; to develop a treatment model that would include the entire family; to develop methods of collecting, preserving, and sharing information, evidence, and progress reports among all interested parties; to identify changes in policy needed to bring about the above; and to develop a training curriculum to teach the necessary skills needed for effective investigations and follow-up in court.

Cohen told us that the project was geographically restricted to Chicago Police Department Area 6. The program would not get involved with an offender with a history of violence or heavy drug abuse. She said that these offenders rarely benefit from such a program.

While the program technically began in April, 1981, it did not gain momentum until August of that year. In the period covered by the evaluative report, the project was involved with about 30 cases. Of the cases, four offenders had been through the entire criminal justice process and had received sentences of probation contingent upon their agreeing to attend counseling sessions with counselors from HELP. Cohen estimated that most offenders would be in treatment for 18 months.

Cohen explained how her project receives referrals. When the DCFS hotline receives an incest allegation it is referred first to DCFS' Division of Child Protection (DCP), which refers it to Child Protective Services (CPS), which refers it to the North Area Office, which finally refers it to HELP. Cohen hoped that by January, 1982, DCP and CPS could be eliminated from the routing process.

Cohen told us that the program begins working on a case by bringing together at the police station all of the involved parties: victim, alleged offender, other family members, witnesses, representatives of the necessary agencies, and therapists from HELP. At this time, the therapists try to determine from the victims just what had occurred. Cohen mentioned that her therapists were particularly skilled at getting incest victims to open up about their experiences.

While her workers attempt to develop a rapport with the victim, police officers interview the alleged offender. At times, HELP staff is called in to offer the police a diagnostic assessment of the offender or to explain the treatment process in which he may be involved. HELP staff also offers the police guidance concerning the psychological makeup of the people with whom they are dealing.

Cohen emphasized that HELP provides treatment to the entire family, including the offender. She said that her staff emphasizes to the family that such treatment will not stop following the initial encounter at the police station. Both victim and offender are told that they will be offered a long-term, viable, concrete treatment plan.

Cohen told us that she does not feel her agency uses the court as a punitive force against the offender, but rather that the court functions as a means of controlling and forcing the offender to accept responsibility for his actions. Often the entire family needs restructuring, she added, which can require the fulcrum of the courts.

Cohen told us that she had been successful in getting State's Attorney Richard Daley to offer "vertical prosecution" in incest cases, a system through which the same assistant state's attorney remains with a case throughout the life of the prosecution. Obviously, such a practice improves any case, but it is particularly important in a case in which a prosecutor needs to establish a relationship with a child victim, and other members of the family.

Cohen described her program as "victim-oriented," and felt that if the family setting were not injurious to a child's well-being, the child should not be "punished" by being forced out of the home. She felt that the offender had to remain out of the home for a time to prevent explosive feelings from erupting, and to allow other family members to establish or reestablish important familial ties. The mother is forced to learn coping behavior, and the family as a whole must decide how to handle possible future incestuous acts.

At the same time, Cohen said, the offender is being protected, in a sense. He is prevented from repeating his behavior, if it is compulsive, by being forced out of the home. The father also is protected against false charges from family members and others. The father still should support his family, Cohen said, and HELP will provide counseling to help all family members understand the necessity of his staying out of the home for a time.

A Chicago Police Department officer who had worked with the program told us that it has been helpful to have HELP counselors and therapists at the station to begin immediate work with a family. It makes it easier for the police to elicit cooperation from all family members. Furthermore, he said that what happens with a family after a police investigation is completed lies outside of the police department's purview. A family could easily disintegrate if offered no therapy, and there is nothing the police can do about it. Having a group such as HELP involved at the start makes it less likely that such disintegration will occur.

This officer praised HELP's immediate response, the agency's ability to cooperate with the police and understand the limitations of its role, and the agency's ability to provide for open communication and closer contact among the important professionals involved in a case. He said that HELP staff and the police had developed a spirit of mutual trust that was quite valuable and that is often missing between the police and DCFS. He added that HELP staff are trusted not to hide facts, and that HELP staff trust the police to act in the best interests of the child.

We also spoke with several Cook County Juvenile Court personnel. Most were quite positive in their comments concerning HELP. One of them recommended that the project be implemented city-wide; another felt that the concept was good but that it was doubtful that the project could be replicated in all areas of the city. Another person interviewed felt that it was too soon to discuss the success/failure ratio of the project, since most of HELP's cases had yet to go to court at the time of our interviews.

We were told that HELP counselors had done an excellent job preparing child victims to testify. They were also praised for helping the police to understand the emotional trauma experienced by these victims.

Several interviewees compared HELP staff to DCFS caseworkers, noting the disparity of both approach and results. HELP counselors were active in participating in case discussions but would not "step on toes of the other professionals involved with a case."

HELP's program was complimented for its philosophy and ability to work with all family members, and for its ability to provide immediate help.

An assistant state's attorney praised the program for its ability to get child victims to testify in court. She described the program as being even more involved with the criminal justice

system than Giarretto's program in California. She agreed with others that the agency has not been "obstructionist" and that its staff know not to overstep the boundaries of their own expertise.

We were also given criticims of this agency's approach. Some court personnel did not feel that HELP staff was fully qualified to do the sensitive work for which they had been hired. One person told us that he wondered if HELP staff would report continuing incestuous behavior discovered during therapy to the court. He said that this would remain a cloudy area until some of the cases reach the probation stage, at which time such behavior may surface.

In general, HELP has been received positively by most of those involved with it. Everyone seems to agree that the concept behind the agency is a good one, but there remain questions concerning its ultimate effectiveness. The program has not operated long enough to be evaluated meaningfully. Thus far, however, the program has been successful in providing services to a geographically limited portion of the city.

E. Conclusion

The following quotations are excerpts from Rachell Anderson's brief 1978 article "Sexual Abuse Begins at Home." They are instructive because they were published at about the time our investigation began, because their perspective is somewhat more Illinois-based than other research, and because the comments are still general enough to be valuable:

> Incest is more serious, from a therapist's point of view, than is sexual abuse. (It is more difficult because by the time it is discovered, the process and the effects have taken their toll with its victims.) Incest is a conditioning process which affects the daughter and the mother. The mother is conditioned to accept the incest, and in many cases, pretends that it is not happening. The daughter's conditioning begins with: 1) frequent body contact, 2) fondling, 3) genital contact, 4) and eventually intercourse. In many cases, a number of years have passed since the process began.
>
> No one knows just how many cases of incest and sexual abuse there are. In a study done in 1967, the American Humane Society reported that one out of every four girls [is] sexually abused before she reaches the age of 18.
>
> The National Center of Child Abuse and Neglect estimates that there are approximately 100,000 cases of incest each year. Many workers in the field believe this to be a conservative figure. There still remain many unrecognized, unreported and underrated cases. In 75-80 percent of the reported cases of sexual abuse, the perpetrator is known to the child. Of these, 38 percent are the child's natural father. The average age of the victim is 11; however, reported cases have shown children

as young as 8 months old being victimized. Venereal disease has also been found in girls as young as 2 years old.

The child who is a victim of incest and sexual abuse becomes confused in the mixture of roles which she is playing (i.e., father's lover, father's daughter, mother's substitute, mother's enemy or rival). There is also a lot of confusion about how she is treated by her siblings. There is envy as well as hostility moving back and forth between them. Feelings of being powerless to do anything about the situation for fear of what it will do to the family and to herself are complications with which she has to deal.

In many cases, the female victim of incest or sexual abuse begins to see herself as some kind of "monster" and feels "everyone is looking at me."

We see these observations repeated in the research and in case studies presented in this chapter. We also note that sexual abuse often is a phenomenon that repeats itself over time: the victim of one abusive incident probably is more prone to be sexually victimized a second time.

Ann Wolbert Burgess and Lynda Lytle Holmstrom, in "Sexual Trauma of Children and Adolescents: Pressure, Sex, and Secrecy" (1975), quote a 23-year-old former victim of sexual abuse: "I think the reason why a lot of kids don't do anything, don't tell anyone, is because an adult is an authority figure and somehow they have been forced to do something wrong by an authority, and therefore it must have been right." This attitude extends beyond submission to men who are not members of the family to fathers, uncles, and other family members. Because of their unique status in the family, children are convinced that they must go along with their relatives' desires.

Burgess and Holmstrom's study showed that almost half of the victims they studied had been victimized by family members. They add: "Four of the offenders were involved with 10 of the victims, which emphasizes the frequency with which one family member is able to gain access to more than one female or male child in the family. One reason that these people have repeated access to the child is because they are family members and their presence is not questioned by the family."

Finally, the authors refer to the problems that develop as these sexual assaults are kept secret. Victims develop fears and tensions that escalate as time passes. Some victims fear being blackmailed many years later. Some women fear that their husbands will discover that they had been sexually molested as children. Others experience a "flashback" to their youth, usually when they are engaging in sex as adults. Such flashbacks may not occur each time that a woman engages in sex, but when they do occur, they bring with them all of the pain and other emotions the woman experienced as a child. The authors point out that a series of such flashbacks can cause serious neuroses.

CHARACTERISTICS OF 14 CASES OF INCEST*

CASE	CHILD'S AGE	CHILD'S SEX	FAMILY/MARITAL SITUATION	CIRCUMSTANCES OF INCEST	MENTAL HEALTH OF MOTHER	MENTAL HEALTH OF FATHER/STEPFATHER	SEQUELAE TO INCEST
1	4	F	Lived with mother and father; frequent violence; mother's second marriage.	Mother oversedated on chlorpromazine (Thorazine).	In treatment for depression; borderline personality.	Paranoid schizophrenic; alcoholic.	Divorce; mother and child moved.
2	8	F	Lived with mother and stepfather; frequent violence mother's third marriage; stepfather's second marriage.	Mother at work; stepfather disabled and at home caring for children.	Anxious	Past treatmentfor depression; explosive personality; episodic drinker.	Stepfather attempted suicide; hospitalized. Divorce pending. Mother developed spastic colon.
3	11	F	Lived with father and stepmother.	Stepmother in hospital having baby.	- (Abandoned family)	Father in treatment; possible alcohol abuse.	Father and stepmother separated.
4	13	F	Lived with mother and father; parents' first marriage; violent.	Mother away on trip.	Chronically depressed.	Alcoholic.	Mother seeking divorce; mother and child moved.
5	14	F	Lived with mother and stepfather; mother's third marriage; past violence.	Child visiting father out of state.	Chronically depressed; past inpatient psychiatric treatment.	Alcoholic.	Child raped.
6	14	F	Lived with mother and adoptive stepfather; mother's second marriage; mother afraid of husband.	Mother away; father "high" on drugs.	Depressed	Personality disorder.	Father hospitalized. Child ran away twice; changed schools. Mother and child moved. Divorce.
7	14	F	Parents separated; past violence.	Patient living with father because mother could not control her.	Chronically depressed.	Alcoholic.	Father imprisoned. Child put in foster care and new school. Divorce.

From "Incest: Children at Risk," Diane H. Browning and Bonny Boatman, in American Journal of Psychiatry, 134, No. 1 (1977), p. 70.

CASE	CHILD'S AGE	CHILD'S SEX	FAMILY/MARITAL SITUATION	CIRCUMSTANCES OF INCEST	MENTAL HEALTH OF MOTHER	MENTAL HEALTH OF FATHER/STEPFATHER	SEQUELAE TO INCEST
8	15	F	Lived with mother and stepfather; frequent violence.	Mother passed out.	Alcoholic.	Alcoholic.	Stepfather suicidal; hospitalized. Mother murdered. Child moved to relative's home.
9	15	F	Lived with mother and father; marital problems.	Mother away on trip.	Chronically depressed; past treatment.	Past inpatient treatment for depression; probably manic-depressive.	Father attempted suicide; hospitalized. Child moved; put in new school. Divorce.
10	9	F	Lived with mother; mother divorced twice.	Maternal uncle babysitting in home.	Past history of psychosis.	Drug Abuse.	Mother and child moved.
11	9	F	Lived with mother; mother divorced twice.	Visiting aunt and uncle.	Depressed.	Alcoholic.	Mother and child moved. Child returned from foster home to mother.
12	12	F	Lived with mother; mother divorced twice and pregnant.	Maternal uncle drunk in home.	Anxious.	Probably sociopathic; violent; past psychiatric treatment.	Child molested by another "alcoholic" uncle.
13	13	F	Lived with both parents; parents' first marriage; poor marriage.	Visiting aunt and uncle.	Depressed; past inpatient treatment for depression.	-	Child developed ulcer.
14	15	M	Lived with both parents; first marriage; poor marriage.	Visiting aunt and uncle.	Depressed; past inpatient treatment for depression.	-	Child placed outside home; later returned home.

*Cases 1-9 involved father-daughter incest, cases 10-12 with uncles, and cases 13 and 14 multiple incest.

In the fourth chapter of the volume Child Abuse by Ruth S. and C. Henry Kempe entitled "Incest and Other Forms of Sexual Abuse," the authors claim that no one economic stratum or race experiences more incest than any other.

They also emphasize that when a child says that he or she has been molested, the child should be believed unless there is evidence that the child is lying for a reason. The Kempes state: "Orogenital molestation may leave no evidence, except the child's story, which should be believed--children do not fabricate stories of detailed sexual activities unless they have witnessed them, and they have, indeed, been eyewitnesses to their own abuse."

The credibility of incest victims is also stressed by the late Dr. Joseph J. Peters in a 1976 work entitled "Children Who Are Victims of Sexual Assault and the Psychology of Offenders." He said that children simply do not fantasize sexual assault, and a professional believing that they do could leave a child unprotected and subject to repetition of the original assault. Unfortunately, the Commission came across just this belief even within DCFS.

Another important idea brought out in the Kempe research and echoed by William R. Shelton's "A Study of Incest" (1975), is that despite the claims of shock and anger exhibited by the mothers of incest victims, most know that their husbands are engaging in sexual activity with their daughters. These mothers, especially in long-term abuse cases, allow the incestuous behavior to continue and should not be considered completely free of blame despite the fact that they are likely to escape the punishment imposed on their husbands. The Commission found this to be true in many of the cases examined during the course of this investigation.

Our research and case studies have indicated that the reactions of incest victims to the crimes committed against them can be varied and severe. In the 1977 article "Father-Daughter Incest" by Judith Herman and Lisa Hirschman, the authors cite extremely poor self-images, feelings of being evil, and, in later life, poor relationships with men as some commonly shared problems of incest victims they studied.

Dr. Peters, in "Children Who Are Victims," stated that a child can suffer extreme emotional damage even if an assault is a one-time occurrence only, as long as the child has to continue to live in the home with the offender. Peters discovered that many victims are extremely angry at the offender but may not project their anger onto him; it may be directed elsewhere, including at the mother which, he adds, is often justified.

An article by Meir Gross titled "Incestuous Rape: A Cause for Hysterical Seizures in Four Adolescent Girls" (1979), focuses on cases of incest in which the victims were physically assaulted by fathers who were in some way under the influence of alcohol; however, the other effects of the incest are the same as those

suffered by victims of less aggressive relationships. The girls studied lived in almost constant fear of being raped again and exhibited very high levels of fear and anxiety. But they also felt a great deal of guilt, just as other incest victims do; they all attempted either to run away or commit suicide. Gross proposes that the girls' hysterical seizures were defense mechanisms. He concludes that any doctor encountering an adolescent girl who experiences hysterical seizures or similar behavior should check into her family dynamics for the possibility of incest.

Gross' conclusion points to a problem we noticed during our investigation: the tendency of the "system" to focus on the reactions of incest victims to their abuse instead of the abusive situation itself.

"The Character-Disordered Family: A Community Treatment Model for Family Sexual Abuse" by Lorna M. Anderson and Gretchen Shafer (1979) presents findings of the Ramsey County Child Abuse Team of the Ramsey County Mental Health Department. Of particular note is a commentary in the article that comes from a passage dealing with court involvement:

> In our experience...voluntary cooperation is usually short lived at best. Without authoritative intervention the family dynamics, including the sexual abuse, continue as soon as the family can close its door on the concerned professionals. Moreover, we have found that the authoritative approach facilitates treatment rather than creating an obstacle to the establishment of a treatment relationship, as is often assumed. Such an approach is usually the only community response that effectively counters the denial and the projection these adults typically display. Often, they do not see anything wrong with themselves or their behavior, and they are rarely motivated to change on their own. The community sanction of a criminal charge, and court order or placement of their children, is often necessary to get these parents meaningfully involved in a treatment process.

Through the case studies presented in this chapter and our examination of the literature and treatment programs both in Illinois and throughout the country, the central dynamics of incest are clear. Authorities in this field are usually in agreement; however, the one area of disagreement has to do with how the offender should be treated, and this consideration can affect treatment and therapy. Generally, there are two camps: those who believe the offender should be brought into the criminal justice process to ensure his attention to the crime and participation in therapy, and those who feel that therapy cannot be achieved if the offender is made to face the possibility of conviction and imprisonment. Although this polarity exists, the vast majority of incest authorities, and the vast majority of incest treatment programs, feel that the offender must be involved in the criminal justice system. This involvement is thought to be more effective and more equitable, regardless of treatment modalities and practices.

The issue of criminal justice system involvement also leads to a discussion of the relationships between workers in the law enforcement and in the social service communities. As we have seen in our case studies, the relationship is often an uneasy one. However, it need not be, as was pointed out in the 1980 article "Police and Social Worker Cooperation: A Key in Sexual Assault Cases" by Jon R. Conte, Ph.D., Lucy Berliner, and Sgt. Donna Nolan. The article reports on a cooperative project between the King County Police Department of Seattle (represented in the article by Sgt. Dolan) and the Sexual Assault Center of Harborview Medical Center of Seattle (represented in the article by Berliner). The article presents generous statistics on individual cases studied in which the social workers from the Sexual Assault Center worked closely with police officers from the King County Police Department. Many of the statistics are case-specific and would be meaningless for our purposes here. The article mentions that many police officers feel uncomfortable handling cases of child sex crime; the project was designed to teach the officers how to handle victims of such crimes as well as to familiarize social workers with the procedures of the police in such cases. The focus of the project was cooperation, so that workers in both areas could understand and work with each other. The project seems to have been a success, as the following excerpt indicates:

> For the police, this close working relationship with social workers was based on the confidence that social workers now better understand the working of the criminal justice system and the realities and frustrations of the police role and responsibilities. Police voiced the opinion that they could rely on social workers to present accurately the problems and requirements of family involvement in the criminal justice system. In addition, they indicated that the availability of social workers to deal with the emotional reactions of sexually abused children and their families freed the police to pursue their investigative and reporting responsibilities.

One of the points behind such a project seems obvious: the roles of the police, representatives of the criminal justice system, and social work agencies should not be completely separate. Goals of the criminal justice system should be congruent with those of social workers. Employees from each area should understand that they are limited in their areas of expertise; frequently, for a case to be happily resolved, the investigative skills of the police, the legal skills of the State's Attorney's Office, and the diagnostic and therapeutic skills of social workers must be intertwined.

In order for the goals of the criminal justice system to be congruent with those of social workers, the criminal aspects of incest have to be studied. J.E. Hall Williams, in his 1974 article entitled "The Neglect of Incest: A Criminologist's View," concludes that criminologists have paid far less attention to incest than have social anthropologists. As a result, the information we have regarding the crime of incest is scarce because many authors view it as a social problem rather than approach it from a criminolo-

gist's point of view. Williams calls for additional research by criminologists.

Despite the many studies and views presented dealing with incest and sexual abuse treatment, there is little information available dealing with prevention. One source we did find, however, is called The Silent Children: A Book for Parents About the Prevention of Child Sexual Abuse, by Linda Tschirhart Sanford.

Most important in preventing such abuse, Sanford writes, is establishing the appropriate family atmosphere. Such an atmosphere will teach children to be "nonvictims" by teaching them self-confidence. Sanford recommends that parents offer their children very specific praise, but adds that criticism also should be offered to children. Sex-role stereotyping should be avoided because it makes girls more prone to be victims and boys afraid to run away from situations.

Sanford feels that parents should think of information about sexual abuse as just additional "survival information," similar to, "Dress warmly because it's cold outside," and that such survival information should be given matter-of-factly and repeatedly. She adds that information about sexual abuse need not be explicit as long as the message gets across.

Sanford adds that parents should be certain to teach their children the difference between a secret, which is never told, and a surprise, which is most fun when it is told. She feels that parents should teach their children to participate in surprises but never in secrets.

In a 1969 study directed by Vincent DeFrancis entitled Protecting the Child Victim of Sex Crimes Committed by Adults, protective intervention is viewed as crucial to attacking the crime of sexual assault against children:

> Communities must reverse the pattern of service emphasis. Greater emphasis must be placed on a preventive focus. Protective, preventive programs must be enlarged. Funds must be made available so that the size, scope, and effectiveness of protective and preventive programs may be sufficiently improved to meet actual need. Intervention must occur at the earliest possible stage to prevent development of the problems into full blown crisis situations.
>
> That children should be sexually abused is a tragic occurrence but it is immeasurably more tragic to find that many children could have been spared the traumatic experience if preventive services had been made available to their families when the first signs of family breakdown became visible.

In concluding this section we note that, like other forms of child maltreatment, incest is being reported more today than ever before. Also, incest is becoming a priority for treatment in most areas. Authorities are beginning to understand the far-

reaching consequences that an incestuous relationship may have. The trend in intervention, victim protection, and treatment is toward methods that involve the criminal justice system. Programs still exist that only treat victims and alleged offenders who remain free of involvement with police and the courts, but they are in the minority. A coordinated, cooperative effort by all concerned parties appears to achieve the best results in treating incest, which must be considered both a crime and societal problem.

Chapter 7

CONTRACTUAL AGENCIES

As we have discussed previously, the Department of Children and Family Services enters into contractual arrangements with local governmental units and private agencies and individuals to provide services to DCFS clients. The Department also provides agencies and individuals with grants through which they may provide services to the Department or to its wards. Contractual agencies and agencies working through grants provide the bulk of service to all DCFS clients. Grants and contracts may range from a short-term agreement with a psychiatrist to provide a few hours of diagnostic evaluation every month, to complete programs that have become totally dependent on DCFS for funding.

The agencies described in this section of the report are representative of agencies providing child protective and child welfare services in the state, although the agencies were not chosen at random. In all cases, we were led to these agencies by the development of our investigation.

Contracted services to clients include diagnostic assessments, foster care, help in securing adoptive care for children, group home placement, supervised living programs (including independent living), counseling, therapy, classes in parenting, and a variety of other services. Almost any need expressed by a DCFS client may be met through contractual aid.

A. Calumet City Youth & Family Services

The Commission looked into the operations of the Calumet City Youth & Family Services in 1979, about a year after this investigation began. The agency, a funded department of Calumet City, is also funded through grant programs of the Illinois Law Enforcement Commission and the federal Law Enforcement Assistance Administration (now defunct).

Investigators spoke with Daniel Kelly and Elaine Krueger concerning the agency's operations. They told us that the agency had developed programs in "pre-parenting and parent information services." They described these as programs which could prevent potential cases of emotional or physical abuse.

The agency had several ideas concerning actual therapeutic technique, including role-play and the establishment of a "Kids Anonymous" group, similar to Parents Anonymous but run entirely by children, with support from agency workers and school counselors.

Kelly and Krueger said that their agency also was responsible for determining what services and programs were available in the community. They viewed awareness of local programs as a preventive measure. Awareness and publicity were particularly important, they felt, in the area of child abuse and neglect.

This agency provides basic counseling and related services and does not depend on DCFS for funding. It is a representative example of a community-funded program providing services to a spectrum of clients, including abused and negected children and their families.

B. Citizens Committee for Children and Parents Under Stress

The CCCPS, otherwise known as Parental Stress Services, is located in Chicago. In 1979, we spoke with Sally Bruckner, Executive Director. Bruckner told us that the agency was started in 1974 as the Citizens Committee for Battered Children and originally focused its efforts on legislation and child advocacy. She said that the agency had become more direct-service oriented over the years because contract money it receives from DCFS requires direct services to clients. Bruckner said the agency provided four major services:

1) Referrals to community agencies for counseling and related services.

2) A 24-hour hotline handling calls of abuse and neglect, staffed by volunteers.

3) Out-reach visits by volunteer workers to help diffuse family problems and crises. These visits may either be emergency or long-term.

4) Sponsorship of the 35 Parents Anonymous groups in Cook County.

Most of the CCCPS staff consists of coordinators for these four functions, although there also is a clinical director. CCCPS, at the time of our interview, received $200,000 a year, primarily from the Kellogg Company and the Joyce Foundation. DCFS provided $32,400 in grant funding and $7,350 in contractual funding. A combination of funding from the United Way, corporate solicitation, and individual gifts provided about $36,000 of the budget.

Bruckner told us that, in order to receive state funds, CCCPS had to approach DCFS and "sell" its services. CCCPS was willing to alter existing programs to fit the needs and requirements of the Department. At the time of the interview, DCFS needed assistance in liaison work with private agencies, in providing services to the Elk Grove Village Youth Agency, and in servicing some of the more problematic areas of Chicago. But overall, she said, her agency's relationship with DCFS was quite good. In spite of this excellent relationship with DCFS, however, she told us that she had to learn financial record-keeping mostly on her own and could have benefitted from assistance or guidelines from DCFS regarding what should be included on forms in order for CCCPS to be reimbursed.

CCCPS apparently sometimes treats cases of child abuse without reporting to DCFS. When we asked Bruckner about this, she responded that the agency feels its methods of diffusing problems

in the home are quite effective. Further, she said she felt that many of the people being serviced would never come to the attention of DCFS; with CCCPS involvement, at least they would receive some help.

Regarding the issue of specific problems at DCFS, Bruckner said that caseworkers were given too heavy caseloads, that workers often had to share a single telephone at the main office at 1026 South Damen in Chicago, and that the offices are dirty and depressing. She felt that conditions could be improved, at the very least.

Although Bruckner was enthusiastic about CCCPS' relationship with DCFS, many of her comments were criticisms of how the system was being run in 1979. Regarding the condition of the office at 1026 South Damen, we also found it to be in bad shape. Its files were not secure and were poorly organized, as we have mentioned elsewhere.

C. Lutheran Social Services

In June of 1981, a Commission investigator interviewed the Reverend Gary D. Stubenvoll, Vice-President and Director of Social Services for Lutheran Social Services. The agency is owned by the Lutheran Church and serves more than 150,000 people per year through 70 programs. Its budget for FY 81 was over $22 million. Founded in 1867 to care for orphans, it has expended its services to the area of foster care and related needs. The agency does not work only with children; it has programs for a variety of individuals with specific problems. Funding is provided by a variety of sources besides the church, including the United Way, foundations, and private individuals.

Programs designed for children include housing and counseling for troubled adolescents at the Nachusa Home near Dixon; the Edison Park Home in Park Ridge; Fox Hill Group Home in Dixon; and the Lutheran Group Home in Sterling. Stubenvoll explained that while children are involved in residential counseling at these facilities, their parents also receive counseling at home so that their children can make a smooth transition from institutional living to the family home.

Lutheran Social Services also operates nine day care programs in conjunction with the City of Chicago's Department of Human Services and runs a care facility for developmentally disabled children in Chicago.

Stubenvoll told us that his agency receives referrals from private agencies, the Board of Education in Chicago, the United Way, the Department of Mental Health, and DCFS. The agency is divided into area offices to coordinate services being provided throughout the state. These area offices are further divided into units by function: Adoption; Foster Care; Family Counseling; and Family Life Education.

Prior to 1969, the agency had been involved in foster care. When DCFS Director Weaver took over, he insisted that the responsibility for foster care rests in the public sector--DCFS--and Lutheran Social Services pulled out of the field. According to Stubenvoll, DCFS failed to monitor its foster care programs sufficiently and some of the children became "lost in the system." Stubenvoll contrasted DCFS' inability to keep track of foster children and provide parents with reinforcement with the prior performance of his own agency.

At the time of our interview, Lutheran Social Services had contracts with DCFS only for sexual abuse counseling and related services in Sterling, Dixon, and through the Peoria Area Office. Stubenvoll said that his workers experienced a high "burnout" rate and had to be rotated periodically when working in these programs.

Finally, Stubenvoll recommended the implementation of multidisciplinary teams to treat cases of child abuse and neglect.

D. Home Intervention Systems

During our discussion of one of the incest cases, we refer to Home Intervention Systems (HIS) in Palatine. As noted, all treatment is provided in the home. The goal of the agency in providing such in-home services is to keep families intact. The agency did not begin operations until the latter part of 1980 and has a DCFS contract calling for treatment of 35-40 cases per year. Its staff consists of a single full-time therapist and four "observers," who go into clients' homes and record notes about family members' behavior.

One of the founders of the agency, psychologist Charles C. Anderson, said he felt that the program was unique in Illinois. He characterized his approach as behavioral family treatment and said that CPS in particular had become interested in his treatment plans. In treating an abused or neglected child, the agency focuses on all of the family members, Anderson said.

Anderson explained the procedure used by the agency when a referral is made by DCFS. HIS staff conduct an initial interview from two to four hours long to gather specific behavioral information on the family. One of the purposes of this initial interview is to screen out psychotic families, as well as families whose members may require long-term placement. If the family is accepted for treatment, HIS staff meet with the referring DCFS worker to confer. HIS observers will begin noting behavior in the home to provide a "baseline" for comparison when therapy begins. Later in the process, the observers will collect specific information determined by the treatment plan for each individual family. The observers arrive at the homes on pre-arranged schedules, when they know that family members will be present. They remain neutral during family interactions and will not intervene in any way while observing. These observation periods each last from one-half to two hours.

Anderson emphasized that the purpose of his program was to actually change behavior. Therapy sessions with family members, and separate sessions with the parents alone, are intended to introduce proper behavioral objectives to clients, based on what has been observed about their behavior in the home. He added that the in-home observers are frequently cross-checked by other observers to ensure reliability of the information being collected. Rating discrepancies are analyzed carefully and resolved.

Anderson mentioned that his observers might arrive at the home very early in the morning, when everyone was getting up. Or they might arrive very late at night. We asked him if these types of visits did not pose problems with families because of lack of privacy. In response, he said that we would be surprised at the acceptance the observers achieve after the initial sessions are completed. He maintained that observers are treated like pieces of furniture and are completely in the background.

We asked Anderson if he felt that some family members might not act differently when the observers were in the home--would they not put on their best behavior for those occasions? Anderson responded that such is not the case. He said that research will bear this out.

Anderson uses videotapes as training aids for clients who lack parenting skills. He said that some parents with no conception of how to interact suddenly get the idea when they view a videotape of a family interacting properly. He said that such aids were also very useful with clients who had trouble reading and writing.

Anderson said that treatment through HIS ceases when the targeted undesirable behaviors have decreased to the point that the family can live together in harmony. If treatment goals remain unmet, HIS staff makes recommendations to DCFS for alternative treatment. Anderson said that an "unsatisfactory discharge" is made when there is an indication that there might be violence to observers or the therapist; when parent or child psychosis is revealed; and when a parent is deemed to require a psychiatric hospitalization.

Anderson also told us that HIS provides aftercare for clients and other follow-up. After behavior levels are reached that are satisfactory to HIS, an HIS observer will visit the family at monthly intervals for six months. Then, every other month for the following year, an observer will visit the home to be certain that the level of behavioral change matches those prescribed by the original treatment plan.

Anderson subscribes to the theory that child abusers were themselves abused as children, and he says that his program breaks the cycle of child abuse both by showing parents behavioral change, and by instilling in their children a new set of learned skills.

Such has been the popularity of his agency's treatment plan, according to Anderson, that cases are taken selectively and only from the northern portion of Cook County. Anderson characterized his relationship with DCFS as very good. His only complaint had to do with billings and slow reimbursement.

E. Catholic Charities

Commission investigators, pursuing a specific case study, interviewed Jadonal E. Ford, the Assistant Director for the Division of Foster Care Services. He provided us with basic background information on Catholic Charities.

Catholic Charities has had contracts with DCFS since the Department's inception. Early services were exclusively for regular foster care placements. In 1971, Catholic Charities added child protective services and has since been on contract with DCFS to provide such services. At the time of our interview (May, 1980), regular foster care services handled about 700 children annually, while the agency's own child protective services unit served about 600 children annually. Services provided ranged from emergency placement, which averaged six weeks, to regular foster care, which lasted anywhere from a year to several years.

Ford told us that the Catholic Charities child protective service unit was divided into three sub-divisions. The first, Protective Services, investigates minor allegations of abuse or neglect that are referred from DCFS. These investigations are all initiated within 24 hours of receipt, according to Ford. The second sub-division is Emergency Protective Services, whose major function is to place children removed from the home in order to protect them from potential harm. The third unit is In-Home Protective Services, a program devised to provide services for abused or neglected children who are to remain in the home. All of these services were described as being significantly different from the types of services designed in "regular" foster care planning.

Ford said that in regular foster placement, social workers from DCFS will have developed a long-range plan for a child before referring him to Catholic Charities for service. Catholic Charities only has to place a child in a home that would fit the requirements of the DCFS plan. Regarding emergency placements, workers from Catholic Charities will evaluate each case and develop a long-range plan for the best interests of the child. As an example, Ford said that workers might suggest adoption, or counseling, or continued foster care, or return of a child to the home.

Ford offered the following "ideal" scenario: DCFS would receive an allegation of abuse or neglect and refer the case to Catholic Charities. Catholic Charities would investigate the case and develop a temporary plan which would be sent back to DCFS for review via a Catholic Charities liaison worker. DCFS would be able to approve the plan or suggest changes or modifications. In six months, the case would be reviewed for effectiveness.

However, in actuality, only workers from DCFS' North and West area offices have made personal visits to review placements, Ford said. In other areas, case review is done over the phone. Ford criticized the latter practice because it reflects on the concern that DCFS has for cases, and also because such case review does not conform with Departmental procedures.

Ford stated that the educational requirements for Catholic Charities' caseworkers are the same as DCFS', while DCFS pays its workers approximately $2,000 more. Ford said he believed that the many pressures at DCFS accounted for the high turnover rate which that agency experienced. He pointed out that the average caseload for a Catholic Charities caseworker was 30 and that the agency intended to reduce that to 25 by July, 1980, when the new reporting law went into effect. Additionally, each supervisor at Catholic Charities is responsible for only six caseworkers. Like many other spokesmen for agencies we talked to, Ford was critical of DCFS reimbursement performances and internal communications within the Department.

Catholic Charities seems to provide many of the same services meant to be provided directly by DCFS. It is a good example of the DCFS philosophy that its mission is to administer programs and find agencies that will provide direct services to children.

F. Joint Service Program for Adolescents (JSPA)

Sy Adler, Chairman of a group known as Group Action Planning (GAP), told us in a 1981 interview that two programs had sprung out of the GAP Project: JSPA and a program called MAPS (Metropolitan Area Protective Services). Adler told us that GAP was a consortium of 21 child welfare agencies and that the two specific programs had come out of planning and conversation that took place within GAP. Adler said that the MAPS project ended in 1978 and that JSPA was originally intended to be a three-year project, with extensions if it proved successful. Adler said he felt that JSPA was a very good program and that it was unfortunate that DCFS did not award it a contract to continue its work beyond 1981.

When we interviewed Douglas Zapotocny, Program Director for JSPA in 1980, he told us that the program was created in April, 1972, based on a joint decision made by DCFS, GAP, and the Welfare Council for Metropolitan Chicago. JSPA was created to deal with children who needed exceptional care.

Zapotocny described JSPA as a consortium of agencies that provide care through a group effort. To Zapotocny, a "successful" placement would be having a child with a history of institutionalization finally in a program "lenient in rules and regulations." Eventually, this person would graduate in to a regular foster home or independent living.

JSPA consisted of seven separate agencies, each of which may have had different components:

Children's Home and Aid Society of Illinois--Drexel Place

Maryville Academy

Methodist Youth Service

Lutheran Social Services of Illinois--Edison Park

Lakebluff-Applewood Homes for Children

Allendale

Mary Bartleme Homes

In addition, JSPA coordinated auxiliary services such as counseling, tutoring, and "child care supervision."

Zapotocny said that all JSPA referrals came from DCFS and that DCFS had a specific liaison person who identified "problem children" for referral to JSPA.

A Commission investigator commented to Zapotocny that he did not see what JSPA was doing that DCFS could not do. The investigator said that the JSPA administration appeared to be a sort of clearing house for placements of children to private agencies already under contract to DCFS. Zapotocny responded that the philosophy behind JSPA was to provide a "service unit" that would centralize services provided by these seven private agencies. Zapotocny also maintained that JSPA could serve children better because the central administration of the agency provided four social workers for assessment of referred children, and that at the time of our interview, these four workers had a total caseload of 55 children. Obviously, he said, they could provide more attention to children because of this low caseload level.

We also analyzed fiscal information for FY 81. JSPA's total budget was $2,471,528. More than $2 million was spent on residential care, with the remainder spent on auxiliary services and staff administration. The following shows the per diem rates for each of the specific programs funded by JSPA for FY 81:

Children's Home and Aid Society of Illinois--Drexel Place	$146.07
Lakebluff-Applewood Homes for Children	$ 97.80
Mary Bartelme Homes (Essex House)	$104.48
Homes for Children (Glenwood Group Home)	$ 50.89
Lutheran Social Services--Edison Park	$ 69.85
Methodist Youth Services	$ 32.75
Maryville Academy	$ 47.61
Mary Bartelme Homes (Residential)	$ 64.07
Mary Bartelme Homes (Independent Living)	$ 21.25
Allendale (Residential)	$ 79.50
Allendale (Group Home)	$ 45.39

JSPA closed in 1981.

G. Volunteers of America Foster Care Programs

In February, 1982, we interviewed Gwendolyn Marshall, Director of Foster Care Programs for the Volunteers of America (VOA). She told us that the VOA was chartered in Illinois in 1911 and has been affiliated with the National Volunteers of America. The VOA's activities have centered on providing professional services to troubled, disadvantaged children, with an emphasis on residential care and counseling. In Chicago, the VOA has a staff of 45-50 full-time professionals operating out of five city locations. In FY 81, the VOA had an operating budget of $1.5 million.

Marshall said that care is provided free of charge to clients and that the VOA relies on a combination of public and private funding. She said that most referrals are from state agencies. In FY 81, the foster care program comprised 47% of the VOA's Chicago-area budget and was funded in the amount of $707,724.

Marshall told us that she had worked for DCFS herself once and did not want to criticize the agency. But she said she felt that any agency the size of DCFS would naturally experience problems that would have to be corrected. She felt that the huge size of the agency and its bureaucratic organization had caused some of its problems. She said she also felt that DCFS was not getting through to the very people it had to help--the lower-income people who would not attend counseling sessions of their own volition but who needed some help in attending, or who needed such services to be provided in their own homes.

Marshall recommended that DCFS focus on getting the very young children in the DCFS system out of the system as soon as possible. These children should be either returned to a stabilized home or placed for adoption. She noted that once a child has become a teenager, no one wants to deal with him or her. Not only that, but the longer a child is in the system, said Marshall, the harder the child will be to deal with. She observed that children kept in the system for long periods of time become bitter and attempt to "get even" for what has happened to them. To the teenager, it is a situation of "us against the world," an attitude very difficult to combat.

H. Associates in Crisis Therapy

We met with Anne Brown, Director of Associates in Crisis Therapy (ACT), on several separate occasions. In September of 1980, we spoke with her about sexual abuse of children in Evanston, where her offices are located. Brown told us that ACT had two contracts with DCFS, one for intake diagnosis with the Child Welfare Division, and the other for "consultation therapy" with the North Area Office in Chicago. Brown commented that the vast majority of her DCFS clients are referred for reasons other than sexual abuse; however, at times sexual abuse surfaces as the real reason behind other more obvious problems. She commented that

sometimes the sexual abuse is not discovered because no one, including DCFS caseworkers, has asked the child what the problem really is.

In addition to the two DCFS contracts, ACT has a private practice serving mostly adult women who have been sexually abused as children.

During this conversation, Brown referred to several problems she had been having with DCFS. She told us she had been having some difficulties with a particular CPS worker, who was involved, along with Brown, in a case concerning a 13-year-old girl who had become pregnant by her own father. Brown learned that the girl was still in her father's home even though the CPS worker had promised to have her placed. When Brown asked the CPS worker what had happened to the court referral she had planned to make, the CPS worker said that the father had told her that he "wouldn't do it again," so the girl was left in the home.

In March of 1981, Commission staff spoke with Brown again at her office. At this time, she said she felt that DCFS would be a more effective agency if it could establish an actual working plan of operation. DCFS operates on what Brown characterized as a "crisis mentality" and is constantly in chaos. She said that DCFS is not mandated to provide primary prevention, but nevertheless should. DCFS at times has attempted to provide all types of care but usually care is rendered on an as-needed basis, she said.

Brown also said it is essential that caseworkers get to know the police, hospital personnel, officials from other state agencies in the area, staff from other private agencies, and citizen volunteers. When we asked if it were feasible to divide the state into areas small enough so that all of these professionals could get to know one another and work together, she said that it was possible and could easily be done in, for example, Chicago's North Area.

I. Youth Services Bureau

In September, 1980, we spoke with William H. Young, Director of Youth Services Bureau (YSB) in Marion, Illinois. Young, a former employee of DCFS, had been with YSB in Marion for five years at the time of our interview. He told us that the YSB was an outreach program designed to help children before they end up in court or in foster placement. He said that they do not offer 24-hour supervision or any permanent living arrangements, such as group homes. The Bureau's primary focus lies in five areas: big brother/big sister placement; peer counseling; counseling for status offenders; counseling and help for pregnant girls; and "stress challenge," consisting of outdoor activities designed to break down a child's psychological barriers. Young added that YSB used to do a good deal of court diversion work, but the program has been considerably cut down recently because the agency has not been able to secure funding for the program.

The agency's eight professionals provide services to an average of 130 children a day, Young estimated. YSB has two offices, in Marion and Benton, Illinois, and serves two counties. At the time of our interview, YSB spent about six months with each child referred; Young said that this would soon change so that each child would receive more intensive counseling during a shorter time period, probably 10 weeks.

Most of the children referred to YSB had problems in school, were runaways, had become pregnant, or were beyond the control of their parents. Young said that most referrals came from DCFS, schools, the police, mental health clinics (although his agency does not serve children with severe mental problems), other social service agencies, parents, and children themselves. Young said that the service plan is established with a child and his parents and will vary in each case. The primary method for resolution of difficulties, however, is counseling of one type or another.

Young commented that within the two years previous to our interview, DCFS had become more efficient and effective. During the six months immediately prior to our interview, though, he felt that the Department again appeared to be in a state of flux. He said that the Department could never stabilize because it was constantly in a state of reorganization. Young also commented that he felt DCFS had allowed too many children to "slide through the cracks" in the system. He said that now that DCFS was focusing on abused and neglected children, adolescent and MINS children were being ignored. He said he felt that foster and group care placements for these older children were inadequate.

Young told us that part of DCFS' problem was constant administrative change and too great a bureaucracy. He said he also felt that the Department was caught in the middle of an ideological battle among its staff over providing casework or supervising case management, with the result that neither of the functions was being developed properly. He felt that the idea of DCFS existing as solely a monitoring agency was fine, but that, either way, someone had to decide how to resolve the conflict. Young said provision of casework and case management at the same time were too time-consuming and inefficient.

Young also commented on DCFS' relationship with contractual agencies, the thrust of this chapter. He felt that DCFS "buried" its caseworkers in paperwork and red tape as a result of poor monitoring functions. Young said he felt that DCFS should place greater trust in its contractors. His contention was that DCFS monitoring was simply duplication of the work already done by the contracting agency. He said that he felt that DCFS paperwork done to verify paperwork done by the contractual agency was a waste of time.

Young compared DCFS' system with similar accountability procedures of the Department of Mental Health. Young said that referrals from DMH were nowhere near as complicated as those from DCFS. Paperwork for DMH was not duplicative, he said.

Regarding general program operations of DCFS, Young said that he was a proponent of decentralizing the regions so that each could be more sensitive to the individual needs of its own area, rather than have to be sensitive to the needs of people in Springfield. He suggested that the central offices in Springfield establish general rules and guidelines and then allow local regions to operate without so many "restrictions and red tape."

At the time of our interview, Young was a member of a special committee established by the Governor to deal with placement of hard-to-place children. His committee work had shown him the numerous criticisms voiced by others regarding the operation of DCFS. While he had heard many criticisms, he said he had heard very few suggestions for change.

J. Rosecrance Memorial Homes for Children

The Commission was primarily interested in the major residential facility operated as part of the Rosecrance Memorial Homes for Children: the Rockford Campus. Rosecrance also runs a "rural campus" facility in Durand, Illinois.

Commission staff visited both facilities. We spoke in Rockford with Phillip Eaton, Director, and Ronald Allen, Program Director. The interview lasted several hours and was followed by a tour of the facility.

Eaton and Allen told us that the facility's therapy program involved "positive peer culture," requiring a staff with extensive training and specific types of education. Incoming staff are expected to hold master's degrees in social work or a related field. In addition, they have to undergo 40 hours of classroom training in the type of therapy provided at Rosecrance. The training is followed by two written examinations. Trainees are evaluated fairly rigorously.

Client referrals come primarily through two sources, DCFS and the courts. Rosecrance allows staff to accept 2% total population private placements, but we were told that such private placements are quite rare. The facility at Rockford was designed for women only and has a capacity of 40; the facility at Durand was designed entirely for males, and has a capacity of 60. Most of the clients are between the ages of 13 and 16. When a client is referred, staff review appropriate documents relative to the client and conduct pre-placement interviews with appropriate parties. In some cases, this will include only the client and her caseworker. In other cases, it might include the client, a caseworker, parents, other state agency workers, and possibly private workers, also. Depending on the outcome of the interview, a client is accepted or rejected.

We were told that the therapy at Rosecrance is very demanding and that clients must be active participants or fail and be transferred out. Eaton told us that clients who are suicidal, homicidal, pregnant, or addicted to drugs or alcohol will not be accepted.

When a client is selected, she and her parents are told that there will be no home visits until the girl is ready to return home; parents, however, are encouraged to visit weekly. Clients are told not to bring radios, televisions, or other personal items because staff wants to discourage the clients from becoming too comfortable.

Clients are divided into groups of ten, each group with a staff leader. The group is responsible for making rules and enforcing them. The only basic rule for the entire Rosecrance facility, we learned, is that no person may engage in "hurting behavior," either to themselves or to others. Each of these groups establishes a separate identity, has a name, and is allowed to utilize a specific part of the campus for themselves.

Schooling is mandatory--there are no exceptions. School is conducted on the campus itself and each student has the individual responsibility to attend and, according to Eaton, to do well. The group is responsible for seeing that each member fulfills her educational responsibility. Credits are given through the local school system in Rockford for work completed successfully.

In addition to schooling, work is mandatory for all clients. Each group establishes its own work assignments, rules, and standards within each living unit. Eaton considered these assignments an integral part of therapy. Because the emphasis of therapy is on clients learning and accepting responsibility for their actions and lives, group leaders do not intervene or interfere with clients unless "hurting behavior" with which the group cannot deal occurs.

Eaton and Allen told us that continuity in the program is maintained through regular staff meetings and maintenance of a daily log on every client. All staff are trained in filling out these logs.

Eaton and Allen said that basically, therapy involves clients' learning to confront the difficulties in their lives and in others' lives, discovering appropriate solutions to the difficulties, and implementing solutions. The actual vehicle for this evolutionary process is a daily group meeting at which problems are raised and confronted and during which solutions are suggested.

When a child feels that she is ready to go home, she will ask the entire group for a recommendation to that effect. If the group agrees, then the group leader will consider the request. If he or she agrees, then supervisory staff will determine whether a child should be sent home. Eaton and Allen told us that the groups deal with problems at all times, and that when a problem arises normal work stops until it can be resolved.

About 50% of the parents are active participants in their child's therapy. The Rosecrance philosophy is that parents are and should be responsible for their children. Each Sunday, parents are requested to visit if they can. Time is set aside for meetings with staff; also, parents have an opportunity each week

to meet with their child alone. In addition, there is a meeting held during the week, each week, for parents to identify and solve problems that impinge on their children's behavior. Parents are allowed to review the daily log and any other records that concern their child. They are invited to all staffings and to 90-day conferences involving their children.

Eaton told us that Rosecrance would like to initiate an aftercare program for clients and their parents. However, there was no reimbursement provided for in the facility's DCFS contract; Rosecrance could not afford such a formal program. Eaton said that staff does provide informal assistance to families who request it.

Eaton also told us that, generally, Rosecrance enjoys good relations with other agencies, including DCFS. However, Eaton and Allen did mention some problems that had arisen. They said that the quality of DCFS workers varies considerably; those who visit and participate in staffings are generally considered to be very good. Those who fail to communicate with Rosecrance staff or the referred child and who do not show up at staffings are generally considered to be poor. They added that a worker's failing to show up at important meetings can adversely affect a child's treatment because the child, according to Eaton and Allen, rightly interprets lack of interest on the part of the worker as just that--lack of interest. This can deal a blow to the child's self-esteem, development of which is one of the key elements of the Rosecrance program.

Rosecrance had developed the policy of informing the Juvenile Court every 90 days regarding a child's progress; this report to the court would include a notation on whether the DCFS worker had been an active participant in the period being covered. Eaton said that this policy had caused some dissension on the part of DCFS, but it had also produced action.

We briefly discussed reimbursement rates with Eaton and Allen. They said that DCFS provided $40 per day per client; actual cost of care was estimated to be $47 per day. They said that they could provide services for this low figure because group leaders are not paid very much and because there are no medical personnel, such as psychiatrists, involved in the program.

We were told that the program is successful with 65-70% of the clients referred, for the following five reasons:

a. Use of one consistent therapeutic approach in which all staff contacting the client are trained.

b. Continual application of the therapy in all situations.

c. Dedicated and trained personnel.

d. An adequate physical facility for programs.

e. Parental involvement in all phases of the program.

Shortly after this visit, Commission staff went to the Durand Campus of Rosecrance to inspect the facility and interview Kurt Friedenauer, its director. He told us that the agency requires that its employees hold Bachelor's degrees in order to be hired. All staff receive the same training in Rosecrance's "positive peer culture" therapy as is required at the Rockford facility.

Friedenauer told us that all referrals come through the courts and DCFS. He added that if they did not have to take referrals from DCFS, they would not do so. He offered these two reasons: children are seldom referred because Rosecrance therapy fits their needs, but rather because caseworkers need to place children somewhere in the state (often, he said, referrals come on mimeographed forms that obviously have been submitted to other placements simultaneously); and most of the children placed with Rosecrance have had multiple placement failures in the past. Few have the sorts of family ties that fit in with Rosecrance's family therapy philosophy.

Although the Durand facility was designed to serve males, it had a coeducational program in operation. At the time of our interview, the facility had four male groups and one female group. Friedenauer said that he would like more balance with groups--more girls' groups. Each of the groups had about ten members and each had a group leader. As at Rockford, rules are established by the groups, and both school and work are mandatory. One difference is that the Durand school is not accredited, although students can transfer their credits to any local school in the state upon graduation from Durand. Work programs are also more extensive than in Rockford.

Again, however, group meetings are established to resolve difficulties. Progress is recorded in daily logs and through periodic staffings. Parents are invited to attend meetings and staffings and to participate in therapy as much as possible.

Friedenauer said that few, if any, DCFS staff from outside of his geographical region have ever come to the campus for anything other than to make the initial referrral. He added that therapy for children referred by these workers was interrupted by this attitude of non-involvement. Friedenauer said that the relationship between Durand staff, the local courts, and the local DCFS office was very good. The Durand staff also submits 90-day reports to the courts, which, Friedenauer said, sometimes angers DCFS workers, because the court learns whether they have made any attempt to be involved with the children at Durand.

Friedenauer reported that one major area of friction between DCFS staff and his own staff was the very purpose of the facility. He said that Durand prepared clients to function on the outside and to be independent, while often DCFS had referred children as part of a treatment plan that included referral to still another program or facility upon graduation.

The Durand campus is reimbursed $30.72 per day per child by the Department. Friedenauer estimated actual costs to be $10-$12 more per day. According to Friedenauer, he has been told that Durand can increase its reimbursement rate by purchasing expensive automobiles and equipment, and by utilizing more medical personnel, such as psychiatrists. Friedenauer said that none of this was necessary but still was frustrated with having to run his program on such a low budget.

In July of 1981, the Commission received from DCFS fiscal information concerning the Rosecrance homes. The licensed capacity for the Rockford campus was 30, and 60 for Durand. None of the costs incurred by either campus was considered excessive.

The per diem rate for the Rockford campus was $39.54 for FY 81, while the per diem rate for the campus at Durand was $30.79. This compares with an average per diem for the Mary Bartelme Homes of $64.07. The Rosecrance facilities had been allowed the maximum DCFS increases in FY 81 (12.5%), but even with the maximum increase, Rosecrance's rates remained low. Actual costs of care at Rosecrance apparently were not reimbursed by DCFS.

The Rosecrance Memorial Homes for Children appeared to our investigators to be a well-run program that was fully accountable to parents, DCFS, and the courts. Problems with the programs are primarily attributable to DCFS caseworker diffidence and reluctance.

K. Maryville Academy

Commission investigators visited Maryville Academy, a residential facility with many DCFS clients, on several occasions, both to discuss details of individual case studies and to develop information about the facility in general.

Maryville Academy is in Des Plaines and consists of a 75-acre campus, including cottages that serve as group homes for most of Maryville's residents. During our visit, we talked with various administrators, including Father John P. Smyth, Executive Director; Donald Ferro, Assistant Executive Director; Kurt Schneider, Director of Evaluation; Sara Salvato, Assistant Director of Staff Education; and Neil Galloway, Director of Residential and Community II Based Group Homes.

Maryville Academy was established by Catholic Charities in 1882 as a home for dependent children. In 1920, the Academy's facilities housed approximately 1200 children. At the present time, Maryville cares for 180 children under the guidance of Father Smyth, who has been Executive Director since 1971. Since taking over as Executive Director, he has added a diagnostic center, shelter care and, most recently, a Family-Teacher Program.

Our examination of DCFS contracts with Maryville revealed that there are two major group care components: Community I, providing group-care for 60-90 placements, a temporary care center,

and shelter care, all located on the Academy grounds in Des Plaines; and Community II, eleven group homes on the grounds utilizing the relatively new Family-Teacher Program. In addition, off-campus there are the Clearwater Group Home in Wisconsin; Maywood House, in Maywood, Illinois; and Virginia Group Home in Chicago.

Father Smyth explained that the Family-Teacher Program was very important in understanding the operations of the Academy. This treatment philosophy is best explained with paraphrases from Maryville's literature, given to us during our interview:

> Eight to nine youths live in each home on the Maryville Academy grounds. A specially trained couple provides a milieu in which children are taught social, self-help, academic, and vocational skills.
>
> The goal of these Family Teachers is to teach children socially acceptable behavior, independent living, and related skills and behavior. The children should be better able to deal with life situations outside of the Academy as a result.
>
> Youth participate in "Family" (self-government) meetings at which the youths learn self-discipline, self-governing, and responsibility, regarding their own behavior and the behavior of others.
>
> Individual treatment plans are developed for each child.
>
> While children are expected to attend school and be involved in other Academy activities, "the conduct and improvement of the youth is totally the responsibility of the Family Teachers."
>
> "It is...our firm beilef that, whenever possible, our goal for youths is their transition from Maryville Academy to natural parents, extended family, foster care, community based homes, etc."

Father Smyth said that the Family-Teacher component of the Maryville programs is licensed to serve 54 boys and 42 girls. Donald Ferro added that it differs from the "typical group home" because it adds competency of care and greater accountability.

We were told that the Family Teachers are totally responsible for youths entrusted to their care. Each home is given its own budget along with the responsibility to use its money conservatively and wisely. Each home is also provided with a twelve-passenger van. Family Teachers must be married and both possess college degrees with an emphasis in an appropriate field such as sociology or social work. Annual starting salary is $15,000 per couple. They are on-call 24 hours a day, seven days a week. For problems beyond the expertise of the Maryville staff, counseling and psychological services have been contracted through Suburban Behavior Consultants and Northwest Guidance Center, Ltd. Family Teachers must be recertified periodically. Training methods include lectures, workshops, and role-playing.

Galloway, who had previously worked at Boys Town in Nebraska for ten years, said that Maryville tends to see youth who have never been taught socially acceptable skills. The Family-Teacher Program attempts to use a cause-and-effect approach to learning situations, thereby not allowing a child's background to be an excuse for inappropriate behavior. Youth are shown the actual steps necessary to attain desired goals.

Each Family-Teacher couple maintains a detailed social history for each child in their care. Observations concerning behavior, activities, and interactions are logged in. However, Galloway distinguished between Maryville's record-keeping and the logs maintained by other group homes by saying that other logs provide information about quantity only, not about the quality of interactions or other behavior. He said that Maryville's records exceed DCFS requirements by providing such information on quality.

We asked Galloway if parents are allowed to visit their children. He said that they are not allowed to visit "if they just show up" but that the agency was planning a "family systems network" in which parental contacts would become regularized and counseling would be provided.

A few days later, we spoke with Harold Bendicsen, Director of Herrick House, regarding the Family-Teacher Program at Maryville. He said that while the concept was good, it had to stand the test of time to assure its effectiveness. He added that the couples who supervise could easily "burn out" because of their long hours, responsibilities, and the interruption of their normal married lives. Finally, he said that youths may be referred to Maryville who would not be right for this program. He said that most of the children served at Herrick House would be inappropriate candidates for the Family-Teacher Program. His was the only criticism we heard regarding the program.

Maryville administrators gave us numerous documents that describe training, hiring, the facility, and types of appropriate and inappropriate behavior. For FY 81, the per diem rate was $47.61. We were also given quarterly reports, service contracts, an organizational chart, and an annual report.

Other information about Maryville is contained within descriptions of individual cases.

L. The Mary Bartelme Homes

The Mary Bartelme Homes came to our attention as we pursued specific case studies and allegations. We learned early in our investigation that the Bartelme system had been providing care for adolescent girls through DCFS contracts for a number of years. We examined the agency a bit more closely to learn more about its contracts and the effectiveness of its programs.

Our inquiry into the Bartelme Homes system spanned 18 months but was not continuous. We followed cases involving several girls

staying at one of the homes operated by the Bartelme Homes system. We will recount interesting and pertinent observations from our interviews, chronologically, so that the reader can understand what lead us to continue to look into the Bartelme Homes' system.

In May of 1980, Commission investigators interviewed Alton M. Broten, Executive Director of the Mary Bartelme Homes. The Bartelme Homes themselves were opened in 1914 by Juvenile Court Judge Mary Bartelme. Originally, the purpose of the homes was to provide residential treatment for adolescent girls with problems. As the Homes grew and developed, additional services were added, such as group therapy and psychological and psychiatric counseling.

In its early years, the Homes operated three group home centers. The girls attended public school and lived under the supervision of group home parent/supervisors. Broten became Executive Director in 1961. When he took over, the system operated only two homes, with a total capacity of eighteen girls. One of the homes was located on Lakewood Street, the other on Wellington Street, both in Chicago.

Throughout the 1960's, 60% of the referrals were from the Juvenile Court. Thirty-five percent of the placements came from the Illinois Department of Public Aid. The remainder came as private placements. DCFS was not involved until 1965 because it did not exist prior to that time; Public Aid handled many of its duties previously.

Today, Mary Bartelme Homes receives almost 100% of its referrals from DCFS. Sixty-one girls are in regular group home placement in eight separate facilities; 75 girls are served through an independent living contract with DCFS. In addition to the eight "regular" group homes, two additional facilities provide service to severely troubled adolescent girls. Broten said that these homes require double staff. These homes are the Essex Group Home and the Dover Group Home. At the time of our interview, the children living at Dover were all DCFS referrals. Those at Essex were referred by JSPA while it was still in existence. When JSPA folded, contracts for the home were assumed by DCFS.

Broten said that Bartelme programs are only reimbursed for about 75% of their expenses. He said that the Department sets limits on expenditures and will not allow some costs at all. Broten felt that DCFS was better in reimbursing than some agencies, but he felt that it had not been altogether reasonable in its reimbursement formulae and rates.

Broten told us that the majority of girls served by his agency have at one time or another been victims of abuse or neglect. This was particularly true, he said, of girls 15, 16, and 17. Some girls referred had been severely abused as infants and had been in other placements as they grew up. Broten said that counseling in his agency's system was designed to address any and all problems that a girl might have.

Broten criticized the information sent to the agency in a referral form, sayng it was inadequate. The standard referral form can become "erratic," he said, depending on how individual workers decide to fill it out. Broten said he felt that these problems were improving at the time of this interview.

Broten said he was very upset that the Department wanted to terminate girls in the independent living program at the age of 18. He said the Department's position was that most of the girls 18 and over just wanted money to live and that such cases should be transferred to the Department of Public Aid.

Broten provided us with fiscal history. In 1978-79, the agency's total income was $2,209,361, of which $1,923,871 was provided by DCFS. Expenses for the same period were divided as follows:

Group Home Program	$1,382,339
Independent Living Program	$ 445,656
Information Clearinghouse	$ 15,133
CETA Program Services	$ 21,961
Management and General	$ 306,069
Fund Raising	$ 17,574

In general, Broten felt that DCFS had been fiscally responsible to the Bartelme Homes. He mentioned a backlog in reimbursements but ascribed them to minor technical deficiencies. He felt that any problems come at the caseworker level, with workers who fail to properly file the right documents that will provide reimbursements. These caseworker delays had caused the Bartelme Homes to be 3-4 months late in receiving payment in some cases, Broten said.

Broten told us that the Bartelme Homes receives referrals from all four area offices in Chicago and on occasion from an office in Aurora. Broten said that all contracts are for one year, at which time negotiations and revisions occur regarding a new contract.

The Bartelme Homes employs 120 people, including 65 house parents and 25 social workers. Broten gave us recent annual reports, an organizational chart, and a sheet of photographs of nine of the Bartelme Homes.

Commission investigators first met with Mary Bartelme staff to develop social history information on some of its residents in July, 1980. We followed up on several of the cases, including one involving a girl referred to DCFS on a Minor in Need of Supervision (MINS) petition.

Commission investigators interviewed Mary Beth Meyer and Susan Caravello at the Wellington House. Meyer was Director of Wellington House and Caravello was a counselor for the Bartelme program. Meyer characterized the Wellington House as a "middle

THE MARY BARTELME HOMES — TABLE OF ORGANIZATION

Standing & Special Committees — BOARD OF MANAGERS — Associate, Senior Boards; Advisory Board; Auxiliaries

Bookkeepers/Accountants; Maintenance Workers; Secretaries - Exec. — EXECUTIVE DIRECTOR — Administrative Assts: Management; Personnel; & Development Coordinators

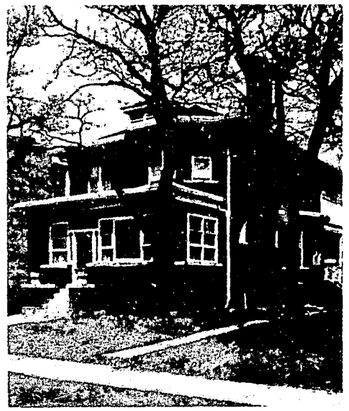
Secretaries

ASST. EXECUTIVE DIRECTOR +++

UNIT I	UNIT II	UNIT III	UNIT IV	UNIT V	UNIT VI
COMPREHENSIVE COUNSELING SERVICE (CCS)	SOUTH SIDE GROUP HOME PROGRAM	NORTH SIDE GROUP HOME PROGRAM	NORTH SIDE GROUP HOME PROGRAM	SPECIAL PROGRAMS	CENTRAL SERVICES
+Independent Living Prog. +Adolescent Mother Prog. +Extension Program +Gunnison Apt.	+South Shore House +Essex House	+Wellington House +Lakewood Hse. +Jarvis Hse.	+Greenleaf House +Touhy House +Chase House	+Dover House +Sandberg Cent. Programs +Trng. Coord.	+Vocational, Educational, Medical Coord. +Pontiac Cent. Programs +New Starts
DIRECTOR	DIRECTOR	DIRECTOR	DIRECTOR	DIRECTOR	DIRECTOR
Social Wkrs. Counselors Child Care Wk. Secretaries	Social Wkrs. Counselors Child Care Wk.	Social Wkrs. Counselors Child Care Wk.	Social Wkrs. Counselors Child Care Wk.	Social Wkrs. Counselors Child Care Wk. Activity Cood. Secretaries	Social Wkrs. Counselors Nurse Vocational Sup. Activity Cood. Secretaries

+++ Special attention to overall coordination of all service programs and systems of the agency.

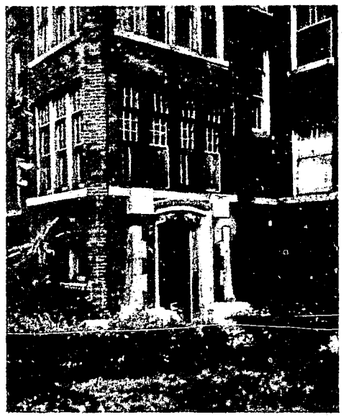
CHASE HOUSE



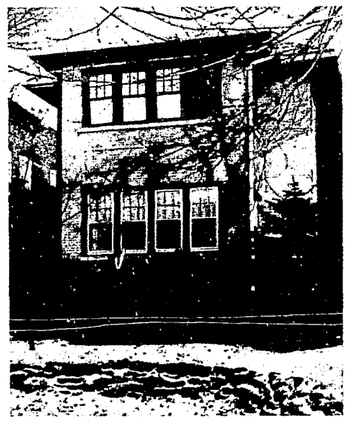
GREENLEAF HOUSE

TOUHY HOUSE

SOUTH SHORE HOUSE

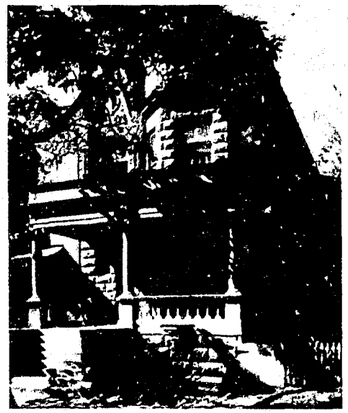


GUNNISON APARTMENT



DOVER HOUSE

WELLINGTON HOUSE



LAKEWOOD HOUSE

JARVIS HOUSE

ground" placement center (although she admitted that they had given "difficult cases" a try on occasion). Meyer said that many of the girls at the Wellington House had been abuse victims, but not in adolescence; she added that most of the girls had gone through multiple placements before coming to the Wellington House. Meyer said that the facility operated on the basis that most girls referred would remain at the home for a fairly long period of time. The program is geared toward directing a girl toward independent living, not toward return of the girl to her home.

Meyer said that the girls are expected to go to school, but they do not always go. Bartelme Homes has its own school, she said, staffed by Board of Education employees. Many Wellington House residents could not attend Public schools, she said, because of their behavioral problems. Meyer said that most of the girls have their afternoons and evenings free if they attend school. At the time of our interview, only one of the girls in the home was trying to find a job. Meyer said that girls are expected to spend their nights at the home, but that they do not always do so. Girls are expected to sign out and indicate where they are going when they leave, but they do not always do so. Each is responsible for cooking one night a week and must keep her room neat. Meyer furnished us with a copy of the rules promulgated for the Wellington House; we noted that often these rules are not followed. By Meyer's own admission, some of the rules are not enforceable.

Besides Meyer and Caravello, there were six full-time child care workers for the home. These workers were required to have high school diplomas and be at least 21; they provided "on-the-spot counseling" for the girls in the home. The base salary for these workers was $540 per month.

Meyer said that DCFS workers are involved only as much as they want to be. She said that some workers want to monitor cases and others are uninterested. In all cases, contact is initiated by the Wellington House worker or by the girl. Meyer criticized DCFS for continual reorganizations; for a lack of uniformity in area offices; for continual reassignments for girls (preventing them from establishing relationships with workers); for referrals coming in without a caseworker to speak with; and for poor DCFS case histories with which Meyer and her staff have had to work.

Meyer told our investigators that there was an acute problem with two girls in the home prostituting themselves. Meyer blamed the problem in part on the location of the home. The two girls involved with prostitution were 14 and 17 and both were involved with pimps. Meyer commented that she was working with vice officers of the Chicago Police Department to try to do something about the two girls' behavior. She added that one of the girls probably would be placed at the Rosecrance facility in Rockford.

Meyer told us that her philosophy at the Wellington House was to give girls latitude to do as they wanted; to try to change the girls by forcing them to do something would not work. She felt that the girls would change when they were ready for change.

She ended the interview by saying, "We try not to give kids the impression that they can do anything they want--we try to give them the impression that certain things aren't approved of and hope this tool is effective."

Next Meyer explained the backgrounds of the six child care workers at the Wellington House, during which time Edwin Be, Assistant Executive Director, joined the interview. He explained the classification system designed for differentiation between Child Care Worker divisions (I through III), each reflecting a difference in salary.

Meyer told us that training occurs on-the-job and through an eight-week, 32-hour course conducted by Mary Bartelme staff.

Meyer described a typical day at the Wellington House as school for most of the girls, a free afternoon, and designated evening activities several times a week, including bingo every Tuesday night.

When asked about counseling, Meyer responded that she meets individually with each girl once a week for about 45 minutes. However, she added that professional counseling may be provided through contract with Dr. Maurice Kaplan, a counselor for Bartelme Homes for the past ten years. She said that he provides initial assessments on the girls and general consultation for staff. Meyer said that, if necessary, Ridgeway Hospital was available for psychiatric crisis intervention. Finally, she said that group counseling is conducted by each house director; at Wellington House, Meyer provided the group counseling "generally" each Thursday afternoon. Meyer admitted that it was difficult to get all the girls together for these sessions, however.

We also asked Meyer about goals for residents of the Wellington House. Outcome goals, she said, were established at intake by DCFS caseworkers and Mary Bartelme staff in consultation with one another. Goals generally are established for "direction, education, and vocational planning." According to Meyer, Kaplan does not participate in establishing goals for the girls at intake "because he does not believe in them." Meyer estimated that 90% of residents remain in placement until release to live independently. The younger girls might go home eventually, and older girls might be transferred to Bartelme's Supervised Independent Living Program.

We compared these assessments with DCFS' Program Plan for the Mary Bartelme Homes Regular Group Home Program, which provides the following outcome goals:

1) At least 60% of its clients will be terminated with adequate planning leading to either:

   a. reunion with family or private family setting

   b. a state of self-sufficiency

   c. a satisfactory independent living arrangement

   d. or, another agency setting

2) At least 55% of all discharged clients will have reached the treatment goals established at admission.

3) It will accept back into the program 80% of all runaways unless it has no vacancy.

The program plan also includes this statement: "The agency sets these goals recognizing that these objectives are not universals and that no penalties shall occur for failure of the agency to achieve its outcome goals."

Meyer elaborated on several Wellington House rules. She said that failure to attend school before a resident's 17th birthday could result in discharge. Drugs or liquor brought into the home were to be confiscated and, in serious cases, given as evidence to the police. Meyer added that breach of the rules results in reduction of the weekly $6.10 allowance that each resident receives. Furthermore, the child care worker responsible for the particular girl will confront her about her behavior and discuss the situation. The allowance could be revoked or reduced. Meyer also said that the $6.10 figure was a base amount and that the girls could earn more, depending on their performance.

When asked about problems at the Wellington House, Meyer responded that the most frequent is curfew violation. She also referred to several former Wellington House girls who had been prostitutes. She added that prostitution was handled by staff "talking to the girl" to try to make her understand the consequences of her actions. She also mentioned that the girls did not prostitute because they needed more money but for psychological reasons.

Edwin Be explained the funding mechanisms for different components of the Bartelme system and also explained the system's structure. The least structured homes are those included in the Regular Group Home Program and the Gunnison and South Shore Homes, which are transitional group homes for girls 17 and over preparing for independent living. He said that the regular group homes (Lakewood, Wellington, Jarvis, Touhy, Greenleaf, and Chase) are more structured than the two transitional homes. Furthermore, he added, the degree of structure in each home is largely determined by each house's internal rules and by the residents in the homes. The next most structured home is the Dover House, which received more money per resident. Be described the home as a special care group home for difficult girls. Eight child care workers were assigned to the home. The most highly structured home is Essex House, which received in 1980 $104 per diem per girl. The staff at Essex House provided supervision for the girls all the time.

When informed that some DCFS caseworkers had complained that Bartelme residents are sometimes transferred from one home to another without notification to DCFS, Meyer said that she considers such transfers temporary and not subject to notification. She called such transfers "time-outs" for girls to move to another

home briefly if they cannot resolve specific difficulties in one setting. Be added that the Bartelme administration considers all of the girls in the homes to be "one family" and that it is not a problem when a girl is transferred from one home to another. Be added that when a girl changes homes to move to a different program, DCFS definitely will be notified, because there will be a change in per diem rates.

Meyer provided us with a list of residents placed at Wellington House from January 1, 1980, to September 10, 1980. Of seventeen girls placed, four remained in the program, four were transferred to the Bartelme Independent Living Program, four ran away, and five were "administratively discharged."

In November, investigators spoke with officials of the Mary Bartelme Homes educational facility, the John V. Sandberg School in Chicago. We spoke with Michael Catania, Principal, and James Scherrer, Director of Residence for the Bartelme Homes and liaison to the school.

We learned that the Sandberg School is one-of-a-kind in the city of Chicago; it serves only those individuals that are part of the Mary Bartelme Homes system. Basically, the school provides special education for high-school-age girls. The program does not differ significantly from that offered in city schools; the big difference is in environment, according to Catania. Students are not affected by the pressures of public school and may be able to learn more. Also, Catania said, the school's teachers are able to provide far more personal attention to the needs of students at Sandberg School. Catania said that most of the students at the school have severe learning and behavioral disorders--sometimes both.

When students graduate from the Sandberg School, they are enrolled in a special education program at a regular high school. The ultimately successful student is the one who can graduate from a regular high school program.

Catania said that students' progress is assessed in quarterly meetings, to which appropriate Mary Bartelme staff and DCFS workers are invited. Catania characterized DCFS response as erratic. Some caseworkers were very conscientious about following up on children referred to the Bartelme Homes; others did not seem to care.

We were told that the teachers at the Sandberg School are both supplied by and paid by the Chicago Board of Education. They all have master's degrees and are state-certified to teach special education at the high school level. Catania told us that the school employed three teachers, a teacher's aide, and one "supportive service teacher." The only cost to the Mary Bartelme agency is for maintenance of the building. Meals are provided by the Chicago Board of Education as part of its normal school lunch program.

We were told that the average length of stay for a girl was a year to a year and a half. We were also told that attendance at the school was mandatory, with transportation for students living south of the Wellington House being provided by the school. Students living north of the Wellington House were expected to take public transportation to the school, for which they were given carfare. Though attendance was characterized as mandatory, we were also told that attendance averages 55-56%. Absenteeism is supposed to be dealt with at each individual home by the child care workers. At Sandberg, excessive absenteeism is dealt with by giving a failing grade.

Finally, Catania told us that 88% of the girls in the Mary Bartelme system were in school: 50% in regular high school programs and the other 38% at Sandberg. Half of the girls in regular high school programs were in special education classes and programs. The other 12% of the girls were enrolled in some form of GED class or had jobs. Catania ended the interview by saying that Sandberg graduates had done exceptionally well in special education programs at regular high schools.

On December 16, 1980, in the midst of our inquiry into the Bartelme Homes, Sandra O'Brien, a resident of Wellington House, was indicted together with a friend, Betty Hinckley, for murder, armed violence, armed robbery, and conspiracy to commit armed robbery in the killing of IBM executive Anthony J. Hopfner.

We examined a report to DCFS Meyer dated October 9, 1980, which states that O'Brien's performance at Wellington House was not acceptable. Included in the report are the comments that "Sandy does whatever she wants" and "needs a kick in the pants." As a result of O'Brien's behavior and this report, a contract was developed to regulate O'Brien's behavior. The Commission received a copy of the contract developed specifically for O'Brien. The contract calls for the following: O'Brien will cook on her assigned days and will "do her chore" on Saturdays. Furthermore, "Sandy will be in on time (11:30 on week nights, 1:00 a.m. on Friday and Saturday) at least 80% of the time (100% is expected; 80% would represent significant improvement)." O'Brien was to continue to let staff know where she was going when she left the home (as mentioned previously, it was standard procedure for girls to sign in and out, indicating destination). O'Brien was expected to secure at least part-time employment and was to spend at least five days per week looking for work until she found a job. Wellington House would provide transportation money. O'Brien was expected to submit written proof of her attempts to get a job. For self-improvement, O'Brien was expected to enroll in some sort of class of her choice and would have to meet with Mary Beth Meyer once each week individually.

We also reviewed an assessment conducted on November 3, 1980, and submitted to DCFS on November 28. Present at this Periodic Service Review were O'Brien, Meyer, and O'Brien's child care worker. O'Brien had improved in her cooking and chores. Out of 24 possible nights, she had been late only once and out all night three

times ("significant improvement"). She remained vague in letting the staff know her whereabouts. O'Brien had not yet found a job, "nor has she demonstrated a determined effort to find one." O'Brien had made no effort to engage in any positive structured program (such as classes) for self-improvement, nor had she demonstrated any motivation to keep individual counseling appointments. Meyer's narrative reports that while O'Brien's "area of basic expectations" had "vastly improved," she had not demonstrated the motivation or ability to improve her life. She was warned that when she reached age 18, DCFS funding might be cut off for her. Meyer adds, "The workers were doing all the work, and felt quite frustrated by Sandi's apparent lack of interest in areas affecting her life."

Commission staff pursued its study of the Mary Bartelme Homes by procuring information on the Essex House. This information came from the DCFS Cook County Licensing Unit. The Essex House facility, while part of the Mary Bartelme system, also served adolescents referred by JSPA. Its licensed capacity is six girls. Licensing documents indicate that the facility serves girls between 13 and 19 who require intensive care and treatment, who are referred by DCFS, and who "present emotional and behavior problems, which may include a history of: running away, school truancy or failure, drug involvement, prior psychiatric hospitalization, minimally mentally retarded, etc." Girls who are suicidal, psychotic, severely mentally retarded, or non-ambulatory generally are not considered for admission to the facility.

The Essex House staffing plans call for two child care workers to be on-call during each of the eight-hour shifts. The House's social worker and residence counselor function as backup.

One of the documents we reviewed was a list of twelve girls served by Essex House between September 1, 1978, and August 1, 1979. The document includes a list of charges. Seven girls were discharged from the home during this period: one to a mental hospital; one to her mother's care; one to independent living; one to another component of the JSPA system; one back to the DCFS referring area office; and two to other group homes in the Mary Barteleme system.

In January of 1981, we spoke at length with Tanya Kent, Director of Residences for both South Shore and Essex House facilities. Among Kent's duties were assuring compliance between wards and the Bartelme agency's rules and regulations, making recommendations regarding issues such as termination, submitting bi-annual progress reports to JSPA, and dealing with any serious problems that may arise. Under Kent's direction were two group home directors, two resident counselors, and 15 child care workers. Kent was directly answerable to Edwin Be.

Kent told us that the house directors spend about half of their time providing counseling for wards under their care. The other half of their time is generally spent on actual administration of the homes. The house directors meet once a week individually with each resident, and in a group setting once a week.

We were told that one "unique element" about the Essex House operation was that counseling meetings with the house director were mandatory. Refusal to meet with the director is dealt with immediately, we were told.

The objective of programs of the Essex House is to provide an atmosphere of understanding, one that will help residents deal with normal adolescent issues as well as the particular problems that confront the girls. Most of the girls referred to the facility have displayed extreme disruptive behavior; therefore, in addition to providing instruction in normal adjustment to adolescent issues, the staff at the facility must deal with social adjustments and mannerisms of the residents. All of the Essex House residents are involved in special education, either at the Sandberg School or in a regular high school program.

Kent told us that at no time during the day will there be fewer than nine staff members present at the home. Girls are not free to come and go as they please; during the first 30 days of their stay, they are not even allowed the right to be alone. Bedrooms and washroom facilities have no locks on their doors. If a girl wishes to leave the facility, she must earn the right to do so, and when she wishes to leave, she must provide documentation regarding her destination, the time she will leave and return, and what she will be doing when she is gone. Kent said that girls are never allowed to leave without meeting these criteria.

Regarding program success, Kent told us that when a girl moves from the highly structured Essex House to a less structured setting, that girl would be considered to have experienced a good deal of success.

We next interviewed several current and several former residents of the Wellington House. Several alleged that residents were allowed to bring alcohol and marijuana into the Wellington House for personal use. One former resident admitted to engaging in prostitution for 5½ of the eight months that she had been in residence, and she alleged that five other girls in the home had been prostitutes while living at the Wellington House. Another former resident told us that there was no "pressure" for any of the residents to attend school. She said that the basic disciplinary action was reduction in weekly allowance. She also told us that drugs were procured and hidden in bedrooms of the Wellington House.

The parents of one girl who had been placed at Wellington House told us that they threatened DCFS with a lawsuit if their daughter were not transferred to another facility. She was moved to the Rockford Campus of Rosecrance Memorial Homes for Children. The parents told us that they had been assured that, while at Wellington, their daughter would receive intensive counseling and would be in a very structured setting. Her father told us that he saw his daughter "hanging out" with her old friends in Rogers Park only a week after the placement had been made. After that, her parents would see her often in early afternoon far from Wellington House. It was obvious that she was not attending school.

After the girl had been transferred, and with her cooperation, Commission investigators furnished officers of the Chicago Police Department with information concerning a man alleged to have been her pimp. The man was subsequently arrested and charged with Contributing to the Sexual Delinquency of a Minor. After receiving his Miranda rights, the man was interviewed by a Commission investigator. In essence, while denying any sexual contact with the minor girl or having acted as the girl's pimp, the man told us that the girl was heavily involved in prostitution when he first met her. He said that she had become involved through another resident of the Wellington House. He added that he was just her "friend," and that he had freedom to call her or pick her up right outside the Wellington House with no interference from staff.

We interviewed Broten again in our offices on October 9, 1981. He spent a good deal of time discussing the history of the agency, which we have presented. Broten said that virtually all of the agency's growth over the past twenty years was the result of an increase in demand for services by DCFS. When DCFS began operations in 1964, Broten said, it realized that it might need contractual services for girls.

Regarding the children served, Broten said that the only thing the girls have in common with one another is age. The agency receives referrals of all types of girls with all types of problems. Individualized services are provided to these girls. He said that the child care worker assists the children with whatever problems they may have and also bolsters services rendered by other professional staff. Broten mentioned that the program is built on "psychoanalytical principles" but utilizes an eclectic approach, which he called "anything that works." Broten commented that the agency's philosophy is not to build a locked-in system, such as positive peer counseling, but to utilize a variety of approaches in order to remain "loose."

Around 1970, when DCFS was demanding more and more services, the agency purchased three of its nine facilities. At this time, the agency also began discussion regarding development of its own independent living program to augment services then being provided in the group homes. Initially, he said, Bartelme ran this program and distributed allowances to clients for DCFS without charge. However, in 1971, Bartelme entered into a contract with DCFS for these services. Bartelme was paid to provide services to the girls and also to funnel DCFS money to the girls for their living expenses. At this time, the Bartelme staff also decided that some of the girls did not seem appropriate either for group home life or completely independent living; as a result, the concept of transitional living in an apartment setting was born and implemented at the Gunnison Apartments, also funded by DCFS.

Also in 1971, Mary Bartelme Homes added both the Dover Group Home and the South Shore Group Home, both of which handle eight girls. Broten characterized the Dover facility as an intensive care and secure home, with two staff members on duty at all times.

Girls at Dover are not allowed to go anywhere unless accompanied by a staff member, similar to what we have learned about the Essex House. Essex House was the next home opened by the agency. He said that it was opened in late 1977 or early 1978 as a "unit" of JSPA. Broten explained that he had been one of the principal architects of the JSPA program and philosophy.

Broten told us that the Sandberg School was opened in 1977. In the same building with classrooms are offices for social workers of the city's north side group homes. The building is owned by the agency.

One program not previously discussed opened in 1978. It is the Adolescent Mother's Program, first begun as an off-shoot of the Independent Living Program. All of the girls chosen for the program are assessed to be potentially capable parents who have specific educational or vocational goals. In 1980, Bartelme had 70 girls involved in independent living and 30 in the Adolescent Mother's Program. Although these two programs had diverged in 1978, they merged again in 1981, according to Broten.

Another program, providing family services, also began in 1978. This program was designed to serve girls living at home or in foster care and is oriented toward counseling (one session per week). There are 30 girls in the program. The families are not charged for the counseling. All of the girls in the program are referred by DCFS.

Broten also addressed the issue of staffings, which are held quarterly. He said that the DCFS worker, probation officer, psychological consultant, and family members are invited to attend these major staffings (he said that there are also "mini-staffings" held periodically and unpredictably as needed). Broten said that an appearance by the DCFS worker is totally unpredictable and depends on the individual worker. Generally speaking, though, DCFS workers do not attend these staffings. In emergency cases, on the other hand, DCFS has a good response rate, Broten said. Broten characterized treatment of the girls in Bartelme's care as a joint effort between his staff and DCFS's. Generally, DCFS staff follow the plans developed by Bartelme staff. Broten added that school staffings are similar to the quarterly staffings just referred to; all interested parties are invited and may show up if they wish. DCFS workers regularly fail to show up.

In addition to the staffings just mentioned, Broten said that the entire counseling staff holds two staffings per week. The first is for individual cases at the intake stage. The second is a staffing with a consultant to discuss individual, specific problems with girls in the homes.

At intake, goals and plans are spelled out for all of the girls. Generally, he said, the goal is to get the girl into independent living or sent home. He added that about 80% of the Bartelme graduates go into independent living arrangements and about 20% are returned to their homes. We asked about interim

goals. He responded that the major thrust of the program was to integrate the girls well in the group home situation. The girls also receive motivation in cooking, getting a job, going to school, saving money, and interacting appropriately with other girls in the home.

Edwin Be, who accompanied Broten to the Commission offices along with Mary Ann West, mentioned that many of the girls sent to the Bartelme homes have been involved in extremely destructive behavior. Another goal of the agency is to help the girls discard such behavior. Be added that each girl has an individualized treatment plan developed for her, sometimes involving traditional therapy and sometimes not. Similarly, when rules are broken, there is no set punishment; each case is decided on its own merits with the particular girl in mind.

When we asked about the success rate of the agency, both Broten and Be stated that they do not keep records regarding such a statistic. They said that they do not think in terms of success or failure. Broten and Be guessed that about 80% of all referred girls either go home or are sent to independent living arrangements. About 20% of the girls are terminated: either they leave of their own accord or the agency decides to send them back to DCFS. Broten explained that some girls simply are not suited to a fairly open community-based group home.

Be said that success is difficult to measure because each girl presents a complex cluster of problems that must be analyzed. It is hard to define recidivism in these cases or determine any sort of long-lasting success. He concluded that outcome measures are difficult to apply to the Bartelme Homes.

Be said that the Bartelme approach is "psychoanalytic," not behavioral. Intimacy between the girls and the staff should help the girls in dealing with other interpersonal relationships. Be admitted that recently the agency has moved in more of a behavioral direction in its programs.

Mary Ann West added that "psychotherapy" is provided by the social workers during individual counseling with girls. Consultants are also called in for counseling. West explained that the group homes provide goal-oriented group therapy, such as trying to teach the girls individual living skills, values, and clarification. The group therapy approach includes periodic community meetings, in which the staff and the girls discuss specific problems occurring in the home.

Be then took over explanation of the treatment approach, which he told us was founded on milieu therapy. This therapy, he said, is based on the idea that everything that happens to a person has some kind of impact. Consequently, Bartelme staff has attempted to build a diverse program that can deal with the many things that may happen to a person during her life. This accounts for the recreational component and some of the skills that are

taught the girls. Be told us also that the style of therapy employed by his agency is based on a book by Al Trieschman called The Other 23 Hours.

We asked the three to comment specifically on how the individual components interact during a typical week. West explained that there is one recreational group activity every week. There is an individual counseling session that is, at most, an hour long. There is one group meeting that lasts an hour, and a community meeting that lasts another hour. West also said that community meetings may not be held each week. Use of consultants, she said, is rare and therefore not built into any weekly schedule.

Individual counseling is traditional: the girls talk about their feelings and how they think they are doing in the group home. Group therapy meetings are also traditional, focusing on problems in the home or a particular topic. For instance, the group meeting might be assertiveness training one week and art therapy the next. The group recreation program is not required, West said.

We asked West what types of restrictions might be placed against girls who fail to obey house and agency rules. She replied that privileges might be denied, allowance money might be withheld, or a more stringent curfew might be enforced. West told us that the house director will tolerate some disobedience of the rules, depending on how long it continues. She added that if the house director or counselor feels that a girl is making progress, she might be a little more tolerant of infractions.

When asked about the allegation that several of the Wellington House girls were involved in prostitution, West said that many of the girls assigned to the Bartelme system may engage in prostitution. West feels that her agency is appropriate for these girls, depending, of course, on how heavily the girls are involved in the activity. She said that they will refuse admittance to and discharge any girl who is or becomes heavily involved in prostitution. She said that sometimes, even after the prostitution has been discovered, DCFS may try to force the agency to continue treatment with the girl. West said that they try to get girls out of prostitution and sometimes are successful. She also commented that the girls that are referred to the agency are particularly prone to sexual exploitation; she felt that prostitution among the agency's population was more of a symptom of a problem than a problem in and of itself.

We asked West about the contract with Sandra O'Brien asking her to obey curfew rules at least 80% of the time. Broten said that that particular contract was "inappropriate." West said that O'Brien's case was extreme and that they probably tolerated infractions of the rules longer than they should have. However, West added, sometimes it becomes extremely difficult to terminate a girl, especially when staff becomes emotionally attached to her. She told us that the decision to terminate depends in large measure on "the amount of investments staff will have in the kids."

Broten allowed that there might be a problem with Bartelme's night supervision. Ideally, he would like to have two people awake at night at all times in all of the homes, but the agency cannot afford it, given the reimbursement rate provided by DCFS.

Broten mentioned that the way the homes are scattered all over the city is both good and bad. On the one hand, the children can blend into their particular neighborhoods and make use of community resources so that they will have more of a feeling of belonging to a community. On the other hand, the distance creates some supervisory problems; no one has direct supervision over facilities as Broten would like to have. Broten felt a need for centralized medical, vocational, and administrative services. With facilities dispersed, it becomes hard to manage such centralization.

Broten told us that there is some flexibility in each facility's rules. This he viewed as related to the idea of each home being part of a different community. Broten said that in enforcing the rules, his staff hopes to err on the side of being considerate, thoughtful, and non-punitive. Broten emphasized that, in spite of flexibility in rules, there is still central control and review.

Toward the conclusion of this long interview, Broten told us that he felt that the Commission had probably made some unfavorable judgments about the agency's operations, especially since he was unable to provide any examples or concrete statistics concerning success ratios. He said that they do not have information that supports actual success. What they do have is the belief that the agency has made a real impact on some children's lives. He said that he personally has seen many cases of success.

Broten emphasized that the Bartelme staff supports girls even if the girls are disobeying rules. These girls are bound to go through cycles of success and failure, and his agency provides the girls with the time to get through some of their problems with support. He characterized the agency's philosophy as steady commitment to a child over an extended period of time with the hope that, in the long run, the girl will come around. Broten felt it very important that the agency be tolerant of the girls' activities without reprisals, while still acknowledging that limits had to be set on their behavior. Broten acknowledged that the agency had been too tolerant in certain cases, partially because staff was aware that there were no other resources for a girl besides a limited number of mental hospital beds.

Broten emphasized that he did not want to overly defend some of the problems that had been uncovered at the Wellington House, including the repeated prostitution by several of the girls, or Sandra O'Brien's contract with the home regarding curfew. Broten said that the real problem was that the entire Bartelme system needed more resources and a better linkage system. Outside resources were also needed, so that Bartelme staff could feel free to recommend a girl's discharge, knowing that she would have some

place reasonable to go. Broten admitted that the Bartelme staff needed to be more consistent in its approach to cases; continuity is necessary, he said. He mentioned that people want to try out new ideas and as a result, rules are not enforced uniformly.

Broten was emphatic in wanting us not to evaluate the entire Mary Bartelme Homes agency on the basis of the problems that we encountered at Wellington House. He told us that he did not think the problems were agency-wide but were isolated to the Wellington House. Broten said that the problems at Wellington House are unique and are not representative of the other homes. Perhaps, he said, the combination of Wellington House's location, staff, and residents had created its problems. He said that these problems may arise at different periods of time in different homes simply because of the nature of the mix of girls present. As girls move in and out, the milieu changes. The Wellington House was located in an area replete with bars, prostitutes, and other unsavory characteristics for a group home location.

We asked Broten if he had any kind of information that might support his contention that the Wellington House was unique. He said that he did not have any. We then suggested that perhaps if we reviewed school attendance records for all of the homes we would see that the Wellington House had much higher absenteeism than other homes. Broten agreed that this should show up in a review of school attendance records. We therefore asked Broten to supply us with school attendance records for girls in all of the agency's homes. We also asked for any records that would indicate that the Wellington House was having particular problems or that might compare the Wellington House with other group homes.

On February 10, 1982, Broten sent most of what we requested along with a letter to our Executive Director, portions of which follow:

> In response to your letter of February 9, I am attaching information on the growth and development of the Mary Bartelme Homes, especially since I became Executive Director in 1961.
>
> On the issue of differences and similarities of group homes, I had emphasized at our conference in October that the Wellington Group Home, which you had singled out for special attention, was established with similar structure as were five other group homes. This meant a similar population, staff structure, basic rules and expectations, available services, equipment. Wellington was part of our Regular Group Home Program.
>
> Although similar in these respects, each group home could differ in its milieu, its strengths and weaknesses, due to such factors as staff abilities, personalities and problems of residents, character of the building itself, resources or temptations of the neighborhood or nearby community, accessibility of special education, etc. Also, as I pointed out in our conference, group home programs do not remain static, and change from time to time as to their makeup and capacity to service certain youth.

Thus, Wellington Group Home was similar to five other group homes; it also was unique--just as large families, which look alike to the outsider, differ from one another due to the people involved and their interaction with one another.

Wellington Group Home operated with the same Basic Rules and procedures as other Regular Group Homes. While there may have been some inconsistencies and errors made by staff, I am convinced through our own evaluation that all staff members of the Wellington House were intent on providing the best possible care for the girls placed there. The immediate leadership--Social Worker and Residence Counselor--were experienced and qualified. There were acknowledged problems in influencing the behavior of certain girls--particularly some with history of curfew violations or runaways.

Contrary to your information, staff members have convinced me of the extensive efforts made to focus on problem behavior as well as develop a good milieu in the House. As criticisms were brought to our attention and as problems occurred, meetings were held with staff members and with leadership people downtown to work together to improve operations and answer criticisms. We found it important to re-stress expectations both of staff and girls and to push for more consistent firmness in management.

In regard to your stated attempt to be fair and objective in this investigation, I have reluctantly concluded that this was not achieved. Even your letter of February 9 tells me this--as you plan to conclude all of our facilities are the same.

Your investigation took a year, off and on. It triggered a parallel investigation by DCFS investigators. While there was interruption in your activity, it did mean for our staff, especially at the Wellington facility, that they were under attack and criticism. Feedback came back to them periodically about visits made to former residents who said that the investigator indicated he was out "to close up Wellington House." Morale of staff suffered. Referrals for this Group Home dropped off.

Unfortunately the Board of Directors decided to discontinue the operation of the Wellington Home effective October 31, 1981. While it is possible that this facility may be reactivated there or at another location, I consider this to be a serious setback in our overall effort to provide residential care for this important population of young people.

We will not attempt to address all of the issues contained in Broten's letter. As the reader is aware, the DCFS investigation was not the result of our investigation but was the result of Betty Hinckle and Sandra O'Brien's being tried for murder.

One of the documents furnished to the Commission is the "Mary Bartelme Homes Disciplinary Policies and Procedures (Group Homes)," several brief portions of which follow:

> Rules, regulations, expectations must be well designed and be relevant to the age and needs of those being served by the program. They should be clearly interpreted and should be administered with firmness, fairness, and consistency.
>
> Many disciplinary problems arise because the rules and expectations have not been clearly determined and explained, or because there is not a consistent emphasis upon them and their enforcement. Violations shall be met with consequences which are related, if at all possible, to the offense, to the conditions, and to the person.
>
> Basic rules shall be set on a uniform level by the agency for all residential units.
>
> More specific requirements shall be set by the individual group home as long as they do not conflict with the Basic Rules and as long as they are consistent with the overall philosophy of the agency.
>
> All such Rules shall be in written form, and shall be first approved by Unit Director--and finally by Executive Director--prior to being established. They shall have input initially from girls and from staff and shall periodically be reviewed.
>
> Critical Incident Reports shall be prepared when important Rules are broken and these shall be submitted as required.
>
> Consequences should be reasonable and appropriate, and should be carried out. (Hasty, excessive actions--which later are changed or ignored--are not helpful.)
>
> Disciplinary actions taken shall be recorded in the log.

We also were furnished with a list of girls attending school, together with attendance records from girls in the different group homes. Of the 70 girls in Bartelme's group home programs, only six were not attending school. The only one not attending from Wellington House was Sandra O'Brien.

We reviewed the group homes' 1980-1981 school year attendance forms. The reader should recall that Broten characterized the Wellington House as being excessive in absenteeism and that an analysis of school attendance records would reveal that Wellington was unique in the poor attendance of its girls. While exact comparisons cannot be made among the different facilities, one gains a good idea of actual attendance by reviewing the separate sheets for each group home's attendance. During the 1980-81 school year, Wellington House had seven girls in the home. Girls attended school anywhere from one month to six months, depending on referral date and whether they were transferred out of the home during

that school year. Regardless of the amount of time spent in school, the sheets we were given break out actual absences, which are comparable among all of the group homes. For these seven girls, during the one to six months the girls were attending school, the Wellington House had 77 days of absence.

The Greenleaf facility had eight girls in care for this particular school year. Two of the girls attended school for the entire year; one attended for only two months. The total number of recorded absences is 76.

Essex House had eight girls in care, three of whom attended the entire year and two of whom attended only three months. The total number of days' absence was 119.

The Maplewood facility had a single girl in residence for the portion of the school year from March, 1981, to June, 1981. This girl recorded 42 days of absence alone. She was present in school only 16 days.

The Dover facility had eight girls in residence, none of whom attended the entire year and one of whom attended only one month. This group home's sheet shows 198 days of absence.

The Chase facility had five girls in residence, two of whom went to school for five months, one of whom attended for three days. Total number of days of absence: 74.

The Touhy facility had eight girls in residence during this school year. None of the girls attended longer than five months. Average attendance was for three months. In spite of these low totals, the girls logged in 133 days of absences from school.

Finally, the Lakewood facility had eight girls in residence also during this school year. Only one of the girls attended the entire year; three attended only for two months. The Lakewood Home recorded 261 days of absence for that school year.

In retrospect, the Wellington House school attendance is actually fairly good compared to school attendance at other homes. Clearly, the comparison of school attendance records failed to distinguish the Wellington House as being unique among the Bartelme Homes.

We also asked the agency for each home's "Critical Incident Reports" for the same period. Our purpose was to examine the number, types, and dispositions of serious problems. The number of reports per home follows:

Wellington.....27
Chase..... 8
Touhy.....16
Greenleaf..... 4
South Shore..... 5
Essex..... 4
Jarvis..... 1

Our analysis of group home rules showed that Jarvis House, the facility with the lowest number of these reports, also had the most stringent rules for residents, far more stringent than the rules for Wellington House. The above figures do suggest that Wellington House was unique in at least the quantity of critical incident reports being filed.

These reports take several forms. Some of them are actual critical incident report forms; others consist of case narratives on plain paper or memoranda from a worker to Broten or Be.

The report on Sandra O'Brien is not a critical incident report, but rather a discharge summary, indicating that she was terminated from the agency upon her arrest by the police. Mary Beth Meyer's summary says, "At the time just prior to the alleged incident, it was decided to refer Sandi to our Independent Living Program, with possible consideration for Gunnison apartment, a transitional group living program. Given Sandi's age, it was felt that further group home placement would not provide the necessary incentive for Sandi to take more active steps concerning her future."

One of the more interesting documents is a Critical Incident Report from Greenleaf House. A description of the incident follows, with the girl's name changed:

> Jill spent the night out without permission, was involved in setting up another girl in the house for a possible rape. Jill and 1-2 boys dragged her onto the "L", took her to one of the boy's houses, where they attempted to get her high, and took her clothes off so that the two boys could have intercourse with her. However, they were unsuccessful in penetrating.

The disposition for Jill? "She will be grounded for 1 week."

We examined some similar reports on girls in residence at Wellington House. One of these reports follows, with the girl's name changed:

> After not going to school and refusing to tell her whereabouts, Leslie was asked to go to her room. She refused to do this and became verbally abusive. She left the house and was told by staff to return only with policemen. She attempted to get back in the house via the fire escape and then threw something at the window in the staff office. She returned with policemen 30 minutes later and was given the option to stay--abiding by the rules or to go with the police--she chose to stay but an hour later began disobeying staff again--would not stay in room, kicked a chair over nearly hitting a staff member, and was verbally abusive. The police were called again and she was taken to 23rd District where she was reprimanded by Youth Officers and booked on disorderly conduct and ungovernable

charges. She was allowed to return to Wellington after signing a contract that she would abide by the rules.

Disposition: Leslie is on restriction and knows that the next time she disobeys that she will be referred to Juvenile Court.

Finally, we reviewed three critical incident reports on one girl in residence at the Wellington House in August, 1981. On August 18, she left the home without permission and was gone for 24 hours. When she returned, the disposition was for her to sit down with staff on duty and "discuss what makes her leave. She agreed to work on feeling better about herself." Another report filed on the 31st, but referring to an incident earlier in the month, mentions that the same girl was brought to the home by police officers who had picked her up for soliciting prostitution: "On call person was notified and decision was to have police charge her. Youth Officer _____ dealt with _____ (yelled at her and lectured) and made a station adjustment." The disposition of the case is: "Police record, counseling on seriousness of this behavior, DCFS notified." The third report concerns the period from August 21 through August 28. The same girl left the house with permission to go to the post office but did not return for three days. She was then taken to Jarvis House for a "time-out." After stealing some money from a staff member's purse, she left Jarvis House via a window. She was returned to Wellington House on the 28th by the police. That same day, while supposedly taking a shower, she snuck out of the house and had not been seen since. The disposition? Staff notified police of a missing person and notified the DCFS worker.

On September 28, 1981, the Executive Committee of Mary Bartelme Homes instructed Broten to close Wellington House, citing financial problems as the cause.

Based on an extensive investigation, we must conclude that Mary Bartelme Homes has serious deficiencies in its internal administration. The problems that surfaced during the investigation have multiplied while nothing has been done to change the rules or regulations of the homes. The group homes enjoy a more-than-reasonable reimbursement rate from DCFS and enter into multiple contracts with DCFS each year. There is no program review by DCFS. If DCFS staff want to come to the facilities or even examine financial records, they must notify administrative staff first. Even when investigating Sandra O'Brien's conduct, they were required to give as long as four days' notice before visiting the facilities. School attendance records indicate a poor performance by the agency in getting its residents to attend school, one of the few specific program requirements spelled out for all residents under 17. We can only suggest that DCFS examine its contracts with this agency more carefully and conduct its own programmatic and fiscal review before entering into contracts for the next fiscal year. Alternative programs and requests for proposals should be considered.

M. CAUSES

The Commission encountered Child Abuse Unit for Studies, Education, and Services (CAUSES) when pursuing several case studies. The agency's performance and position concerning involvement with other parties in protective services caused us to examine it closely.

In late January, 1981, several Commission investigators interviewed Robert Antrim and Ernest Green of DCFS' Internal Audit Division regarding a recent audit of CAUSES. The auditors cited as a "weakness" the fact that for every case examined in which Dr. Greenberg had been personally involved (regarding consultation with CPS workers), there was absolutely no documentation in the CAUSES files. The explanation offered by a representative of the agency was that the DCFS worker should have the documentation in his file. The only way to verify Greenberg's time spent on cases would be to review every CPS worker's file on every case in which consultation was provided. The auditors did not consider this very practical.

Twelve of CAUSES' employees are paid as independent consultants or contractors, including Dr. Greenberg, despite the fact that Greenberg is listed as the director of the agency. The auditors asked to see copies of the contracts for the twelve contractors, but CAUSES could produce no contracts in effect at the time. They did produce three or four expired contracts, including one that had been for Greenberg.

Green also provided us with information regarding contracts and grants that CAUSES and Greenberg have with DCFS. Three of these are with CAUSES and two with Greenberg personally. The amounts for these contracts and grants are listed below:

1)	Purchase of Service Contracts:	$118,000
2)	Child Abuse Grant:	$ 40,000
3)	"Shelter Center Contract":	(amount unknown at time of audit)
4)	Individual DCFS Consultant:	$ 40 per hour
5)	Contract with the University of Illinois Medical Center:	$ 16,943

Of these contracts and grants, the "Shelter Center Contract" appears to be for diagnostic consultation that Greenberg provides at the DCFS emergency shelter care facility, the Cleaver Street Shelter. Green also told us that DCFS pays the fifth amount listed above directly to the University of Illinois Medical Center to cover part of Greenberg's university salary.

Green told us that Greenberg and CAUSES also share two grants from the federal government, administered by the National Center on Child Abuse and Neglect (NCAAN) of the Department of Health and Human Services (HHS). The first of these grants is a "Clinical Treatment Demonstration Grant" in the amount of $126,200, plus $53,000 in funds carried over from the previous fiscal year. The

second grant is titled "Institute Grant for Sexual Abuse," in the amount of $200,000.

Green added that Greenberg had told him that he spends 40% of his time working through the DCFS contract, 20% of his time working through the DCFS grant, and another 40% of his time working on both federal grant projects. Greenberg's work at the Dwight Correctional Center supposedly is part of the DCFS contract work that he provides.

In March of 1981 we were able to review the actual compliance audit documents themselves. The audit was prepared by Green and Matthew Ciotti. Six major issues were brought to light through this audit.

The first issue is CAUSES' internal controls and an evaluation of present operational procedures. The audit disclosed that not all funds raised were accounted for; it recommended that better business practices be used in accounting procedures in the future.

The second issue was salary and fringe benefits for CAUSES employees. The audit repeats what we have mentioned about the twelve employees also being contractors, including Greenberg. The audit recommends that DCFS' Contract Unit not approve further budgets until CAUSES' subcontractual documents are on file with the Department as required.

The third issue is a review of the basis for allocation of all other costs and a review of CAUSES' disbursement records. The audit determined that occupancy costs were not allocated to all programs being provided by CAUSES. Reasonable accounting methods would have provided the same allocation of 40% for the DCFS contract programs, 20% to the DCFS grant programs, and another 40% to the federal grant programs. The federal program received no allocation at all and there was no accounting classification for management and general expenses. The audit recommended that CAUSES produce documentation to show why occupancy costs were not included in fiscal information; that CAUSES allocate reasonable sums to management and general expenses; and that CAUSES offer documentation as to why DCFS should not request a refund for overpayment.

The fourth issue was travel expenses; the auditors made no recommendation regarding this issue.

The fifth issue was an examination of assets. No assets were purchased in FY 80, and no recommendations were made.

The sixth issue was billings submitted to DCFS from CAUSES. The auditors found that CAUSES' clients' files were missing quarterly reporting forms; that CAUSES' files lacked up-to-date information on clients; and that there was nothing to document that an interview had taken place on the date reflected in billings made to the Department. The auditors found some files with virtually no documentation. The auditors concluded that the case file review in support of billings was not conclusive. The audi-

tors recommended that CAUSES promptly document each client contact in the client's file. The client contact would then serve as evidence of service for each counseling session billed to the Department.

In March of 1981, DCFS furnished the Commission with a progress report on an incest treatment program performed by contract for DCFS. The period covered by the report was July 1, 1978, to June 20, 1979. Greenberg comments in the report that when the incest treatment project began, some of the CAUSES staff had limited knowledge in certain areas concerning incest and incest treatment. Though this lack of knowledge existed, the program proceeded, using what knowledge they had as a basis for diagnosis and treatment of certain types of cases. The project was characterized, in part, as a learning experience.

The incest treatment program in fact consists of two separate programs. The first is the treatment program, which treats families that remain intact with no law enforcement and/or court involvement, or families that remain intact following a report to law enforcement officials, provided there is no further legal action taken.

The second program is a research component. Incest cases are used for data collection. There supposedly had been 400-500 of these cases, of which the treatment cases were considered a "subsample."

Two initial goals of the project are first to attempt to reduce the crisis quality that prevails after the incest is made known outside the family, and the second to promptly provide treatment and services with continuity. The report makes it clear that the agency does not want to handle cases in which there is continuing police or court involvement. The report mentions, as we have, that all sexual abuse cases are referred to CAUSES, and it is at CAUSES' discretion to accept or not accept a case for treatment.

On December 19, 1980, a Commission investigator spoke with Kee Macfarlane, Project Officer for the National Center on Child Abuse and Neglect, Office of Human Development Services, Department of Health and Human Services in Washington, D.C. MacFarlane is a Program Specialist in the field of sexual abuse. We called her to ask for information on the grant awarded to CAUSES for diagnostic assessment and treatment.

We asked MacFarlane what type of grant CAUSES had been given and what the nature of its reporting procedures was. MacFarlane explained the difference between the two grants that had been awarded to CAUSES. The first grant had been awarded in 1978 for a period of 3½ years. This grant is for treatment alone; referrals from DCFS would most likely fall under the purview of this grant. Quarterly reports required by HHS would not list clients' names. The second grant was for $200,000 and covered a three-year period. This National Training Institute Grant was to allow interested

parties to receive training at CAUSES in ways to combat child sexual abuse.

MacFarlane told us that since no methods in use at the time of our telephone conversation seemed to be producing results, new methods must be found that will. She said that CAUSES has offered a program plan that sounds encouraging. She added that she has visited the CAUSES offices and found both projects "hopeful."

MacFarlane also told us that she was responsible for collecting and reviewing all documentation on programs that provide treatment for sexual abuse. She told us that there are about 25 projects that deal with intrafamilial child sexual abuse and two research projects that treat the same subject. CAUSES has one of the latter two grants.

We asked MacFarlane about CAUSES' philosophy of generally not treating separated families or families involved with the law. She responded that NCCAN was hesitant to fund only one type of treatment program. Rather than choose one type of program, it had attempted to fund the full range of programs. She added that there are so many factors that can influence a case of sexual abuse that it is important to have a range of treatment modalities available.

The first year Training Institutes were funded, NCCAN received five proposals and funded one (Henry Giaretto's sexual abuse program in California); the second year, NCCAN had 16 applicants and funded four (including Greenberg's). MacFarlane said that NCCAN chose a national panel of experts in the field to review the proposals before grants were awarded. Six people were chosen, half from public and half from private agencies. MacFarlane said they ran into a slight problem with the panel because it seemed that all of the experts knew one another. MacFarlane said that she did not even read the proposals before the panel made its decision because she knew all of the people submitting proposals.

MacFarlane said that the two ends of the treatment spectrum are represented by CAUSES at one end (no police or court involvement, intact families) and the Harborview program in Seattle (strict criminal justice system involvement). She said that there were legitimate projects not funded because they were too similar to other projects receiving funding. Thus, unfortunately, the merits of the programs mattered less than where they fell on the spectrum. MacFarlane said that this was actually the panel's system and she wasn't sure she agreed with it.

We asked MacFarlane if it were not dangerous to train CPS workers using standards that lay at one end of the spectrum if that end of the spectrum turned out to be wrong, or inappropriate for treatment. In that case, would a state have to retrain its workers in the proper procedure and treatment? MacFarlane responded that these questions were exactly why she was against funding training institutes. Nonetheless, she said that the reason NCCAN could fund Greenberg's program, which generally was opposed to cooperating with police and the courts, was that such a lack of cooperation was not illegal under Illinois law, as it would be under many other states' laws. In many other states, the police must be notified regarding allegations of abuse. Then she said that treatment for sexual abuse is so new that when you provide some service you do not damage the child--you just use different methods if the original methods do not work or are wrong.

MacFarlane claimed that she had challenged Greenberg on more than one occasion about his attitudes and methods. He responded, "I'm a shrink. My job is healing, working with people, it's treatment, it's health. Locking people up is not my job. I don't believe in it. I think it makes them worse. And I won't do anything to support that system." MacFarlane then added that she gets calls all the time from across the country about how incest cases taken to court just do not work. And MacFarlane, who is a psychologist with a private practice, said that she has seen incest victims much worse off because of their involvement with court proceedings.

Soon thereafter, we received a number of documents from MacFarlane. Included was a breakdown of funding for CAUSES' Incest Training Center. Of the $200,000 granted, $92,436 was allocated for personnel expenditures, $51,000 was allocated for contractual services, and $21,800 was budgeted for "other." The budget breakdowns indicate that Greenberg was providing a total of $302,290 in "non-federal resources." This funding consisted of $25,000 from the applicant; $157,290 from the State of Illinois; and $120,000 from "other sources." The budget projected that Greenberg's project would need $200,000 per year for the next three years in federal funds alone.

Included in the federal documentation is a good deal of narrative information about CAUSES, its past history, and its future treatment goals. Relevant information will be excerpted from those documents here. The CAUSES narrative states that the agency was begun in 1973 and first offered parenting training to expectant mothers who were found to be "at-risk." The determination of service needs had been carried out through specific testing done at Illinois Masonic Hospital and three Chicago Department of Health clinics. When DCFS' Child Protective Services unit began to refer children to CAUSES, the realm of services was expanded to include full diagnostic evaluations prior to long-term treatment that included individual psychotherapy and family group therapy.

The document states that CAUSES has received 442 referrals in the previous three years. Regarding CAUSES' relationship with CPS, Greenberg's narrative states that CAUSES has a written agreement with CPS "which authorizes CAUSES to develop a sexual abuse registry on all CPS incoming case reports, to monitor the processing of these cases and jointly with CPS, to assess and plan services for them."

In a section on the program's objectives and expected benefits, the narrative predicts that the training institute will serve 32 trainees, resulting in 12 to 16 new sexual child abuse treatment programs.

Personnel and Budget information also is contained within the material sent to us by NCCAN. Greenberg, as Program Director/Psychiatrist, will earn a 12-month salary of $5,000, devoting 100% of his time to the program. Other staff include a Director of Professional Services, who also will devote 100% of his time to the project, but who will be paid $35,000 a year, and an Institute Program Director, also devoting 100% of his time, and being paid $20,000.

Finally, a portion of this narrative addresses how families will be referred to CAUSES for actual treatment, as well as the governing philosophy behind the agency, a portion of which follows:

> CAUSES Intrafamilial Childhood Sexual Abuse Grant Project serves patients throughout the County of Cook who are referred by the Illinois Department of Children and Family Services, Child Protective Services. Intake criteria for referrals is that there is no evidence that sexual abuse has or might have occurred in an intact family. There should be minimal or no law enforcement/court complication in a case at the point of referral.
>
> The separation of family members including the placement of children occurs only in the context of its therapeutic value. Such procedures are not carried out simply because of law enforcement or agency policies and procedure. The principle, the central or overriding consideration is what will best serve the initiation and continuation of working cooperation to build a functional and serious therapeutic alliance. This treatment philosophy does not imply what is sometimes interpreted to mean that the family should remain intact for the sake of intactness. The overriding and central concept is the development of therapeutic relationships in keeping with the well-being and future development of the child and other children in the family. This point of view recognizes and respects that even an abused child, harmed and exploited by a parent or one so entrusted may well have strong emotional investments in that person. And that it is to that child's short-term and long-range betterment for her hope for a healthy, caring, nurturing and protective parent to be realized through changes in the parent brought about through the commitment of a therapeutic relationship with the parent as well as with the child.
>
> This orientation is not in opposition to separating a parent from a child for the child's protection from continuing sexual abuse and to reduce crises. However, separations are not carried out capriciously or arbitrarily or subjected to the whims of personal emotional convictions and the re-integration of a family living together likewise, it is based on its therapeutic indications which include the child's safety.
>
> The preparation for a family to once again live together needs to be carried out in the context of the family assuming such responsibilities, just as the initiation of a treatment relationship constitutes the responsibility of individuals based on trust, confidence and a growing awareness of the family's and individual's problems so also must these considerations govern their living together again.

> The ordering or commanding through external authority and the coercive power of a threat of punishment built into that situation not only interferes with treatment development but denies individuals of a rare opportunity to begin to assume personal responsibility which is an essential requirement for change. Likewise, the ordering of a family to live apart and then issuing at some unknown later time the command to reunite deny them those opportunities to assume a responsibility for their own lives and future in which the future well-being of a child can best be provided and protected.
>
> Although this project accepts referrals from criminal court and will accept into treatment services to families with a reasonable chance of reunion within a few weeks or months, we are not a component of court-based services and consider this program divisionary from both criminal and juvenile courts.

MacFarlane provided us with a paper that Greenberg had written titled "Ethical Issues in the Treatment of Child Abuse and Neglect," to which is appended a note that the paper was to be published in Proceedings of the Conference on Sexual Victimization of Children: Trauma, Trial and Treatment (Washington, D.C.: Children's Hospital National Medical Center). The paper describes Dr. Greenberg's philosophy and attitudes about incest treatment and the legal system; the excerpts that follow fairly characterize its content:

> The identification and treatment of maltreated children and their abusive parents have come under increasing influence if not control of legal systems including abused and neglected child reporting acts, law enforcement agencies, and juvenile and criminal courts. The meshing of legal systems and child and family services are [sic] a matter of diverse opinion.
>
> One viewpoint states that an effective therapeutic approach depends on the awesome powers of the court and especially so in the matter of intrafamilial childhood sexual abuse or incest. A very different perspective holds that conditions of legal coercion and the threat of punitive action are incompatible with treatment orientations.
>
> Interventions of a social or mental health type and those which characterize legal system interventions may be directly in conflict from an ethical viewpoint.
>
> When a Child Protective Services worker is required to generate information which is of a criminal investigative nature for possible use in law enforcement and prosecution or when a parent is required to offer a plea of guilty in a court of law so that prosecution is less likely and thereby time in a penitentiary is also less likely, the compromise from a strictly social service and mental health model has been made on the side of the legal justice systems. The concept of plea bargaining has entered the world of social and mental health services. Such compromising on the side of certain innovative

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interventions does in fact bring about the erosion of clinical professionalism, its standards and ethics, some of which need to be discussed.

Ethical rules are not synonymous with public opinion and the professional is not entitled to take public opinion as a directive; the professional has an affirmative duty to help shape public attitude.

In the encouragement of open discussion and in the urging of renunciation of concealment by abusive parents of their untoward behavior towards one or more of their children, there is an understanding in psychotherapy that talking about forbidden behavior will not bring about punishment or rejection. The assurance of non-rejection and of a non-punitive response is not possible when the initial interview is being carried out by a worker as an agent of a legal agency not provided with the privilege of professional confidence or by a law enforcement officer serving as a child protective service worker.

The revelation of ideas, relationships, feelings and activities recognized as forbidden and punishable, or as shameful and humiliating is difficult under conditions where the patient or client is safe from punitive consequences or their threat. To assume that this is possible under punitive conditions or their threat or where ordered by an authority under coercive circumstances, approaches the incredulous. A therapeutic relationship involves the search for understanding without rebuff.

Informing a patient that a condition of service is the sharing of information with the court or with law enforcement recognizes that such information could influence decisions on family dislocation, reunification and other major family conditions. These conditions of service certainly influence the content and facility of communication during treatment sessions and pose questions regarding the feasibility of treatment under conditions in which the clinician, social worker or therapist is in fact, directly or indirectly serving as an agent of the court, a clear conflict of interest. When those who represent themselves as professionals, concerned with the feelings and needs of children for their parents, understanding of relations between a cohesive family and the emotional well-being of its members, when these professionals also participate in interventions which serve state ordered threat of penalty involving possible arrest and prosecution, loss of employment, family dislocation and the postponement of efforts to establish working relationships among family members, there occurs serious breaches of ethical conduct.

Greenberg's academic and related appointments listed on his curriculum vitae, which was received from DCFS in 1981 and was undated, follow:

Director, Child Development Clinic and Research Unit, Department of Psychiatry, University of Illinois Abraham Lincoln School of Medicine	1961-present
Associate Professor, Department of Psychiatry, Abraham Lincoln School of Medicine	1967-present
Psychiatric Consultant, Niles Township High Schools	1972-present
Medical Director Childhood Lead Poisoning Control Program, City of Chicago Department of Health	1974-present
Senior Consultant--Child Protective Services (Cook County), Department of Children and Family Services	1974-present
Executive Director Child Abuse Unit for Studies, Education and Services Illinois Masonic Medical Center	1975-present
Clinical Associate Institute for Psychoanalysis, Chicago	1976-present
Consultant, Head Start Training Center, Tuskegee Institute, Alabama	1977-present
Attending Psychiatrist Illinois Masonic Medical Center	1976-present
Chairman, Interdisciplinary Committee On Child Abuse and Neglect, City of Chicago Department of Health	1976-present

We interviewed Greenberg in Commission offices in September, 1981. He told us details of his background, and we asked him questions concerning his involvement in incest treatment and child protection, including the operation of CAUSES.

He told us that he had been involved in a variety of research projects at the University of Illinois Medical School, in cooperation with the Chicago Department of Health, in the 1960's. This work led to the formation of a community health program in Uptown called the Maternal and Child Health Center in 1969. The purpose of the group was to provide services to children in a community health program setting. Greenberg was involved, he said, from

1969-1972 and eventually became the director of the center. Subsequently, Greenberg became the director of a program that grew out of this original project; the new program was called the Uptown Neighborhood Health Center. As he became aware of the fragmented services available to children, Greenberg put together the Uptown Task Force on child abuse. Greenberg said that several DCFS staff members became involved and one of the DCFS administrators noticed the work that he was doing in case consultation. He said that she invited him to become a case consultant for DCFS.

Greenberg's first involvement had to do with intake: he became active in sitting down with night staff to see how they handled calls. Eventually, his involvement led to his availability to all DCFS intake staff.

As the years passed, Greenberg was asked to become more involved in one-to-one consultation with workers. He began visiting area offices to help workers solve problems in their caseloads. Greenberg said that eventually his work became almost a seminar approach, based on case studies that he had done.

Greenberg said that he began case consultation during Director Jerome Miller's tenure, but added that it was during the tenure of Director Margaret Kennedy that he became a paid consultant. Greenberg also wasn't sure what his agreement was for consultation, though he said that he was sure that he would have wanted it to be "pretty much open-ended as far as time spent." Greenberg told us that he put in many more hours than he billed the Department for or was paid for. Greenberg guessed that the consultation rate for that time might have been in the range of $20-25 an hour. He added that though he put in more hours, he guessed that he billed the Department for only four hours per week.

Greenberg told us that one of the problems he tried to deal with early in his work with the Department and now is the Department's lack of clinical services for clients and a concomitant lack of training for staff. Greenberg stated that his frustration at not being able to get clinical services from within DCFS led him to create CAUSES. He felt that DCFS' having to go to the "outside" for clinical assessments and services was a failure, but at least the services then are available. Greenberg told us that the true mark of his success will be if CAUSES goes out of existence because its services have been drawn into the Department where they belong.

Greenberg said that part of his involvement with DCFS is made possible through an arrangement between DCFS and the University of Illinois Medical Center. Through this arrangement, DCFS underwrites part of Greenberg's salary at the university. He said this is in the amount of $15,000, a half-time salary based on 20 hours of work. He added that this amount should go up to $18,000 in 1982.

The contract that DCFS holds with CAUSES for diagnostic center work is separate and makes use of other professionals at CAUSES,

Greenberg explained. Greenberg said that his function is only to assure that services actually are delivered to DCFS clients. Greenberg said that he receives no money from the contract with CAUSES diagnostic center.

Greenberg also told us that the last year he held a contract as DCFS consultant was 1979. He said that this was a personal contract that is no longer in effect. However, he still provides consultation for CPS through the contract that DCFS has with the University of Illinois Medical Center. Time spent through this contract also includes any hours he spends working with the diagnostic center. This payment, then, is based on 20 hours of work per week; Greenberg indicated that actually he puts in 30-40 hours per week. In addition to this time, Greenberg said that he sees between three and five private patients per day.

Greenberg then explained the nature of his relationship with the University of Illinois. In 1961, he was awarded a 10-year career investigator position by the National Institute of Mental Health. In effect, he was awarded a tenured position to conduct research "which enhances the body of knowledge" at the University. He said that the work he does with DCFS fulfills his obligation to the University.

The other half of Greenberg's salary is provided by the Chicago Department of Health for 12-14 hours of work per week.

Greenberg said that the University places no restrictions on his time; he added that he does very little teaching for the University.

Greenberg stated "for the public record" that he intended to retire at age 55 (four years from the time of the interview).

Greenberg told us that since the Directorship of Margaret Kennedy he has had a grant for the study of sexual abuse, but that 1981 would be the grant's final year. He added that he has very little knowledge of the financial elements of the grants and contracts held by CAUSES. Greenberg estimated that he probably spends 15 hours a week on the sexual abuse area. Greenberg estimated that he works 80-90 hours per week, on the average. He added that the number of hours he spends on these different areas will vary from week to week, depending on what is most urgent.

The next project that Greenberg mentioned was the CAUSES program at the Dwight Correctional Center. Greenberg said that he tries to "get down there" at least once a week. He added that his only personal reimbursement was for travel expenses. The emphasis of the program, he said, is on the establishment of "mothers' groups" within the prison and on training Dwight staff to help them deal with abusive mothers. Also, CAUSES staff was providing psychological studies on women coming to Dwight to help identify the group that needs service the most. He told us that Clifford Rot is at Dwight twice a week; that Judy Gentile visits twice a

week; and that Bernice Kravitz is there three times a week. Kravitz supposedly was "inundated" with calls from women requesting her help. Greenberg also said that CAUSES has been active at Dwight for three years, only one of which was through a grant. He said the other two years they provided volunteer services.

We asked Greenberg if CAUSES receives every case of child sexual abuse that comes in to Cook County CPS. He said that while these cases had been referred in the past, the referral was no longer being done. Greenberg added that CAUSES collected data from these referrals, which was then given to DCFS. Greenberg did not know what DCFS did with the material.

Greenberg said that CAUSES will be getting out of some areas of sexual abuse study. The agency still will provide training where there is interest; it will also still provide diagnostic assessments. But he said he will not request any additional funding from DCFS for research on sexual abuse. Greenberg said that he has been involved for some time in the study of infant mortality with the Chicago Department of Health, and he probably would devote more time to that work as his involvement with DCFS decreases.

We specifically questioned Greenberg regarding his views on the role of the criminal justice system in dealing with the physical and sexual abuse of children. Greenberg responded that he felt the issue of the social service system versus the criminal justice system never had been adequately addressed. He felt that any effort to treat a child victim from a criminal justice point of view would end up compromising the social service part of the equation. Either no treatment will be possible in such a case or attempts at treatment will be limited by what the criminal justice system will allow. Greenberg felt that working with a child to get him to testify at a trial could not be considered therapeutic.

Greenberg continued by saying that programs that deal with the criminal justice system rely upon "admissions of guilt" by the father before children or families will be accepted into treatment programs. This admission of guilt, to Greenberg, does nothing but establish a plea bargaining position amenable to the police and the prosecutor. Greenberg claimed that in all of his years in the sexual abuse field, he has encountered only one man who did not admit his guilt (and he felt that man was innocent).

Greenberg's other major complaint about programs that work with the criminal justice system is that many of the offenders actually go to jail. He told us that Henry Giarretto had once mentioned to him that more than half of the men in his own program go to jail for at least two-three months.

In January of 1981, we spoke with John Goad, a CPS supervisor in Chicago. Goad had been briefly involved with one of the incest cases that we have included in this report. We asked him to explain the role that Greenberg and CAUSES had played in the case, and then asked him more general questions that arose from his com-

ments about treatment and reporting. Goad told us that he had problems with the content of reports submitted by CAUSES. But, he added, he thinks that in working with Greenberg, the agency has made progress with reports. At the same time, Goad told us that he was very satisfied with the work that Greenberg has done. He told us that he "trusts Dr. Greenberg without reservation."

Goad also referred to the specifics of the incest case, which had been in and out of treatment with CAUSES for a fairly long period of time. We asked what CPS had done while the case was in treatment, and what it had done when CAUSES terminated treatment with the family. Goad told us that while the family was in treatment, CPS did nothing on the case. When CAUSES terminated the case, apparently CPS still did nothing because, Goad said, the family continued to see Dr. Greenberg as private patients. Goad even said that during most of the period from the first referral to CAUSES until their final termination, the family case file was closed.

When we interviewed then-Cook County CPS Director Jeanine Smith, we asked about Greenberg's involvement with her CPS unit, its history, and what she thought of the work that he had done. She told us that when she came to Cook County, Greenberg already was providing consultation services to what was then called Emergency Protective Services (EPS).

As reports of sexual abuse began to increase in Cook County, Greenberg began to specialize in that area. She told us that Greenberg's "major contract" with the Department was to provide diagnostic services. She said the contract was provided by the Centralized Resource Unit and that she did not write it or work on it. She added that a Request for Proposal (RFP) came from Springfield and Greenberg responded to it. Smith established a five- or six-member advisory committee to review all of the responses to proposals for child abuse grants. Greenberg's grant was one of the first to be awarded by this committee, in 1976-77.

We asked Smith to explain the criteria for sending sexual abuse cases to CAUSES. They include: non-court intervention; a decision based on case staffing with CAUSES workers; and a request for help by a DCFS worker.

We mentioned that CAUSES could do both a diagnosis on a case and a case assessment. The result would be that CAUSES staff could refer the case, by assessment, to CAUSES for treatment. Smith maintained that this was no problem because the DCFS worker would have to instigate this action. She said that it is not true that all cases of sexual abuse are referred to CAUSES. She said that CAUSES receives a copy of each case report, but this is for statistical purposes, not for treatment. Smith added that Greenberg's work in gathering statistics was valuable because it has added to the "body of knowledge" in the field.

We asked Smith about records submitted by CAUSES. She said that individual DCFS case files should contain copies of any mate-

rial submitted or written by CAUSES staff; this would be the responsibility of the DCFS liaison worker. Smith said, then, that not all information is always in the file because of the confidentiality provision regarding mental health cases. However, she said that a telephone call to Greenberg usually could get documents into their hands quickly. Smith also mentioned that the possibility of court intervention might play a part in certain information being omitted from CAUSES records that would go to DCFS.

Smith said that the ultimate decision to take a case to court rests with DCFS, not Nahman Greenberg. Thus, if he is handling cases that require or receive no court intervention, it is because DCFS decided not to take the case to court. Smith added that the DCFS decision to take a case to court or not can happen before, during, or after CAUSES' involvement. She said that Greenberg will follow through on some cases with which the courts are involved, or in which the children have been placed outside of the home, but not many.

We spoke in April of 1982 with Dr. Robert Stein, Cook County Medical Examiner, to see what progress had been made on a program funded by part of one of Greenberg's DCFS grants. This particular grant called for the provision of four separate services, the last of which was for Greenberg to assess the role of child maltreatment in infant and child mortality and to design prevention strategies. This part of the grant called for coordination with the Cook County Medical Examiner's Office and the Infant Mortality and Child Abuse Committees of the Chicago Department of Health.

We learned from Stein that Greenberg had first approached him regarding this service in April, 1982, though the project was to have concluded on August 31, 1981. No one from his office had been approached about establishing cooperative efforts with Greenberg prior to April, 1982.

Also during April we spoke with Doris Ausbrook, Administrative Director, Bureau of Family Health, Chicago Department of Health regarding the same contract. Ausbrook was not aware of any such program or cooperative effort with Greenberg. She called Greenberg, and an investigator spoke with him. He told us that "no real serious program exists but there have been a series of communications--that is what I brought about."

Greenberg said that the program had in fact been instituted through his continuing informal conversations with staff of the Chicago Department of Health and the Cook County Medical Examiner's Office. He said that he had spoken just that week with Dr. Stein.

Greenberg asked our investigator how much time the grant required him to spend on this program. When told the contract called for 18-20 hours per week, Greenberg responded that it would have been impossible to do all the grant called for because there were not enough hours in the day. He told us that we had taken the wording of the grant too literally.

To provide a contrast to Greenberg's method of treating incestuous families, we will refer to an interview that our investigators conducted with Michael O'Brien, Director, Incest Offender Treatment Program, Minnesota Department of Corrections in St. Paul, Minnesota. O'Brien provides case management for convicted sex offenders in treatment. He also provides information for the court when a probation officer needs to present a presentence report. O'Brien told us that his program grew out of the Minnesota legislature's realization that there needed to be some sentencing alternative for incest offenders. O'Brien felt Minnesota had always been in the forefront of states recognizing incest as a special problem. He mentioned that 10% of all reports of sexual child abuse that reached the American Humane Association had come from Minnesota. Obviously, he said, Minnesota does not have 10% of the incest cases in the country, but the state does have a better system for identifying cases.

O'Brien told us that there are 300-400 cases of incest reported in the state each year. The cases are identified through either the child protective services system or the criminal justice system. He estimated that 70% of all cases go unprosecuted.

O'Brien told us that it was important for the incest offender to be removed from the home because it places the responsibility for the crime solely on the offender. If the offender must leave the home, the victim is more likely to feel that the offender was to blame for the incident, not the victim. He also said that the offender then has a goal to work toward--to get back in to the home. Finally, O'Brien pointed out what we have mentioned before, that the power in the family is frequently skewed on the side of the offender and that his power base can be disrupted by forcing him to leave the home, thereby giving the mother and other family members a greater opportunity to develop some strengths of their own.

In contrast to his own approach, O'Brien volunteered information on Greenberg's CAUSES program. O'Brien called the program interesting. He told us that Greenberg feels that the problem exists within the entire family and therefore the entire family must remain intact in order for treatment to be effective. We asked O'Brien what he felt about the problem, and he said that there is a fairly good likelihood that there will be no future abuse even if the offender does remain in the home. The offender usually is very scared about what has happened. However, he said also that the victim should not have to remain afraid to be in the home with the man she has accused of a crime.

O'Brien mentioned that he has met Greenberg and talked to him on occasion at conferences. He indicated that Greenberg felt that incest was misunderstood by the court and that it was a problem of family dysfunction, not a problem of criminal proportions. O'Brien felt that not only should the criminal justice system be involved in treatment of incest offenders, but that it could be an asset to therapy. He said that even for the offender to plead guilty might be good for his mental health.

O'Brien also mentioned that a "typical" sentence in Minnesota will be 5-10 years probation for charges of incest, including successful completion of an incest treatment program. O'Brien's program charges its families for therapy; these charges usually amount to $3,000-$4,000 per year. O'Brien felt that this was an extremely cost-effective approach to counseling, considering prison costs and the possibility of further anti-social behavior by either offender or victim if they remain untreated.

O'Brien gave our investigator a document titled "Guidelines for the Assessment of Incest Offenders." The following excerpt from the document more fully explains this particular treatment approach:

> If the offender is to be treated on an outpatient basis, it has been our experience that such clinical intervention is more effective when it is mandated by the court as part of a disposition in a criminal proceeding. Initially, the offender may make a serious effort to understand himself, his feelings, and the reasons for his offense. Family and marital problems which may have played a contributing role in the offense may be submerged as wife and children feel pressured to unite with the offender against the external threat of prosecution, conviction, incarceration, and disruption of the nuclear family. When these immediate threats and pressures subside, however, there may be a re-emergence of the offender's characterological behavior.

Several other pertinent excerpts from this document are added below. They generally contradict the guidelines used by Greenberg and CAUSES:

Treatment Conditions

1. You are dealing with an unmotivated client. He is not self-referred. It will, therefore, be important to insure his cooperation in a treatment program by having his participation mandated by an external authority such as a court.

2. His sexual offense is not only a symptom, it is also a crime and needs to be dealt with on both levels, requiring a combined mental health/social service and criminal justice intervention.

3. He fears the adverse social and legal consequences of disclosure and will, therefore, tend to deny the offense or minimize his responsibility for his actions. He must not be allowed to deny his offense, minimize the seriousness of his behavior, or project responsibility for his actions elsewhere.

4. He has operated from a position of power in regard to his victim and has maintained his control by effecting secrecy in regard to his offense. The conventional therapeutic contract typically involves confidentiality. For this type of client, confidentiality contributes to the dynamics of secrecy and reinforces the offender's position of power and control. It should be waived. Not only must any suspected or known incident of incestuous behavior be reported to the proper authorities, but also if the offender's spouse is not aware of the situation, he must inform her of it, describing what has occurred. In the case of sibling incest, the parents must be similarly informed. The offender should be told from the outset that the worker may divulge information obtained in treatment to court, probation, parole, or other agencies upon request and whenever such disclosure seems warranted in the judgment of the worker. The clinician's primary responsibility is not the offender-client but the protection and well-being of the victim.

5. Although incest is a sexual offense, it is not predominantly motiviated by sexual needs. It is the sexual expression of non-sexual needs. It will be necessary, therefore, to help the offender uncover the underlying non-sexual needs and issues prompting his offense....

6. Although other family members may play a contributing role in the evolution of the incestuous relationship, the offender's responsibility for the offense cannot be mitigated by viewing incest as solely the product of family dysfunction. The offender must be held accountable and, therefore, family therapy should not be the only and especially not the initial plan of action. It must be preceded by individual treatment.

As this report is being written, CAUSES continues to receive referrals from DCFS and is still operating through federal grants to treat the victims and the perpetrators of child sexual abuse.

Chapter 8

OUT-OF-STATE VISITS AND MULTIDISCIPLINARY TEAMS

This chapter brings together two very important areas of our investigation: a synopsis of investigative activity conducted in other states, and an analysis of the multidisciplinary team approach to child abuse and neglect.

Though we had learned about multidisciplinary teams before we visited seven states, far than Illinois, we learned a good deal about this particular response to the child abuse problem while out of state. The trips provided perspective concerning several different child protection systems; most states provided an interesting and useful contrast to the system in Illinois. The trips also allowed us to explore particular programs of which we had been aware as the investigation progressed.

Many of the states that we visited had established the multidisciplinary team as a tool for handling cases of child abuse and neglect. Still, the different states varied in their approach to use of the M-D team and to methods of formation. This chapter compiles information gleaned from interviews, conferences, and research concerning multidisciplinary teams.

A. Out-of-State Visits

An important part of our investigation was a brief examination of the way other states address child abuse and neglect. We accomplished this not only through a review of available literature, but also through visits to seven other states.

The states we visited were California, Colorado, Florida, Michigan, Minnesota, New York, and Virginia. These were selected for a variety of reasons. One was the level of government responsible for administering child protection programs. According to a 1979 survey by the American Humane Association, Child Protective Services are administered at the state level in 32 states, including Illinois. In the 18 remaining states, such services are administered by county or local agencies but are supervised by the state. Two of the states we visited, Florida and Michigan, have state-administered programs, while the remaining five have county-administered programs. We concentrated more heavily on states with county administration to find out whether placing responsibility at the lower governmental level would have any obvious benefits applicable to Illinois.

There were a variety of other reasons for selecting these states as well, such as a specific program that we wanted to examine first-hand, or the nature of the child abuse problem in the state. In California, for example, we wanted to take a closer

look at the Child Sexual Abuse Treatment Center in Santa Clara County. In Virginia and Colorado we wanted to examine the widespread, and apparently successful, employment of multidisciplinary teams to coordinate the response to child abuse by the wide range of agencies that come in contact with the problem. Traveling to Colorado allowed us to meet with officials of both the American Humane Association and the National Center for the Prevention and Treatment of Child Abuse and Neglect. And New York's system was of particular interest to us because the Illinois statute, as well as one of the model statutes, was drawn from that State's law.

We approached this part of our investigation with caution, however. Making comparisons between states has many limitations since, despite similarities, no two state systems are identical. In fact, there are many differences, sometimes vast differences, between states: in the legal authority of different agencies, the way state and local governments are structured, funding levels, resources, population patterns, the scope of the problem, and the way responsibility for child protection is parcelled out within and among the agencies that address the problem. A program that works quite well in one state may be a total failure if simply transplanted without modification to another.

Consequently, while we tried to learn about the structural organization of the agencies we visited to better understand the context of child protection activities, our overriding interest was in how each state has resolved, or failed to resolve, specific issues that any system that deals with child abuse must address. Specifically, we looked at the following nine elements that exist in any child protection system: definition of child abuse and neglect, identification of abused and neglected children, reporting of suspected abuse, record keeping, investigation, initial intervention, evaluation, formal intervention, monitoring, and ultimate disposition of abuse and neglect cases.

1. Legislative Definitions of Child Abuse and Neglect

As has already been mentioned elsewhere in this report, there is no commonly accepted definition of child abuse and neglect. Most people possess a common-sense understanding of what child abuse is and is not, but the understanding is so imprecise as to render it meaningless for purposes of enforcement by government agencies. The following example of a definition that would be accepted by most people is offered by Brian Fraser: "In the simplest of terms, it [child abuse] is damage to a child for which there is no reasonable explanation. Child abuse is usually not a single physical attack or a single act of molestation or deprivation. It is typically a pattern of behavior. Its effects are cumulative. The longer it continues, the more serious the damage."

The legislatures in all 50 states had to begin with a similar understanding of child abuse and then translate it into statutory language that is enforceable in a consistent manner. They had to describe specifically both the nature of the "damage," as well as the circumstances of the "damage," which, in combination, would be considered child abuse.

Although statutory language is different in every state, there are many similarities, if not in the wording, at least in the application to actual cases. The seven states we visited were no exception. All seven consider physical harm by other than accidental means to be child abuse, and all in some manner attempt to exclude reasonable parental discipline. All of the states we visited also include (directly or indirectly) sexual assault or abuse in the definition. Failure to protect a child from harm is again included as neglect in all seven states. Finally, all but Colorado incorporate mental or emotional abuse into the statute.

With the exception of Colorado, all of the states have what would be considered very broad definitions of child abuse. Colorado limits the definition to incidents or circumstances "which seriously threaten...the health or welfare of a child [emphasis added]," while the other six define abuse simply as "harm."

The broader definition allows for greater potential intervention by government authorities, at least during the initial investigation stage (which will be discussed further). In application this may not be the case, since those states with broad definitions, according to the officials we interviewed in the various states, tend to screen calls more thoroughly prior to initiating an investigation. In fact, initial screening is favored by the American Humane Association.

According to Larry Brown, Director of the Child Protection Division of the American Humane Association, the intake worker who answers the phone is the most crucial person in the system. He should be highly trained and be able to speak at length with the caller to determine whether a field investigation is necessary. Brown felt that the intake worker should be able to use his or her discretion in screening calls, even using subjective screening criteria based on the person's experience. He was critical of the Iowa and Colorado systems, which require field investigations of all allegations, and of the Illinois system, which uses the following substantive screening guidelines: 1) there must be a specific circumstance of harm or expectation of harm, and 2) the involvement of the caretaker in the harm or expected harm must be described.

Without screening by professionals, valuable resources are wasted on unnecessary field investigations. According to Brown, "you can have professional people make responsible decisions." He admitted that there will be mistakes, but emphasized that no system is perfect.

In contrast to this position, Karen Beye of the Colorado Department of Social Services told us that the child protection worker will be dispatched to investigate every allegation of abuse, "no matter how shaky the call."

If the seven states we visited are representative of all states, the broad definition in combination with subjective screening by in-

take workers is the preferred approach. This does not necessarily mean it is the best, however.

2. Identification

Before child protection service workers can intervene to protect a child from harm, they have to be aware that a child is in danger. The problem has to be identified by someone and reported to the proper authorities.

According to a 1976 national study done by the American Humane Association, approximately 40% of cases are identified by a friend, neighbor, relative, parent or parent substitute, a sibling or the victim himself (see Table 8-1). These people are generally in the best position to observe abuse or neglect first-hand. Other reporters (e.g., police, teachers, or doctors) usually can report only on the basis of after effects of abuse, such as injuries or behavioral change in an abused child.

Because child protective workers must rely on others to identify possible abuse, improving the ability of people to recognize abuse as well as promoting the willingness of people to report become major goals of any child protection agency.

Though it is so crucial to effective child abuse intervention efforts, no state that we visited had a comprehensive strategy to improve identification. Most efforts were piecemeal and limited to public awareness campaigns that focused on the existence of child abuse rather than how to identify it, or were limited to occasional training grants geared toward selected subgroups of professionals, such as teachers. Without exception, officials reported that more cases of abuse could be detected earlier if more people knew what to look for and what questions to ask. Oftentimes cases are overlooked simply because abuse is not even considered a possibility.

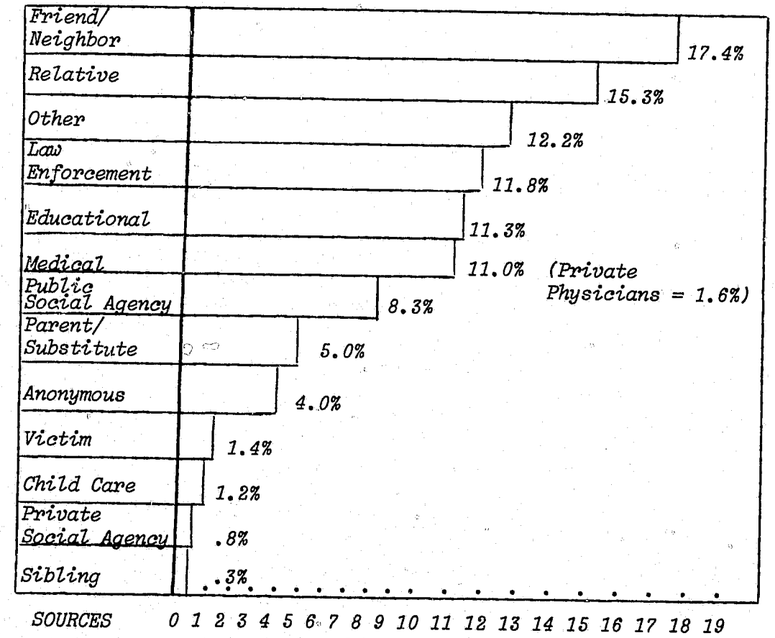
We found one unique program to identify abuse and neglect in Minnesota. Paul Spears of the Minnesota Department of Public Welfare told one of our investigators that every medical assistance report involving services rendered to a child is reviewed to detect possible unreported cases of child abuse. Spears said that the request for reimbursement contains a description of injuries or a list of the symptoms and diagnosis. If the case appears to involve possible abuse or neglect based on the description, a letter will be sent to the doctor reminding him of his child abuse reporting responsibilities. Spears could not supply us with any information regarding the success of this program. However, he said that the Department frequently receives hostile letters from physicians who are upset that their diagnoses have been questioned.

3. Reporting

Although the total number of reported cases of child abuse has increased since the first reporting statute was adopted 20 years ago, it is widely believed that most cases of child abuse still go unreported. To reduce the number of undetected cases, every state has enacted legislation requiring certain professionals to report

Table 8-1

SOURCE OF INITIAL REPORTS - ALL CASES, 1976
(N = 99,701)



From American Humane Association. National Analysis of Official Child Neglect and Abuse Reportings: An Executive Summary. Denver, Colorado, 1978.

suspected child abuse to the agency designated by law to receive such reports. These statutes generally include immunity provisions for reports made in good faith; civil or criminal sanctions for failure to report; and, usually, abrogation of doctor/patient and other specific types of confidentiality privileges.

The language of these reporting statutes varies significantly from state to state. Nevertheless, the group of professionals required to report--law enforcement personnel, doctors, nurses, educators, social workers, and so on--are similar.

The statutes were passed to overcome the unwillingness, or inability due to confidentiality requirements, of many professionals to report suspected abuse or neglect. To the extent that professionals failed to report because of confidentiality or a fear of being sued, the reporting statutes have been successful. However, according to officials in all seven states we visited, the threatened sanctions are totally ineffective in overcoming the professionals' unwillingness to report because they do not trust the system or because they do not want to inconvenience themselves by becoming involved. The law is almost impossible to enforce.

Robert J. Masterson, Deputy District Attorney of Santa Clara County in California, told our investigators that his office vigorously tries to enforce the mandatory reporting statute, but without much success. He said the District Attorney has prosecuted three physicians for failing to report. None of them was convicted.

Similar stories were told to us in other states. About the only time prosecutions are successful is when there is a confession of child abuse that the professional does not pass on to the proper authorities, and an eyewitness to the confession does report it. These occasions are extremely rare.

Recommendations for bolstering the confidence of those professionals who fail to report because they do not trust the system are the source of one of the most hotly debated issues in the child protection field: recommendations about what agency should receive reports of suspected child abuse.

Essentially, states have directed that reports of child abuse be made either to a social service agency, a law enforcement agency, or both. For the last several years, there has been a nationwide campaign underway to remove law enforcement agencies from the picture, except in the most extreme cases. The effort has been based in part on the theory that many professionals and private citizens alike are often reluctant to report their suspicions of abuse for fear that it will lead to punitive and destructive intervention by the police.

We found no solid evidence to support this theory, either in our review of relevant literature or in our visits to other states. In three of the states--Colorado, California, and Minnesota--reports are received by either a social work agency or the police.

These agencies are then required to exchange reports. In the remaining states, the reports are received by a social services agency, which in turn notifies police only if the case meets certain severity standards established by law, rule, or regulation.

Although we have no quantitative data, our impression is that willingness to report is related more to the perceived effectiveness of the overall system than to who receives the report. Satisfaction with the overall system, and thus greater respect for the system, seemed to be higher in Minnesota, Colorado, Virginia, and Michigan than in the other three states we visited. Officials in the former states still reported some problems in overcoming the unwillingness of some people to report, but they were more positive in their statements of progress. The important factor in these states is not who receives reports. Rather, it seems to be the widespread use of multidisciplinary teams, made up of police, state's attorneys, mental health workers, physicians, nurses, and educators in addition to social workers--representatives of all groups of mandated reporters--to review and monitor child abuse cases. The other three states make use of multidisciplinary teams much less and more sporadically; when used they are generally much less representative of community professionals. Even in these states, officials reported greater satisfaction and fewer problems in areas that make use of broadly based multidisciplinary teams, or where close cooperation existed among the many professionals who came in contact with child abuse, including law enforcement personnel.

4. Record Keeping

Most states now make use of statewide central registers to record all reported cases of child abuse. The register in some states is manual; in most it is computerized. The purpose of these registers is generally to assist the responsible authorities in diagnosing and monitoring individual cases of abuse, as well as to provide a means to statistically assess the problem on a statewide level. All states that use central registers must, by federal law, take measures to ensure the confidentiality of the information contained in them.

Generally speaking, a person who suspects child abuse can report directly to the central register, to the responsible local authority, or to the police. No matter who receives the report, it eventually should be forwarded to the central register, within a specified period.

While most authorities in the field agree with the concept behind, and the stated purpose of, central registers, these same authorities have also been quite critical of their actual operation. Douglas Besharov, for example, a proponent of properly operated central registers, states in his 1977 article "Putting Central Registers to Work," that:

> ...nothing is so striking as the failure of almost all existing central register systems to fulfill their stated diagnostic, monitoring and statistical functions....
>
> In their present condition, all but a few registers are unused and unusable. The records in them are grievously incomplete, inaccurate and out-of-date, making the central register a largely ignored appendage of the state's child protection system, one whose existence no one can easily justify.

Central registers have also been the subjects of controversy due to privacy issues. Some authorities believe that the mere existence of central record keeping is an invasion of privacy. In most commentaries we reviewed, however, the concern focused on the inaccuracies that plague almost all central registers, primarily the problem of recording, and later failing to expunge, allegations that prove false. Furthermore, privacy concerns are the source of heated arguments over who should have access to the information.

During our site visits, we confirmed that many problems referenced by Besharov and others are still present. Minnesota was the only state that did not have a central register, but all of the other states complained that a large percentage of reports received by the proper agency are not passed on to the central register. Also, many workers are remiss in forwarding follow-up information. Because of manpower shortages, Colorado officials told us there can be several weeks' delay in getting information entered into the central register even when reports are properly referred to them. And in Florida, where the central register is manual and is used for a variety of other purposes besides keeping track of child abuse cases, we were told that many gaps and inaccuracies are reflected in the files.

Despite these problems, officials in all of the states we visited said the deficiencies are gradually being worked out and expressed the belief that central registers are useful. Some information, even if the accuracy and completeness is suspect and thus has to be double-checked, is better than none. On the other hand, we did not find anyone who believed that a significantly improved central register would lead to major improvements in the quality of child protection. Furthermore, we did not find that the inaccuracies in, or the very existence of, central registers were burning issues among the people we interviewed.

In most states the central registers are maintained by a state social service agency. In Minnesota, which has no central register, the social service agency in each county maintains central files. In California, the Department of Justice maintains the only statewide central file of child abuse reports. This was the only state where only law enforcement authorities have access to information contained in it. Generally, all other states allow access to at least social service agency staff. Most allow at least limited access to medical personnel and police as well. However, Virginia does not without a court order.

5. Investigation/Initial Intervention

As mentioned above, one of the most controversial issues in the field of child protection centers on who should receive reports of suspected abuse or neglect. Part of that dispute is tied to the controversy over who should conduct the initial investigation of child abuse allegations. Simply stated, those on one side of the issue view child abuse as a social problem and therefore believe allegations of abuse should be reported to and investigated by social workers. Those on the other side view child abuse as a crime and insist that the police should investigate reports just as they would any other allegation of criminal wrongdoing. Brian Fraser outlines the position of the two groups as follows:

> Proponents of Police departments as the receiving agency argue that child abuse in serious cases is a crime and that the police are available twenty-four hours a day and seven days a week. Furthermore, the proponents argue that people are accustomed to reporting acts of violence to the police and that police have the unilateral right to enter a home without court permission if they believe that a child is in imminent danger. Opponents, on the other hand, argue that once the parents have been arrested and charged with a crime, it is very unlikely that they will cooperate with the Department of Social Services and begin voluntary treatment. Furthermore, a successful conviction for child abuse in the criminal court is rare and even if a prosecution is successful, it only addresses the need for retribution and not the issue of treatment. Opponents to police departments being the repository of reports of child abuse also argue that child abuse is a very complex problem and police officers do not have the necessary expertise and training to deal with it. Also, the police are viewed as a punitive agency and this punitive ambience will inhibit abusive parents from seeking help. Opponents also argue that police are not viewed with respect by the other agencies and it is unlikely that a police department would be able to develop a cooperative approach.

Fraser also mentions that some commentators have suggested that the juvenile court receive and investigate allegations of child abuse. The primary arguments against the court's involvement in the investigation are that it is already overburdened with cases and that it is also viewed as a punitive agency like the police. Fraser then goes on to offer his own position as follows:

> Over the past few years the majority of commentators and the majority of states have isolated the Department of Social Services as the most appropriate agency to receive and investigate reports of suspected child abuse. They argue convincingly that to prevent child abuse from recurring, it is necessary to provide treatment and the Department of Social Services is uniquely qualified to provide that treatment. Furthermore, personnel in the Department of Social Services are the best trained and the best qualified to handle these cases. Also, the local department is viewed as being non-punitive. They are likely to obtain the

necessary cooperation from parents to make treatment successful. The Department of Social Services also is the agency most likely to be able to develop cooperation with other agencies and professionals. The Department of Social Services can provide treatment in addition to the receipt and the investigation of reports and, in many cases, the Department is already involved with the parents and the child and can intervene before serious injury is inflicted. There are critics of the Department of Social Services, but when all the factors are weighed it is apparent that the Department is the most appropriate agency to receive and investigate reports of child abuse....

Many of the relevant articles we reviewed agreed with Fraser's position. Our field interviews revealed added depth to this issue. It is not clear, as Fraser and others suggest, "that the Department of Social Services is the most appropriate agency to receive and investigate reports of child abuse." Furthermore, we learned that the issue is not simply one of either police or social workers receiving reports. Almost everyone we talked to believed that law enforcement should conduct the initial investigation in at least severe cases of abuse or neglect. For example, Larry Brown of the American Humane Association, an agency that is strongly behind therapeutic intervention in child abuse cases, told our investigators that law enforcement should be included at the initial stage when the social worker's life might be in danger, when child abuse is taking place at that moment, when a child must be removed, and when a severe crime has been committed and evidence must be gathered immediately.

Nevertheless, it was Brown's opinion that child abuse is not a criminal problem, explaining that if cases wind up in court it is usually juvenile court. Therefore, the police, who tend to look for evidence leading toward criminal action, are not needed in 80 percent of the cases. In most cases, Brown said, the way to proceed is not to put the abuser in jail. Social workers should contact the suspected abuser and should establish a therapeutic atmosphere from the beginning by telling the family that they are there to help. Everyone we interviewed felt that law enforcement should be involved in certain cases of child abuse and neglect.

Likewise, everyone we interviewed agreed that there are some cases of minor abuse or neglect in which law enforcement authorities need not become involved. Most police departments already have more than enough demands placed on their resources. Opinion was divided over whether or not a law enforcement presence would be detrimental to the successful handling of less serious child abuse cases.

The heart of the issue seems not to be <u>if</u> law enforcement should be involved, but who decides <u>when</u> they will, and whether or not the mere presence of police has a negative impact on any possible rehabilitation efforts. In those states where police must be advised of all child abuse reports, agreements have generally been worked out between law enforcement agencies and social service agencies

that provide for a prescreening of cases. Those that appear less serious will be handled by the social worker, while those that appear more serious will be handled by police. These agreements also generally provide that the findings of the initial investigation will be reported to the other agency.

In Jefferson County, Colorado, a police officer in plain clothes accompanies a social worker on every investigation. The social worker takes the lead on less serious cases, while the police officer handles those in which criminal action might be warranted. The officials we interviewed in Jefferson County reported a high degree of satisfaction with this arrangement.

Jackie Howell of the Los Angeles Police Department and Sgt. Carole Painter of the Los Angeles County Sheriff's Department are strong advocates of police involvement in child abuse cases. They point out that there is no difference between child abuse and assault, and they observed that the social workers in the Los Angeles area have begun to realize that law enforcement and the courts are helpful in treatment. Often an abusive parent might be helped by treatment but will not voluntarily go along with treatment recommendations. The courts provide the incentive.

The officers added that social workers are not trained to take formal statements, make advisements of legal rights, or collect and preserve evidence. "When you take kids out of their home," said Painter, "you better be able to do that." Even in Juvenile Court proceedings the case has to be properly documented, they stressed.

In states where police are not required to be advised of child abuse reports, these cooperative agreements also exist, although to a lesser extent. In Nassau County, N.Y., for example, the police and county social service agency reported a good working relationship and strong commitment to cooperation. However, in Albany County, the District Attorney had to force the county social service agency to enter into an agreement to notify him of the more severe kinds of cases. The agreement was prompted after two children had died following separate instances of repeated abuse continuing over a period of 18 to 24 months. The social workers in these cases never advised the police or the District Attorney's office until the deaths of the children, preferring instead to handle the cases themselves without law enforcement or court intervention.

Contrary to the views of some commentators, we could find no evidence during our visits to other states that police involvement per se is detrimental. To be sure, some authorities provided examples of police who investigated cases of abuse in an insensitive and incompetent way. But we were also provided examples of social workers who handled investigations just as poorly.

More important, we were given scores of examples of skilled intervention by both police and social workers. The crucial element to successful investigations was proper training for both the

police and the social worker, according to those we interviewed. A critical factor in the success of a child protection program appears to be strong cooperation between the police department and the social service agency. We have seen first-hand that such training and cooperation are possible.

Whoever responds to the report of child abuse, the purpose of the investigation cannot be considered, first and foremost, to be the establishment of a therapeutic relationship with the family, or to put the offender in jail, or even to protect the child. These purposes presuppose that a child has been abused and that there is evidence already on hand to prove it. The fact is that a large percentage of reports are unfounded. In Michigan, for example, we were told that 50% of the reports called in later prove to be false. Consequently, the first thing that must be determined is whether or not an incident occurred or a condition exists that warrants further government intervention. Unless proper grounds can be established, there is no reason to attempt establishing a therapeutic relationship, and there is certainly no justification to put someone in jail or to take any other action to protect a child. Even if abuse is indicated, unless the person who responds properly documents the facts, any immediate action taken will be reversed by the courts, rendering futile all previous efforts.

In serious cases of child abuse, a social worker is clearly not the proper person to conduct the initial investigation. The police should do it with or without a social worker. On the other hand, there appears to be no compelling reason for the police to become involved in the least serious cases. For those cases that fall in between, it appears that either a properly trained police officer or a social worker (or both) could conduct the initial investigation. Since it is frequently not known whether an allegation is even true, much less in which category a case would fall until after the initial contact, it appears crucial that cooperative agreements be worked out between law enforcement officials and social service authorities in advance as to who should respond. This may mean that police should investigate many more reports than, upon further inquiry, the circumstances might really demand.

6. Evaluation, Formal Intervention, Monitoring and Ultimate Disposition

Because of the limited time available to us during our out-of-state trips, we were unable to construct a complete picture of these last four elements of the child protection system in each state. There is not always a clear distinction where one stage ends and another begins. The process can move from evaluation to ultimate disposition within a few days or be extended over several years. There are so many options at each of these later stages, even within a single state, that a comparative discussion of each stage separately could be more confusing than enlightening.

One problem seems to be universal. Too many cases that come into the system remain too long without satisfactory resolution, according to the officials we interviewed. This tends to overload

the entire system and to reduce its effectiveness throughout. Resources for assessing or evaluating cases, for temporary and permanent placement of children, for treating the abused as well as the abuser, and for monitoring progress on cases are strained beyond the system's capacity in every state we visited. Although this strain exists at every step in the process, the problem is most apparent in these later stages, beginning with evaluation.

Evaluation, or assessment, overlaps with the initial investigation. After it is determined that a report is founded, the official on the scene must decide whether or not to take the child into temporary custody for his own safety, and whether immediate criminal action is warranted by the circumstances. Taking custody of the child is justified only when there is cause to believe the child is in immediate danger, and an immediate arrest is usually warranted only in severe cases. A decision on whether to proceed administratively, in civil court, or in criminal court can usually be deferred until later, as long as the facts are properly obtained and documented, and any evidence is gathered and protected.

The availability of temporary placement facilities and the backlog in both civil and criminal court are factors that are taken into consideration at this point. The decision is not based purely on the danger to the child or on evidence that a crime has been committed, according to many we interviewed. Resource limitations seriously affect the quality of the initial assessment of the family situation, which is important for the preparation of a treatment plan.

After the evaluation stage, the process becomes utterly confused in several of the states we visited. Theoretically, the nature of the formal intervention should be based on the assessment and the treatment plan. However, if criminal charges have been filed, the process easily splits between actions taken by the social services agency and actions in criminal court. In those states or areas of states where there is strong cooperation between law enforcement and social services, this split tends not to occur. Those areas that make use of broad-based multidisciplinary teams to review cases of abuse have, by far, more success in keeping all actions--whether administrative, civil, criminal, or a combination--coordinated and focused toward a common goal. They tend to be able to bring more professionals into the overall treatment picture, including teachers, school social workers, family doctors, and others.

The need to have intervention focused toward a common goal in child abuse cases has been widely recognized as vital for many years. Indeed, this is the primary reason for designating a single agency, usually a social service agency, to be responsible to oversee the entire process. In some states we visited, this oversight responsibility has been interpreted to mean total control. The evidence seems overwhelming that in some states, social service professionals have made conscious efforts to conceal incidents of child abuse from the police and prosecutors to maintain control of cases at the formal intervention stage.

Still, many cases of abuse are going to come to the attention of police and prosecutors regardless, since social services and law enforcement have overlapping jurisdiction in most cases. If cooperation does not precede this, law enforcement officials tend not to have much regard for the suggestions of the social workers in the case. An atmosphere of mutual hostility is thus established and becomes self-perpetuating. The ultimate loser is the child the system is supposed to protect.

Within a few months after formal intervention, the responsibility for monitoring cases generally becomes the sole responsibility of the social worker. Where applicable, the court and/or a multidisciplinary team also reviews the case at extended intervals. If the case cannot be brought to a satisfactory resolution quickly, it tends to linger in the system for years without much direct oversight by any government agency. Usually a private agency takes over responsibility by default.

The situation in Illinois is similar, but a child need not languish in the system until he or she is 21. Not every case is disposed in the manner described above. Juvenile Courts maintain a guardianship calendar that contains notations concerning the cases of each ward of the state of Illinois. These case files are reviewed periodically, usually every six months. Not only does a guardian ad litem, an assistant state's attorney, or a judge have the opportunity during these reviews to determine that a child can be released from involvement with the system, but such a determination can be made anytime between these six-month reviews.

All too often, unfortunately, these cases are simply continued until the next six-month review. A judge may decide that if a DCFS worker does not appear in court to present arguments for a child to be released from the Department's care, no such reason exists. And judges are too busy to review all of the 27,000+ cases maintained by DCFS.

Children who are victims of abuse or neglect may not have to enter the labyrinthine DCFS sytem. Sometimes a worker will try to divert a child from the system, and sometimes the worker is successful. Many cases are disposed of without delay. Those that remain in the system generally have been handled poorly, slowly, or involve multiple accusations of abuse.

The system reflects those involved within it. If all caseworkers, judges, and others had more manageable numbers of cases and performed appropriate review of those cases, the system would of course be better. In Illinois, and in other states, too many children do remain part of the system until they reach majority.

B. Multidisciplinary Child Protection Teams

> The increasing frequency of violence of all kinds and in particular the battering of children and women are social phenomena that the ordinary citizen finds hard to understand. The prevention of such brutality should be the aim of civilized societies,

> and those with highly developed social services should be better able to avert them than those less favored. The report of an inquiry into the death by starvation of a baby boy who weighed only 4.5 kilograms at 16 months has therefore caused great disquiet since it revealed a disastrous breakdown in communications between various people involved in trying to offer help. The family doctor treating the child's mother for depression did not know that a health visitor attached to his own practice had been called in to see her son, and in her turn the health visitor, unaware of any urgency concerning the baby's condition, did not report the fact that the mother had twice denied her access to the boy. The senior social worker involved did not recognize the danger signs and failed to call a case conference, and an inspector of the National Association for the Prevention of Cruelty to Children, called in by a neighbor when she was worried about the child, did not call for three days and never gained admission to the home in spite of 13 attempts--but never told anyone else of his involvement in the case.
>
> --John Lister, M.D.
> New England Journal of Medicine, Vol. 294, No. 13

The case mentioned above illustrates how a number of trained professionals can be assigned to a case and still fail to protect a child from abuse and, in this case, death. Social workers and others involved with the protection of children have struggled to find ways to coordinate efforts better, to provide professional case consultation when needed, and to integrate the various roles played by the same professionals in protecting the health and lives of children.

One answer to fragmented and confused services is the multidisciplinary, or interdisciplinary, team concept. The idea behind the use of such a team is simple enough: it merely involves getting representatives of all of the agencies and groups involved with child protection to meet on a regular basis as a team--hence the title, multidisciplinary team (or M-D team). Beyond this simple idea, however, are many varieties of structure, composition, and use. Most such teams consist of at least one social worker, a hospital representative, and a representative from the judicial system. That list, though, represents the bare minimum of professionals who might be involved with a team.

There are so many types of teams it is difficult to describe them, either by function or composition. Some are mandated by state law and consist of representatives of the state department of child welfare, together with other professionals. The list of professionals can be extremely long; it can include police officers, attorneys, doctors, nurses, judges, social workers from both the public and private sectors, counselors, homemakers, and volunteers. Some M-D teams add interested citizens from the community to balance the team and give it more range of composition. Some teams are organized according to the state child welfare sys-

tem. Others are organized along county or community lines. Some are strictly volunteer; others consist of professionals paid for their participation on the teams. Some staff individual cases; others are available to consult on a case that has presented particular problems. Others might develop rules and strategies for coordination of services that then are applied, theoretically, to all cases coming into the child protective system.

In Illinois, DCFS is mandated to establish M-D teams for staffing cases "to the fullest extent feasible." (Ill. Rev. Stat. Ch. 23, ¶ 2057.1.) They can be composed of any professionals or others who seem to be able to cast light on problematic cases. The Commission looked into the value of M-D teams both in Illinois and in other states to see if they might help child protection in Illinois. We reviewed the practices of teams in other states. We examined several different models. We attended conferences in which the very issue of the value of such teams was discussed. Finally, we reviewed the literature that has treated the composition and actual practical use of these teams. This section of the report will reflect what we found through an analysis of the maze of different teams that exist or have been considered for implementation.

1. Information from Interviews

Certainly not all of those with whom we spoke felt that M-D teams represented the most useful or innovative concept to come along. One of the detractors of the concept of the M-D team is John Forrest Lewis, a Program Specialist for the National Center on Child Abuse and Neglect. Lewis offered one of our investigators some definite comments about M-D teams: he told us that the idea looks good on paper but is fraught with shortcomings. Lewis said that the use of M-D teams in Colorado had been successful, but he still felt that it was but one of many useful models for ild protection. Lewis felt it impractical to expect profess nals to devote much time and effort to these teams. It was more likely, he felt, that along with the skilled teams come all of the professional jealousies that exist anyway, just adding to disruption in the system and on individual cases. Lewis felt that often the social worker would be crowded out, even though the social worker should know the subject best. Lewis told us that, in his experience, professionals lost interest in teams and began to send others to take their places at meetings, effectively contradicting the purpose for establishing a team to begin with. Eventually, the team members know nothing about the cases that they are supposed to staff. Eventually, according to Lewis' gloomy prognostications, interest wanes and the team finds itself following the recommendations that a caseworker can make alone.

Lewis qualified his remarks by saying that he felt M-D teams could be useful, to a degree, in smaller cities and in rural areas, where the professionals probably would know each other anyway. He did not think that these teams could be of value in larger metropolitan areas. Lewis commented that cohesion is necessary for such a team to function properly, and that cohesion is lacking in densely populated areas.

As a matter of fact, a Commission investigator sat in on a meeting of the Adams County Multidisciplinary Review Team on Child Abuse in Colorado to determine the effectiveness of just such a team. Colorado state law provides for each county to have such a review team; further, it provides that every report of child abuse be analyzed. The meeting itself is handled in two parts: the first brings together a team leader from the Adams County Social Services Department, an attorney from the District Attorney's Office, and a public health nurse. The second session consists of a meeting with these three people, but joined by representatives of several other agencies and disciplines.

In the meeting that our investigator attended, the public health nurse was not present. A social worker and an attorney read through each case and discussed anything problematic. Each case was presented with caseworker comments and recommendations. At this first meeting stage, the decision would be made to accept the caseworker's recommendation, make a minor change, or refer the case to the larger group for further discussion and review. Of the 30 cases that the small group examined, about half were held over for further review by the larger team.

The larger team would examine significant issues regarding the handling of the case in addition to making new recommendations, if needed. The team would ascertain that the police had been notified as required, the amount of time the social work investigation took, and similar issues. During the larger meeting that we attended, it was determined that one police department or unit had not been reporting cases of abuse as required. The police representative of the team decided to call the appropriate youth officer in the other unit to find out what the problem was.

Other specific cases were analyzed in detail. Questions were raised about the appropriateness of behavior by day care operators and in group homes. In one case, the representative of the county mental health department recognized a family name, so the decision on the case was deferred until the next meeting the following week to bring in additional information. In still another case, it was pointed out that a 13-year-old was in charge of his siblings for several hours each week. The team determined that there did not appear to be a role for the state in the case, but one of the team members mentioned that there was an afternoon program for children at a nearby park that might be appropriate for these children. So even though this last case involved neither abuse nor actual neglect, a solution was proposed to a familial problem.

Our investigator determined from the meetings, conversations, and a review of fact sheets that this team was review-oriented rather than treatment-oriented, as hospital-based teams usually are. The review process allowed individual cases to be discussed, assessments to be modified if necessary, and inter-departmental communication to be fostered, which might not have occurred otherwise. We will include below three paragraphs from the team's guidelines:

The MRT serves in an advisory capacity to the county Department of Social Services and is under its auspices. The Team is required to review the files and other records of a case, including the diagnostic, prognostic, and treatment services being offered to the family in connection with the reported abuse, and makes reports to the county department with suggestions for further action. The public is permitted to attend those portions of the team meetings where the mandatory discussions of public and private agencies' responses are evaluated and to hear the recommendations regarding these responses if they were not timely, adequate, and in compliance with the law.

In addition to review, the Team plays a supportive role to the Social Services staff and can help share the burden of responsibility in making decisions regarding filing court action, removal and return of children, and general case planning. The Team also identifies systems issues when breakdowns occur and advises the Department in ways to educate other agencies and professionals in the community regarding the Child Protection Act and procedures for reporting and completing investigations.

The Team provides feedback or comments on case presentations by making recommendations and suggestions. When recommendations are given, the worker is required to carry out the action; when suggestions are made, the decision to carry the action out is left up to the worker and supervisor.

In Illinois, former head of Cook County CPS Jeanine Smith commented on multidisciplinary teams when we interviewed her. She felt that DCFS needed consultants, not M-D teams. She stressed that someone had to be held accountable for decisions and if the team made a wrong decision, the social worker would be held accountable.

An investigator mentioned to Smith that we had heard the opposite from team members, including social workers, in Denver, when we visited that city. In fact, the social workers had told us that having teams prevented them from becoming scapegoats whenever a poor or unfortunate decision was made. Smith still disagreed and maintained that caseworkers would be held more accountable than other team members. She felt that the teams do have a role in providing consultation to caseworkers, but she strongly felt that the decision-making process was strictly in the province of the caseworker and the supervising caseworker.

Commission staff also visited Michigan, where they talked with two members of the Child Abuse and Neglect Interdisciplinary Team, Social Work Center, University of Michigan at Ann Arbor. We spoke with Kathleen Faller and Donald Duquette, who told us that the team was begun at the University of Michigan in 1976 to help establish a policy for treatment of child abuse. The team was established to consist of professionals from the university's Law, Medical, and Social Work Center schools. The team was set up in such a way that it would handle cases in treatment to see if po-

lice decisions made were really feasible and helpful. Finally, the team was to develop training programs for the Department of Social Services to provide aid to caseworkers.

Both Faller and Duquette are teachers at the University of Michigan and admitted that their roles are more in teaching and training workers than in helping actual team workers to plan treatment for specific cases. As a result, they were able to address such topics as training in more specific terms than actual treatment provision.

Both agreed that caseworkers did not receive adequate training in Michigan. They felt that the lack of training contributed in large measure to caseworker burnout. They were concerned that workers were being sent into the field without proper training. Duquette said that fully half of all child abuse cases in Wayne County would end up in court, yet caseworkers are not trained concerning legal matters or procedures of the courts.

Both also agreed that casework supervisors had often lost touch with what it was like to handle a case on the street. Often they had forgotten the demands of heavy caseloads and the emotional stress of the job that caseworkers had to perform. Generally, they said that this was a problem encountered throughout the public sector. Those who had become most removed from actual work on the streets were making policy that often had little to do with reality. They recommended that caseworkers take a stronger role in actual policy-making.

Both Faller and Duquette talked briefly about interagency communication and the teamwork concept. Their impression was that such communication and cooperation was essential to planning and treatment of child abuse and neglect cases.

As we have mentioned, M-D teams can take many forms and can come about in many different ways. An investigator spoke in 1981 with Scott Nemanich, Chief of the Juvenile Division, Will County State's Attorney's Office, in Joliet, Illinois. Nemanich told us that he had been with the Office for almost four years and had been head of the Juvenile Division for 18 months. He was brought in to clean up a "mess" that existed with the handling of abuse and neglect cases. When he began work in Will County, he said that DCFS workers were at odds with representatives of other agencies and, consequently, little or nothing was being done to combat or treat child abuse and neglect.

Nemanich said that he formed what is called the Youth Action Council, a group composed of representatives of police departments, DCFS, Illinois Status Offender Services (ISOS), Catholic Charities, the Will County Mental Health Department, and a few other interested agencies. The groups met together on a regular basis to develop policy and plans for treatment and planning of child abuse cases. Nemanich said that everyone became very involved with the group and the overall reaction was very favorable. At about this time, DCFS

administrators replaced the old Aurora Region Administrator with a new person, who was described by Nemanich as just what the region needed to become aggressive in providing services to families. The new regional administrator, Les Townsend, conducted a housecleaning, according to Nemanich, that forced the primary "troublemakers" within DCFS to leave.

Because of Nemanich's interest in child abuse and his efforts in Will County, DCFS Director Coler appointed him to the Statewide Advisory Committee on Child Abuse and Neglect. Unfortunately, unlike the M-D team that he had devised, he described the Committee as a failure because of Coler's refusal to consult with members of the committee or to implement their plans.

In 1980, as part of our investigation into child molestation and the response of the criminal justice system, we analyzed a copy of a child abuse grant proposal to fund a Child Protection Team in Lake County, Illinois. The grant came about following the implementation of a treatment-oriented team at St. Therese Hospital in Waukegan (to which we will refer shortly). In basic terms, the hospital program consisted of professionals from the medical, legal, and sociological professions: they included a staff doctor, a hospital social worker or nurse, a DCFS social worker, and a representative from the Lake County State's Attorney's Office. Funding from this grant would employ one assistant state's attorney and a clerical person. The major responsibility of the team would be to organize teams similar to the one at St. Therese's at other hospitals in Lake County. The grant would have provided funds to be utilized by DCFS, after approval. The proposal we analyzed does not describe in narrative form the manner in which the team members would interact, but does break out different functions and responsibilities for the different members of the team. The total budget, which seems quite reasonable, was $38,423.59. Of course, if the grant proved successful, probably additional funding would be necessary to implement this program in every hospital in Lake County.

During that investigation, Commission staff interviewed Dr. Carlos J. Puig, practitioner of emergency room care, member of the Northern Illinois Emergency Physicians, and the physician assigned to the Lake County Child Protection Team (CPT). Dr. Puig was a member of the original team at St. Therese's Hospital in Waukegan. Dr. Puig was critical of DCFS but felt that the use of teams could alleviate some of the more obvious problems facing DCFS workers and administrators.

Puig told us that the team began after Dennis Ryan, State's Attorney of Lake County, read about a multidisciplinary program in Europe which focused on three elements: determining if child abuse had taken place; obtaining input from various fields and disciplines when child abuse was indicated; and providing advice from the team to the court. Ryan then convinced David Kropp, then Director of the Lake Villa DCFS Office, to participate in the program by assigning a social worker from DCFS to the team. Puig mentioned that the team at the time of the interview consisted of

an assistant state's attorney, Puig, a social worker or a nurse from the hospital, and Donald Warner, social worker from DCFS and chairperson of the team. Puig added that DCFS had awarded the grant, allowing DCFS and the State's Attorney's Office to allocate one worker each for the purpose of expanding the concept to other hospitals in Lake County.

Puig told us that his role was to establish "hard evidence" of child abuse for presentation in court. He told us that after 18 months of operation, 38 cases had been staffed by CPT from his hospital alone. All were staffed within 72 hours following the initial physician's report. Puig mentioned that the one problem facing the team was eventual "burnout," when cases begin to become routine and simply alphabetical. He said that the problem could be prevented by shifting staff assigned, but then the team would lose the close working relationships established, as well as the expertise that had been demonstrated by the team already working. Puig had no solution to this problem.

Puig told us that five to seven cases had gone to court. One of the judges in Lake County had commended the team for keeping "nonsense" cases out of court. Puig also mentioned that many doctors are afraid of lawyers; therefore, they do not always report child abuse cases when they should. He said the fear comes from the presentation of their testimony in court. The doctor is always right when it comes to medicine, Puig said, but on cross-examination the doctor's diagnosis can be easily disputed. Puig felt that his own willingness to testify in court on specific cases, and as an expert witness, had been a good example to some of the doctors in the area.

Puig said that the purpose of the team was therapeutic, not to generate criminal cases or statistics. The team had not handled any cases of homicide and apparently would not. He said that the team was designed to concentrate on separating marginal cases from severe cases, to screen sexual abuse, and to assure that perpetrators of severe injuries are prosecuted.

Based on his team experience, Puig offered several suggestions for improvement of child protection. He felt that some arrangement should be made for parenting to be taught. He said this is particularly important in incest cases; in these cases, often the parents are offered counseling and nothing more. He said that counseling will not affect their inappropriate behavior.

At the time of our interivew in 1980, Puig was in favor of a central registry for collection of important data.

Puig felt that each county could be divided into units geographically, each with a child abuse team with the authority to investigate child abuse. Lake County, he felt, could easily be divided into four such areas. He felt that cooperation was the key to success with these teams and that representatives of both private and public agencies had to pool their expertise in order for them to achieve their goals. He added that "personal problems" should not defeat the intended purpose of the team.

Puig felt that judges had to be made aware that those who have repeatedly abused their children, particularly following court intervention, are "diseased" and will be unable to parent their children. They will be able to help themselves only temporarily. Their relapses cannot be prevented, Puig added, indicating that children in such a family should be placed out of the home. He said that therapeutic failures should result in placement because the parents just do not understand how to be parents. Puig recommended that there be legislative guidelines for judges to make determinations on whether children should be removed from the home or allowed to remain. Similarly, there should be guidelines concerning sending children back into the home after they have been removed.

Puig was in the forefront of the M-D team concept in Illinois; his comments and experiences should be important to considerations for implementation of similar teams in the future.

Also in 1980, we interviewed Lake County Juvenile Court Judge Bernard E. Drew, Jr. At the time of the interview, he had been assigned to Lake County Juvenile Court for approximately two years. He had been aware of the work of the Lake County Child Protection Team since its inception. Drew told us that the CPT was a sophisticated and professional approach to child abuse prevention that had his wholehearted support. He was particularly happy that team members study a case from all angles before it is brought to court.

Drew was in favor of more hospitals implementing teams similar to the Lake County model. Commenting on a hospital in Highland Park that had actually said that it had seen no cases of child abuse, they are only "burying their heads in sand," he said.

In late May, 1982, we spoke with Gail Tuler Friedman, a Lake County Assistant State's Attorney, regarding multidisciplinary teams now in effect in that county. She told us that she has been responsible for establishing these hospital-based teams for the past two years or so; she had been hired through the DCFS grant for that exact purpose. She mentioned that in Lake County, there is an agreement between the hospitals, her office, and DCFS that all suspected child abuse and neglect cases coming from hospital pediatric units or emergency rooms be handled by one of these M-D teams.

She told us that each hospital has a team consisting of a representative of her office, a DCFS worker, and various hospital personnel (these individuals could include a pediatrician, emergency room doctor, pediatric nurse, emergency room nurse, hospital social worker, etc., depending on the case). Apparently this agreement extended only to those cases referred from hospitals. According to Friedman, in other cases of child abuse, DCFS feels it is in conformance with the law by having a multidisciplinary team composed of a DCFS nurse from the community, a DCFS investigator, and other DCFS workers staffing cases. In other words, DCFS' M-D teams consist of DCFS employees of several different specialties.

Friedman referred us again to the Colorado and Michigan statutes, both of which mention multidisciplinary teams by name. Commission staff examined the statutes. For purposes of comparison, Colorado's statute follows:

> "Child protection team" means a multidisciplinary team consisting, where possible, of a physician, a representative of the juvenile court or the district court with juvenile jurisdiction, a representative of a local law enforcement agency, a representative of the county department, a representative of a mental health clinic, a representative of a public health department, an attorney, a representative of a public school district, and one or more representatives of the lay community. Each public agency may have more than one participating member on the team; except that, in voting on procedural or policy matters, each public agency shall have only one veto. In no event shall an attorney member of the child protection team be appointed as guardian for the child or as counsel for the parents at any subsequent court proceedings, nor shall the child protection team be composed of fewer than three persons. When any racial ethnic, or linguistic minority group constitutes a significant portion of the population of the jurisdiction of the child protection team, a member of each such minority group shall serve as an additional lay member of the child protection team. At least one of the preceding members of the team shall be chosen on the basis of representing low-income families. The role of the child protection team shall be advisory only.
>
> (Colo. Rev. Stat. ¶ 19-10-103)

Michigan's statute reads:

> The department, in discharging its responsibilities under this act, shall provide, directly or through purchase of services from other agencies and professions, multi-disciplinary services such as those of a pediatrician, psychologist, psychiatrist, public health nurse, social worker, or attorney through the establishment of regionally based or strategically located teams.
>
> (Mich. Stat. Ann. ¶ 25.248(9))

Numerous other individuals interviewed for this investigation commented on the use and value of M-D teams.

2. Information from Workshops

Commission staff concentrated on M-D teams when they attended the 5th National Conference on Child Abuse and Neglect in April, 1981. Staff attended three workshops and picked up descriptive literature on a program operative in Moline, Illinois.

First we will summarize the workshop "Multi-Disciplinary Teams: Are They Really Helpful?" The session's moderator was Francine J.

Vecchiolla from the Department of Children and Youth Services in Connecticut. Members of the panel included:

Larry Breitenstein, Director, CPS, South Carolina Department of Social Services

Jolie Ikard, Administrator, CPS, Arkansas Division of Social Services

Linda Radigan, State Child Protection Coordinator, Social and Rehabilitation Services, Concord, New Hampshire

William Chamberlain, Staff Associate, Child Abuse and Neglect Resource Center, Athens, Georgia

The purpose of the panel discussion was to examine experiences of representatives from several states that had all developed and implemented multidisciplinary teams.

All of the workshop participants mentioned that the multidisciplinary teams with which they worked were new in concept; each state had different ideas concerning how these teams would operate. Nonetheless, many of the problems facing the teams were common to all of the participants. The problems encountered most included issues of confidentiality, the role of members representing different jurisdictions, and what member agency would be responsible for the implementation of recommendations or suggestions developed at team meetings. In addition, the participants were concerned with the fiscal feasibility of maintaining such teams.

Breitenstein, from South Carolina, had worked with both hospital-based teams and treatment advisory teams. He said that his state legislature had mandated the creation of 46 treatment advisory teams, one for each county, to provide assessment and treatment services for cases of abuse and neglect. In addition, the state had one sexual abuse team, three hospital-based teams, and eighteen "community councils" designed to offer public education concerning abuse and neglect.

Breitenstein commented that the early problem, in 1978, was in interesting doctors and teachers in the work the teams were to do. Many of the early teams had little knowledge even about what child abuse was. Breitenstein commented that while the idea behind the teams was good, only those teams that had existed prior to the legislation mandating each county to have one were really successful. Breitenstein said that before a team is created, a careful needs assessment must be done. Because the needs of each community vary, as do their resources, the teams will vary in composition and focus. In organizing teams, educating team members was seen as very important. Classes were held in identification of abuse, the reporting laws, the role of CPS workers, the concept behind treatment and assessment, and other issues. Prevention was also a big issue when the teams were first developed;

he learned that many professionals were completely unaware that prevention services were available to team members.

The panel discussed the issue of confidentiality. In South Carolina, the information developed by a team cannot be shared with anyone outside of the team. Breitenstein told the workshop participants that this provision in the law only made team work more difficult, because if a teacher wanted information, for instance, about a student who may have been an abuse victim, the advising team could not give it to her unless she decided to become a team member.

The South Carolina incest team had done little to affect the problem. However, the nature of the problem didn't prevent the team from working. The team members simply were not dedicated; Breitenstein said that no single member of the team wanted to be held responsible for a child's well-being in incest cases.

Linda Radigan, of New Hampshire, mentioned that there are ten M-D teams operative in her state, eight of which are community-based and provide consultation services. Radigan indicated that the confidentiality issue had not caused too great a problem but still would like to see a legal standard set for the state. Radigan said that numerous questions had been raised regarding this sensitive issue, such as: should a client or her attorney have the right to know about such meetings? Should information discussed be made a part of the client's file? Should confidentiality rules for the team hold precedence over those for the individual agencies?

Radigan said that some of the teams had experimented with discussing cases without using the case name; apparently this tactic had been quite successful with some teams. However, among other teams, the practice had proven to be counter-productive because it fostered distrust among team members. An additional problem was that, at times, team members had open cases on people being discussed and did not know during the meetings that the discussion was about their clients.

Members of the audience with experience in the use of M-D teams were asked to comment on what the teams had done in their states and what the major issues were.

In Minnesota, the state had developed a number of guidelines for the use of M-D teams:

1) All team members sign an agreement that they will abide by some standard which the state agency sets, and that the overall purpose of the team is to protect the client.

2) Clients should always be informed of a meeting and be allowed to attend.

3) A written itinerary should be sent to each team member before a meeting so that work can begin promptly.

4) Non-team members invited to attend must agree to follow the rules of confidentiality that apply to team members.

5) Any written summary should be entered into the client's file.

A representative from Madison, Wisconsin, mentioned that issues included whether the team should actually provide case management and, if so, who should provide it. This person was primarily concerned with interagency cooperation and communication.

The primary issue in Arkansas was confidentiality; the same was true in Vancouver, Washington. In Washington, a representative raised the issue of how one assures confidentiality.

In North Dakota, the primary issue was finding a way to provide resources in the rural community.

A Commission staff member also attended a workshop titled, "Multi-Disciplinary Teams: What Have We Learned?" The presenters included CPS administrators, administrators of state social service programs, and a staff member from the Region IV Child Abuse and Neglect Resource Center. Three were from poor southern states, and two were from the New England area.

Presented first was the multidisciplinary team approach used in Arkansas. We were told that Arkansas is 49th among the states in per capita income and has the highest teenage suicide rate. In Arkansas, the increase in reports of child abuse and neglect increased from 1975 to 1981 by 1400%. During the same period, there was only a 15% increase in social service personnel. There has also been a 25% decrease in funding.

Arkansas has five M-D teams throughout the state, three of which are hospital-based. The other two are community-based. None of these five teams was formed at the request or mandate of any state agency. All were private initiatives. Membership in two of the teams is not even formally defined. Only one of the five has a formal review process; still another completely rejects the formal review approach. Two of the five groups have specific criteria concerning what to place on their agenda. At the same time, though, all of the teams respond to crisis situations. None of the groups meets only by appointment or schedule. The presenter said that most team members "are not formally trained or educated" in multidisciplinary team work, though each represented a specialty on the team. In spite of the many differences among the teams, all five were viewed as being quite successful.

It was pointed out that Arkansas M-D teams probably don't offer better case management than do individual caseworkers, but there are pluses in that workers learn skills, gain added strengths, and provide better liaison to the community.

Another presenter, from Region IV, stated that the primary purpose of teams is to fulfill community needs, not to provide case

consultation. He said that teams should function for the following purposes, and in this particular order: as community-based teams; for case consultation as social service teams; as treatment-providing teams; and as mixed models (teams that provide portions of other services just mentioned). He added that urban teams must differ from rural teams, though he did not elaborate.

He also said that M-D teams in the future will have to address two very important areas: prevention, and effective use of community resources.

All of the presenters agreed that there are three major problems facing multidisciplinary teams right now. These are confidentiality; legal liability of individual team members; and the cost to government to organize and maintain teams. The representative from Region IV stressed that it is imperative that we educate our legislators concerning what a team is and how it operates so that confidentiality does not continue to pose a problem.

Several presenters agreed that teams should begin at the community level with volunteer professionals. They mentioned that these teams are experimental by their very nature and should be allowed to go through natural change. The presenters admitted that the problem with teams that are not mandated by law is that the team members are at greater risk of becoming legally liable. A panel member from one of the southern states mentioned that just such a problem had arisen in his state. Still, they generally agreed that as social services dwindle, low-level community involvement is the way to move--particularly with volunteers.

They mentioned that there is usually an initial fear among social workers when teams begin. They are afraid to utilize them. Teams can point out mistakes that workers have made, they may at least initially increase the amount of paperwork required, and they can present "turf" problems, from the social worker's perspective.

One of the panel members mentioned that if a "systems approach" is not developed, any team will take a full year to just get started. When we asked what a "systems approach" is, we were told it refers simply to good, thorough planning. Volunteers in particular must be trained and oriented before the team begins to work, not after.

One of the panel members said that volunteer hours and any donated or in-kind costs should be totalled and the amount given to legislators, who might feel that teams are too expensive to implement. She said that in Connecticut, each team of volunteers saves the state $13,000 per year in donated time and services. One of the other panel members added that it makes no sense to create teams that do not utilize volunteers because it will save no money. South Carolina pays a portion of the costs of M-D teams, but one person noted that Louisiana spends $500,000 per year just paying professionals to serve on teams, an expense very difficult to justify to state legislators. The only way to determine if the use of teams is really cost effective, the presenters agreed, is to

look at the costs of not using the court so much, not using jails, and perhaps determining costs saved by not utilizing other services.

One of the panel members raised the issue of liability again. One presenter said that it is essential that legislatures provide immunity from liability for the work that professionals do on M-D teams. One panel member noted that in Alabama the problem is avoided because all cases that are staffed are treated as "hypothetical cases," as though no one knows the case is real or knows the identity of the people involved. He added that this process also skirts the confidentiality problem; then he added that the problem with using cases in this way is that it may also be illegal.

All of the panel members agreed that the teams that fare poorly are usually set up by "outsiders" from the state department of child protection or welfare. One panel member mentioned that state-sponsored teams "did more damage than they helped." The state social service workers have tried to turn the problem around by stressing, in their team consultation, education, prevention, and pure case consultation. They have backed away from interference in "local matters."

The representative from South Carolina mentioned that information in his state may be shared only with other team members, not even with teachers or policemen who may have reported a case.

The panel members agreed that, when possible, those involved with a case, particularly the client, should be notified when the team is going to discuss their case. Not only might they have a legal right to be present, but the panel members felt that the prognosis for work with that person would be better.

The presenters agreed that the law is needed to "legitimize" teams. The panel member from New Hampshire suggested that all team members agree to be bound by the same legal restrictions as CPS workers. This would alleviate the liability and confidentiality anxieties. All non-team members invited to a meeting would have to agree to the same restrictions.

A Commission investigator also attended a session at the Conference titled "Working Together: Ways to Implement Statewide Training Programs for Mandated Reporters." The workshop was presented by Paul M. Kiley, Consultant, Minnesota Department of Public Welfare, St. Paul, Minnesota. The focus of the workshop was on the Minnesota experience in developing and implementing statewide education and training for child development, counseling, education, and law enforcement professionals. The workshop was identified as one of those that treats multidisciplinary ideas.

Kiley mentioned early in his presentation that one of the first things he learned from his work in Minnesota was that one cannot assume that mandated reporters even know they are mandated reporters. They have to be told, and then told what sorts of training might be available for them to better learn how to identify and report child abuse. In determining who should provide training oversight for

reporters, Kiley mentioned that each state should determine who can perform the task as well as do it cost-effectively. He added that the Minnesota experience had shown him that it is best to "rely on the disciplines to train themselves (cops train cops; teachers train teachers; etc.)." Then it is the responsibility of the overseeing agency to train the trainers. Kiley mentioned important qualities to look for in selecting trainers. They include: credibility within their discipline; experience with their discipline; and honesty about their feelings.

Kiley said that the trainer of mandated reporters has to deal with peoples' fears of what their report will mean to them. And they need to understand how the system is set up to monitor calls. They need to know what will happen after a report is made. Kiley recommended that CPS staff provide training regarding this part of the report. Kiley commented that "the real goal in training is not so much an increase in the number of reports, but in the accuracy of the reports made."

Kiley also made the point that proper training of reporters can foster a degree of cooperation among the different disciplines. He said that it is very important for people to understand how they fit into the realm of child protection and that the breaking down of "territory" by one profession will not weaken anyone's position within the overall system.

Of greater value was material we picked up at the Conference that dealt with the Council on Children at Risk (CCR), the Inter-Agency Coordinating Project in Moline, Illinois. The Council presented its materials at one of the several forums presented at the Conference, in which Conference participants could pick up descriptive literature and, if they wished, speak with representatives of different programs.

The CCR serves the entire Quad-City area by assisting agencies in coordination of service delivery to families that have been identified as abusive or at risk. The project brings together all agencies, both public and private, involved in cases referred to it. The project consists of several different teams, each of which is diverse and composed of several different team members. Team members might include, for instance, a representative from the law enforcement sector, a school representative, someone from a local hospital, someone from a private social service agency, the referring agency caseworker (such as a DCFS caseworker), and representatives from other public social service agencies. The CCR would then coordinate the activities of all the team members on any given case.

In order for a case to be referred to CCR, the following criteria must be met:

1) The case must be open either with DCFS or the Iowa Department of Social Services.

2) Severe or chronic abuse must be present, or

3) The case must be a high risk/potential abuse or neglect case.

4) Multiple problems must exist within the case--e.g., marital, financial, mental or physical health problems in combination.

5) The activities of at least three agencies should be coordinated.

The family involved must agree to cooperate and sign a release of information to allow team members access to all information, including the State's Attorney if there is to be court involvement. Interestingly, since involvement by the family is voluntary, they can include or exclude whichever team members they want. It is the responsibility of the referring agency to keep team members abreast of court dates and the outcomes of hearings.

Finally, we will present a few excerpts from the literature disseminated by the CCR, including a portion of the group's project description:

> The Council on Children at Risk Inter-Agency Coordinating Project assists Quad City community agencies in coordinating and planning services for individual families in which child abuse or neglect has been an identified problem or risk. The project's purpose is to provide a vehicle through which available community services can be used efficiently and effectively, casework goals can be achieved through the concerted efforts of all involved service providers and the client family, and needed services can more readily be identified and developed.

Objectives

A. Ventilate case related concerns and frustrations.
B. Share decision-making responsibilities.
C. Resolve conflicts.
D. Provide positive feedback and affirmation to workers and families.

Inter-Agency Case Coordinating Process
Guidelines Regarding Confidentiality

1. Because absolute confidentiality cannot be guaranteed, client families should be informed of this reality by the referring caseworker.

2. The release of information form must be approved and signed by the client family before case coordinating services can be implemented.

3. The family should be informed that a written staffing report will be disseminated to the team members.

4. Only representatives of the agencies/organizations listed on the release will be permitted to participate in the staffing process. The family must approve the addition of new team members by having their names added to the release form.

5. Summary staffing reports will be stamped confidential and sent only to authorized team members.

6. In order to release information shared at staffings or copies of the staffing reports to persons who are not listed on the release, team members should refer to their own organization's policies concerning confidentiality and the release of information. (If no such policy exists, please check with the appropriate person in your organization for guidance.)

So pressing is the confidentiality issue that the CCR spends a great deal more space in their descriptive information dealing with it than with the entire process of team development, referral, termination of services, and evaluation. It must be a consideration in the development of any multidisciplinary team.

3. Research

One of the earliest documents that we reviewed during our investigation is the 1978 "Multidisciplinary Teams in Child Abuse and Neglect Programs," a special report from the National Center on Child Abuse and Neglect. The general introduction points out that M-D teams are needed because child abuse is a problem with multiple consequences among overlapping professions.

The report also describes the types of teams in use at the time it was written. Hospital-based programs usually provide evaluation, consultation, and crisis intervention rather than continuing direct service. The report singles out one program in Baltimore that has provided such direct treatment; it is considered successful because it is composed of staff members who are willing to become intensely involved with their clients.

Interagency programs are another category of M-D team. These community-based teams enhance communication and cooperation between the many agencies involved in child abuse. They also may provide a network whereby "hospital-shopping" abusive parents (those who abuse their children and take them to different hospitals following each injury to escape detection by authorities) can be identified. These teams may try to educate the community regarding the reporting of abuse. Further, "Some teams combine the function of interagency cooperation with that of direct responsibility for case management and service delivery."

Another type is the "state-mandated multidisciplinary team" provided for by law. The report specifically mentions teams that have been established in Colorado, Michigan, Missouri, California,

Pennsylvania, and Virginia. Each of these states has a program that differs slightly from the others. The language of the enabling statutes ranges from very specific to extremely vague, as in California's authorization of pilot M-D teams in three counties. The authors also have included in the report a directory of those programs throughout the country that utilize a multidisciplinary approach. Included are two Illinois groups, both located in Chicago: the Child Advocate Association, and the American Red Cross' Parent Aides--Volunteers in Support of Visiting Nurses Association--Neglected Children. Singled out as a team approach that appears to be exemplary is Virginia's. A portion of that state's guidelines follows:

> In order for a multidisciplinary child abuse and neglect team to meet the full spectrum of a community's needs, the team should consist of two general components or committees: a case Consultation Committee and a Program Development Committee.

The guidelines indicate that a community-based team should:

1) have a written statement clearly identifying its purpose;

2) obtain sanction and support from influential community groups;

3) have a written statement of operating procedures;

4) be permanent;

5) use state laws to write operational definitions of abuse and neglect;

6) base their size on their purpose, and reflect the spectrum of preventive and treatment resources available to abused children in their membership;

7) involve a representative from the military if a military installation exists within the community; and

8) develop ways to involve citizen participation.

Finally, the guidelines also address the proper area for a team to cover, more about citizen participation, parent and child rights, inter-agency agreements that might be necessary, and methods of program evaluation and research.

The report focuses also on the Pennsylvania model, noting that this state's guidelines recommend written statements of goals and operations procedures and that such a group be permanent and supported by community groups whenever possible. Pennsylvania's guidelines for team composition follow in part:

> Representatives from the fields of social service, health, mental health, education, law enforcement, legal profession, and elected governmental officials should be included.
>
> In areas where military bases are located, a representative of this sector should be included.
>
> There should be representatives from the community at large (non-agency members)....
>
> Qualifications include the ability to contribute to the solution of problems and carry out the responsibilities of membership through a willingness to serve on a continuing basis. Minimally, members shall have demonstrated an interest in and concern about child abuse and neglect.

The Pennsylvania guidelines also address citizen participation in detail, areas to be covered geographically, community standards of care, program planning and development, case consultation, and evaluation and research.

Commission staff also reviewed Design and Development of Multidisciplinary Child Protection Teams: Considerations for Use in Implementing Section 7.1 of The Abused and Neglected Child Reporting Act by Greg Busch, a Special Consultant to DCFS. The report includes an Illinois directory and a brief discussion of five specific teams.

Busch's report presents his own interpretation of the section of statute that mandates the use of M-D teams in Illinois, as well as DCFS' interpretation of what that statute means. The salient excerpts from his arguments follow:

> To the fullest extent feasible, the Department shall cooperate with and seek the cooperation and involvement of all appropriate public and private agencies, including health, education, social service and law enforcement agencies, courts of competent jurisdiction, and agencies, organizations, or programs providing or concerned with human services related to the prevention, identification, or treatment of child abuse and neglect.
>
> Such cooperation and involvement shall include joint consultation and services, joint planning, joint case management, joint public education and information services, joint utilization of facilities, joint staff development and other training, and the creation of multidisciplinary case diagnostic, case handling, case management, and policy planning teams.
>
> New requirements imposed by section 7.1 do not obligate the Department to use multidisciplinary teams, but do require that an effort be made to make them a part of child protective services. A strict interpretation would suggest that only when multidisciplinary teams are demonstrably not "feasible" should their use not be pursued.

...the most obvious role for multidisciplinary teams is to provide advice or consultation on the different decisions CPS Units must make.

The Act does not prescribe an organizational locus for multidisciplinary teams of any type. But, teams based outside the Department seem most likely, and are clearly consistent with the intent of section 7.1.

Busch states that three of the state's eight DCFS regions are without a single team; also, less than 2% of child protection cases in the rest of the state have any type of team involvement. Busch also lists the three types of M-D teams, based on the three major phases of CPS functions. As we shall see momentarily, the greatest number of teams provide diagnostic and service planning. Case coordination or treatment has a single program in the Aurora Region and another in the Peoria Region. Under the heading "community policy planning," there is only one team in the whole state, in the Aurora Region. Regions with "diagnostic and service planning" teams are broken down as follows:

Aurora..... 7
Cook County.....20
Marion..... 3
Peoria..... 3
Springfield..... 1

Busch comments that all Illinois teams vary according to team type, functional duties, and the "availability of participants." He notes that almost all Illinois teams utilize permanent, voluntary members: "Exceptions are found in Springfield's team with rotating members, Rock Island's diagnostic team with paid consultants, and the two case coordination teams in the State."

Regarding the relationship that these teams have to DCFS, Busch offers the following:

...multidisciplinary teams shall have an advisory relation to CPS units. An exception to this rule may arise if treatment services of some types arranged for but not provided by the Department are performed by a multidisciplinary team. Advisory relations might take either a voluntary or contractual form. In the former case, a written agreement should, and in the latter must, provide the basis for the relationship...the multidisciplinary team might relate either to a CPS unit...or to a Regional Office.

Busch also addresses the issue of confidentiality, though he provides no solutions:

Since no general authorization for release of Department CPS records to members of multidisciplinary teams appears in the Reporting Act, one may certainly question how it is that teams are to obtain the information they need to assist CPS Units.

MULTIDISCIPLINARY TEAM FUNDING BY REGION

REGION	FUNDING RECIPIENT		FUNDING SOURCE		
	COORDINATOR	OTHER MEMBRS.	DCFS*	IN-KIND	OTHER
Aurora	7		7	8	?
Cook Co.			20	20	
Marion	1		1	3	
Peoria	2	1	2	4	2
Sprfld.	1		1	1	1

*Includes lump sum grants, purchase-of-service contracts in which team services are units of care to a case, and staff support and participation.

NUMBER OF MULTIDISCIPLINARY TEAMS WITH ESTABLISHED POLICIES ON TARGET POPULATION/CASE SELECTION

REGION	NUMBER OF TEAMS
Aurora	1*
Cook County	?
Marion	0
Peoria	1*
Springfield	0

*Both of these are case coordination type teams; and both report a need for further refinement of policies and DCFS-team communications.

MULTIDISCIPLINARY TEAM MEETING FREQUENCY BY REGION

REGION	WEEKLY	REGULAR MONTHLY	OTHER	AS NEEDED
Aurora		1		8
Chicago	15	1	1	3
Marion		2	1	
Peoria	1		1	2
Springfield			1	

Design and Development of Multidisciplinary Child Protection Teams: Considerations for Use in Implementing Section 7.1 of the Abused and Neglected Child Reporting Act. Greg Busch, Special Consultant, DCFS, c. 1981.

DCFS TABLES ON MULTIDISCIPLINARY TEAMS

NUMBER OF DIAGNOSTIC AND SERVICE PLANNING TEAMS WITH SELECTED MEMBERS BY REGION

REGION	MEMBERS								
	DCFS	SOCIAL WORKER	M.D.	COORD.	PSYCH.	ATTORNEY	DEV. SPEC.	LAW ENFORCE	OTHER OCCASION
Aurora	7	7	7	7				6	7
Chicago	20	20	20	20	1	0	0	0	15
Marion	3	2	1	3	3	1	2	2	3
Peoria	3	3	3	3	1		2	1	2
Springfield	1	1	1	1	1	1			1

LOCATION OF MULTIDISCIPLINARY TEAMS BY REGION

REGION	LOCATION	
	HOSPITAL	COMMUNITY
Aurora	7	2
Cook County	20	0
Marion	2	1
Peoria	1	3
Springfield	1*	0

*Sponsored by non-hospital organization.

NUMBER OF TEAMS IN TYPE OF RELATION TO DCFS BY REGION

REGION	FORMAL RELATIONSHIP			
	VOLUNTARY	CONTRACTUAL	CPS UNIT	REGION
Aurora	8	1	9	
Cook County	20			20
Marion	3		3	
Peoria	2	2	4	
Springfield	1			1

Busch also briefly describes several of the teams operative in the state, including the program in Moline that we have summarized. Also briefly summarized are Springfield's Family Stress Consultation Team, Waukegan's Child Protection Team (also described herein), and two "case consultation treatment teams," one in Lake Villa and the other a function of the CCR in Moline.

Busch concludes his report with this statement:

> It is likely that important lessons can be learned from the study of the multidisciplinary teams that have "gone out of business" in the past few years in the Champaign, Marion, Peoria and Rockford Regions....The lack of systematic evaluative studies of multidisciplinary teams makes selection of program policies more difficult. It is impossible to point to an "ideal" team model, nor is it likely that any single approach would work throughout the State. This suggests that an exploratory approach should be taken, perhaps through demonstration projects with evaluation components, and/or evaluations of existing teams....It is likely, in the author's view, that any study of multidisciplinary teams will conclude that they are infeasible unless team services are targeted on particular kinds of cases most in need of such intensive intervention. The present willy-nilly use of most multidisciplinary teams in Illinois is not only a questionable use of resources, but appears in some instances to detract from effective service delivery....The Department now funds teams through Child Abuse Grants and purchase-of-service agreements, and provides technical assistance formally (e.g., in the Marion region) and informally (through individual field staff initiative of various kinds). Additional or alternative methods for each should be explored if the team approach is to be expanded.

Clearly, Busch's role was to provide justification for the Department's use of multidisciplinary teams as they have progressed in Illinois. Unfortunately, he is correct when he points out their "willy-nilly" nature. The Commission will address the issue of these multidisciplinary teams specifically in our conclusions and recommendations.

Another source describing an M-D team in Illinois is Theodore R. LeBlang's 1979 article "The Family Stress Consultation Team: An Illinois Approach to Protective Services." LeBlang is a counsel and Professor of Medical Jurisprudence at Southern Illinois University School of Medicine in Springfield. He directs a family consultation team similar to that described in his article.

LeBlang's interdisciplinary team includes representatives from the following disciplines: child psychiatry or psychology, social work, medicine (pediatrics or family practice), public health, and law. The team meets weekly, and each of these disciplines has at least six representatives, thus ensuring that at least one is available each week to represent his discipline.

Besides the staff mentioned, a team coordinator, a DCFS liaison, and a "protective services consultant" (possibly a CPS worker) also attend each session. All of the team members are volunteers except for the team coordinator, whose job is to schedule cases that need to be discussed and to be sure that all pertinent information has been gathered. He also prepares an agenda and minutes, acts as liaison to DCFS and other agencies, and chairs each meeting.

The other professionals present specific information and make recommendations from their respective fields. The primary process is described as follows:

> The most critical component of team functioning is the multidisciplinary consultation conference, held weekly and on call at the request of DCFS caseworkers who are dealing with abuse or neglect situations requiring additional professional input ....The informal atmosphere at the sessions permits free exchange of opinions....This free interchange helps develop multidisciplinary recommendations.

This particular team has enjoyed considerable success, according to LeBlang. In less than three years the team had resolved more than 100 cases originating in central Illinois and had received a positive evaluation from DCFS.

Continuing our review of the research, we analyzed the federal Department of Health and Human Services User Manual on the subject, James L. Jenkins' A Community Approach/ The Child Protection Coordinating Committee. Jenkins and his co-authors state that, like many social problems, child abuse is a problem of the total community, thereby making the community responsible legally, morally, and ethically to assume an active role in response to child abuse.

This manual was designed to be used by community members (not just professionals); it describes some of the essential activities involved in planning, organizing, and operating a "community-wide child protection coordinating committee." Such committees are essential because

> A coordinated community is better able to initiate essential services that do not currently exist and to minimize duplication of services....The committee provides an organizational structure in which community agencies, organizations, and concerned individuals can work together to overcome the problems of child maltreatment in the community.

Specific functions include encouraging agencies to develop policies for cooperation; analyzing needs and resources; determining community awareness needs and resources; making program recommendations; developing new community resources as needed; reviewing service delivery; serving as advocates for children and families; and, most importantly, establishing and/or facilitating multidisciplinary child abuse and neglect case consultation teams. The manual also mentions who should sit on the committee, a list that

we have presented before.

The manual states that, in order to succeed, three or four professionals will have to sit down and assess community needs and resources. These three or four people, as a core group, must be dedicated and concerned individuals. Before establishing a larger group, this core group has to determine strategy. The manual includes charts and narrative information to help such a group get started.

Specifically regarding the facilitation of multidisciplinary consultation teams, the manual states: "The following steps are suggested as one approach to organizing and facilitating the development of case consultation teams":

*agree on purpose, goals and objectives

*appoint members

*select leader

*define the roles and responsibilities of members

*establish guidelines and procedures for case discussion

*determine meeting schedules and identify procedures for calling emergency meetings

The manual stresses that the coordinating committee be accountable to the community at large and to its member organizations and agencies.

Finally, Commission investigators were given a good deal of material regarding multidisciplinary teams when they visited New York State. Most of the material we received was given to us by Mary Jane Cotter, Coordinator for the Mayor's Task Force on Child Abuse in New York City. We also received material that is state-oriented. When investigators spoke with Cotter, she said that within the last two or three years there had been a great deal of interest in multidisciplinary teams in the New York City area. Ultimately, from a series of meetings, each of the five boroughs of New York City developed a team. Two major types of teams were considered: diagnostic and treatment, and prevention. The prevention team is not really what it appears; this team would deal with cases in which abuse has been reported but has been determined to be unfounded, but where there is still reason to believe the family may be at risk to abuse or neglect a child in the future. This team would also examine cases referred by an agency in which there had been no report of abuse made.

The consultation committees considering establishing these teams determined that they could be set up at field offices of social service departments, or at other agency offices. The teams could take a lead role or simply have an advisory role. The committee also determined that decisions concerning focus would have to be made: would the teams deal with all cases of abuse, or would there be a specialized team to handle cases of child sexual abuse, for instance?

One of the documents we received noted that the idea of interdisciplinary teams had met with great resistance from the Staten Island Field Office. Caseworkers there felt that teams would infringe on their responsibilities. These workers were insecure in their jobs. A particularly successful team in the Bronx had avoided this problem by introducing the idea of the team long before its implementation, making clear the responsibilities of different individuals participating in the team process.

Also included in this documentation is a position paper from the Human Resources Administration which affirmed its support of the establishment of these interdisciplinary teams: "Looking at the accomplishments of the past year, we find that the interdisciplinary team has proven to be a most effective means for delivering quality child protective services." The position paper also comments on two teams that were in existence prior to the coordinated effort to establish these teams in each borough: "Although they function according to different models, each team reflects a coordinated approach which utilizes the expertise of Social Services and community agencies to diagnose and treat families reported for suspected child abuse or maltreatment."

a. The Role of Educators

In our research on M-D teams, we reviewed several books and articles on the responsibilities of the different professions involved in such teams. One of the key issues we addressed is the role of the schools and educators in the prevention, reporting, treatment, and, follow-up of abuse and neglect. In 1977 Brian G. Fraser published a booklet with the National Committee for Prevention of Child Abuse in Chicago entitled "The Educator and Child Abuse." Fraser points out that many educators are fearful to admit or report cases of child abuse. Such reluctance stems from ignorance of laws protecting educators from liability for reporting a case that is determined to be unfounded. Furthermore, Fraser's booklet points out that educators are required to report child abuse, since they are among the list of "mandated reporters," and that they can be penalized if they fail to report child abuse. Fraser also presents the argument that often teachers and other educators are the "last of line defense" against child abuse: if they fail to detect and report child abuse, maybe no one will.

Another document we reviewed is another manual in the User Series previously mentioned. This one, by Diane Broadhurst, is titled The Educator's Role in the Prevention and Treatment of Child Abuse and Neglect. The manual points out that schools are the only place that children are seen daily over periods of time by professionals, who are in a position to note and evaluate their physical appearance and behavior. The manual also notes that abuse and neglect are tied closely to learning, citing research that had demonstrated that abused and neglected children often perform below grade-level in key academic areas.

The manual strongly recommends the school's notifying the parents if abuse or neglect is suspected in children. It mentions that communication can solve some of the problems that may have led to the abuse or neglect to begin with. But the manual warns that an educator should never contact a parent with the object of trying to "prove" abuse or neglect through accusations or demands for explanations. The manual states that, increasingly, schools should notify parents about reports being made to the authorities. Such notification typically states the legal authority for the report and casts no blame on a parent. Parents are told to expect a visit from a CPS worker and are told that they can expect the concern and appropriate support of the school. The manual says that schools that have instituted this procedure report good results in working further with the parents.

The manual mentions many difficulties in the reporting of abuse by school personnel. It says that some teachers strongly feel that parents should be allowed to utilize any discipline they feel is essential. Some principals fail to file formal reports and try to deal with the abusive parents themselves or ignore the abuse altogether. We will present the responses of several principals to general questions presented by our investigators early in this investigation. The responses, to be included in the second part of this report, show the range of feelings about reporting among principals. This manual mentions that principals who fail to report are not only obstructive but are breaking the law. Superintendents of school districts who fail to provide in-service training relative to abuse and neglect identification and reporting are also viewed as obstructive.

The manual presents an array of services and attitudes that the school can provide once abusive or neglectful behavior has been identified. Educators should be alert to further abuse but remain non-judgmental. Schools can provide programs on parent education, early childhood, adult education, and counseling. Social workers in schools can make special efforts to work with the parents of abused children. Furthermore, the manual suggests that at times abused or neglected children may need special school services, much the same as handicapped children need. The manual suggests, when possible, that schools approach such programs with the active participation of the parent. Such special programs are most often effective if the parents are involved. Abused children can also benefit from school-related functions already available, including free lunches, visits from the school nurse, and after-school day care.

Broadhurst urges that educators be included in M-D teams, which usually are composed of concerned community doctors, nurses, social workers, attorneys, and other professionals:

> The team concept is an excellent one, and one with which educators are thoroughly familiar. In fact, in many communities, the school individualized educational planning team can serve as a model for the community-based case consultation teams.

> Educators can make additional contributions to the team. They can lend their expertise in the areas of child development; "special children," e.g., hyperactive or retarded children; and the educational needs of children, etc."

The manual also mentions the kinds of curricula that can be adopted by high schools and even junior high schools to prepare children for the eventual task of parenthood. Many schools do not offer courses in parenting. The manual states that in some school districts, married students and adolescent parents are excluded from the traditional academic programs and extracurricular activities. Broadhurst points out the likelihood that such exclusion can only heighten the loneliness and isolation already experienced by these adolescents.

The manual also addresses the issue of corporal punishment in the schools. Broadhurst says:

> The issue of corporal punishment in schools requires careful examination. There is a paradox in discouraging parental use of corporal punishment while permitting educator use of it. One may argue that it is a matter of degree. But educators too may become angry while punishing a child, and the result may not be discipline, but abuse. Strict control of corporal punishment may be another way to prevent child abuse and neglect.

Finally, the manual recommends that schools sponsor programs jointly with various community groups to deal with child abuse and neglect, including training seminars for persons who work with children, and general public awareness campaigns.

On September 25, 1980, a Commission investigator attended the Third Annual Governor's Conference on Child Abuse, sponsored by the Illinois Chapter for Prevention of Child Abuse. One of the workshops he attended was titled "The Roles of Schools in Child Abuse" and was moderated by Richard J. Martwick, Superintendent of the Cook County Education Service Region. Several large issues concerning the role of the schools in child abuse and neglect reporting, treatment, etc., were discussed at this session.

One of the first issues concerned possible preventive measures that schools could adopt. There was disagreement among workshop participants over whether schools could in fact prevent child abuse. The participants agreed, however, that bringing the subject of abuse to the attention of students and teaching respect for human life, coupled with education programs and other parent education through the PTA/PTO, should be considered effective preventive measures.

The participants agreed that the major role that schools play is in detection of abuse and neglect. All agreed that all school personnel should be conversant with the appropriate laws regarding

detection and reporting of child abuse, including their duty under the law. In-service programs should be provided by schools and districts. The participants agreed that though there is no legal requirement beyond mere reporting, a team composed of the reporting teacher, the school nurse, and the school psychologist or social worker should be involved in child abuse and neglect situations.

Some workshop participants expressed the opinion that the stronger reporting law, which now requires teachers to report directly, may actually have a negative effect on reporting. They were concerned over the identity of the teacher being known as the reporter of abuse. One school still had a policy, contrary to law, that a teacher report abuse to the school nurse or psychologist so that the teacher is not drawn into further proceedings.

In a discussion of identification, it became clear that schools were not doing their share in reporting and identifying abuse and neglect. It was pointed out that DCFS gets reports in about 50% of their cases on children of school age. However, only 5-6% of their reports at the time were coming from schools, indicating that there is a wide gap in school identification/reporting and the actual incidence of abuse and neglect. The participants in this workshop were unable to agree on the profile of a "typical" abused child and said that the indicators of abuse and neglect are too broad. Teachers agreed that they needed to adopt a questioning attitude if they were to detect abuse at all.

Some participants pointed out that there is a covert kind of relationship between school officials and parents, and that this relationship is destroyed when a parent is reported. The otherwise confidential nature of the parent/school relationship is altered when a report is made. The teachers agreed that it is important to adopt an unemotional method of telling the parents that a report has been or is about to be made. Only if that process is handled professionally can one expect the case to be resolved successfully. Often parents become scared or hostile if notified in the wrong manner. Some teachers mentioned that it is essential that schools become aware of community resources; at some point in most abuse cases, the school no longer will be the appropriate place to deal with abuse, and referrals should be made.

In discussing the issue of legal responsibility of a school toward a child, most participants and listeners alike at the workshop agreed that it often didn't seem to do any good to make a report to DCFS if DCFS unfounds the case and thus does not follow up on it. This was one reason that schools have to develop local resources--to deal with those times that they feel that abuse has occurred but DCFS disagrees, effectively denying any further involvement or treatment. One school official commented that he puts through the call to DCFS but mentions that the school will handle the situation itself. Then if DCFS gets involved, fine, but if it doesn't, something still will be done about the case.

The teachers discussed follow-up. They agreed that follow-up is necessary in all cases, particularly for the sake of the child. Some teachers said that they felt partially to blame for the abuse occurring. Most teachers agreed that DCFS should report back to them on cases so that they know what is happening to prevent recurrence of abuse or neglect. The teachers agreed that this procedure was not generally followed. One teacher pointed out that under the new reporting law there can be a requirement placed on DCFS to report back if requested.

In "The Educator and Child Abuse," Brian G. Fraser points out that an immediate indicator of abuse or neglect is habitual absences from school. Educators also should be wary if the parents, once contacted, appear to be alcoholic or drug addicts or if they show signs of loss of control over a child. Fraser recommends that educators take an overly-active role as opposed to a too-passive role.

Commission staff also analyzed Michael Halperin's 1979 book Helping Maltreated Children: School and Community Involvement. Halperin's initial chapters discuss the fact that schools have already involved themselves in many aspects of a child's health; there is ample precedent and reason for them to be further concerned that a child is not being abused or neglected while at home. He makes the interesting point that no school that endorses and utilizes corporal punishment can effectively assess anything but the most severe child abuse in the home, because the techniques used by school staff to enforce rules might be exactly the same as the parents'.

Ideally, a school should develop a child study team that would deal with any child with an educational or social problem that might prevent a child from reaching his potential. These teams would operate as small multidisciplinary teams but without the multiplicity of disciplines. They can address issues in the school, schedule conferences with parents, and try to provide for follow-up in the home.

Halperin specifically addresses the role of the guidance counselor. This person should: act as the reporting official, particularly when the principal is absent; provide supportive individual and small group sessions for children experiencing problems at home; observe children through classroom visits and also in their own homes; serve as leader of any child study team developed; and coordinate school and community resources.

b. The Role of Hospitals and Physicians

Another User Manual from the National Center on Child Abuse and Neglect is entitled Guidelines for the Hospital and Clinic: Management of Child Abuse and Neglect, by Barton D. Schmitt and others. It presents a number of charts and forms that can be used as models for hospital personnel. It also provides step-by-step instructions concerning management of child abuse and neglect cases by hospital personnel. The document states that it is cri-

tical for a hospital to designate a single person to be the liaison person to monitor reports of child abuse and neglect so that they do not get lost in the hospital. Without such a person, any response to alleged cases of abuse or neglect will be handled extremely inconsistently.

Further, all hospitals should have written policy and guidelines for the handling of child abuse and neglect cases. All hospital personnel should be familiar with the procedures. Cases of alleged abuse and neglect should be given the highest priority, according to this document.

The document states that hospital personnel should always be aware of the possibility of abuse and neglect with child injuries but should not incriminate the parents in thought or action. Parents should be notified when a case may be diagnosed as abuse or neglect and should be allowed to admit their own children into the hospital if they agree, without intervention by the hospital, the police, or the local social service agency. Only when the parents refuse should these other agencies be brought in to obtain protective custody. The document does state that parents should only be told of a likely diagnosis of abuse/neglect when that diagnosis is fairly certain. If personnel are not certain but are suspicious, the document recommends that personnel tell parents that a child needs hospitalization for further observation and tests. In speaking with the parents, the manual says, "One can state: 'Your explanation for the injury is insufficient. Even though it wasn't intentional, someone injured this child. I am obligated by (your State) law to report all suspicious injuries to children.'"

The manual states that all siblings should be brought to the hospital for a full examination within 12 hours of the initial case report on a child abused or neglected. A court order may be necessary to accomplish this, the manual states.

The manual reiterates what we have learned is DCFS policy: that the ultimate goal is for the parents to assume responsibility for their children and to provide for them adequately. Parents should be encouraged to visit frequently, and it should be stressed that parental interaction with children may be a key to their further ability to retain custody of their children. Hospital personnel should keep a running log of dates of visits, duration of these visits, and what each parent does during such visits.

The manual states that, in court, a physician's statement that it is highly unlikely that an injury was accidental puts the burden of proof on the parents to show that they did not injure their child. Successful court hearings are assured by a doctor retaining accurate and complete medical records, reviewing them before the court hearing, and sharing his knowledge with the protective service agency's lawyer. ER records should be brought to court to be submitted into evidence, and x-rays and photographs of injuries also should be brought to court.

This manual provides some information about failure-to-thrive infants. There are many causes for failure-to-thrive, but physicians must remain aware that two of the most common are underfeeding (nutritional deprivation) and general neglect. These problems are confirmed when a failure-to-thrive infant below normal age weight when brought to the hospital easily puts on weight. In many of these cases, though a mother may claim that a child is receiving adequate calories, children are placed on restrictive and bizarre diets, for a variety of reasons. The manual points out that in 5-10% of all failure-to-thrive infants there are also broken bones, which are usually found only when x-rays are taken. These fractures usually are in some stage of healing and are rarely recent. If they were, they would be indicative of abuse and the child's weight problems would be seen as concomitant to the abusive environment from which the child comes.

We also reviewed a 1976 article by noted child abuse expert Eli H. Newberger, M.D., entitled "A Physician's Perspective on the Inter-Disciplinary Management of Child Abuse." Newberger was at that time Director of the Family Development Study and Chief of the Family Development Clinic at the Children's Hospital Medical Center in Boston. He also was an instructor in Pediatrics at Harvard Medical School.

The focus of his article rests on "limiting factors" that Newberger has identified as retarding successful interdisciplinary response to victims of child abuse and neglect. These include: lack of understanding by members of one professional discipline of the ethics and procedures of others; lack of communication from one agency to another; confusion as to which agency should assume responsibility at different times; "professional chauvinism"; too much work for everyone in the child protective field and the ensuing sense of helplessness by all, leading to abandonment of the interdisciplinary approach; "institutional relationships" that limit communication among professionals, such as staff at one hospital being hesitant to communicate fully with staff from another hospital; the prevailing attitude that abusers should be treated in a punitive fashion (because many professionals, such as doctors, may turn away from a system perceived or designed to be punitive and not rehabilitative); lack of confidence and trust across disciplines; and cultural isolation of professional personnel (most professionals are white and of a particular cultural tradition and probably know nothing about other cultures or traditions).

Newberger also makes the interesting point that in the hospital the doctor is accustomed to thinking of himself as the "boss" and may be reluctant to share his information or skills with others, particularly other doctors at other hospitals. Newberger sees this as extremely unfortunate, but he feels that it can be corrected with proper education and retraining.

A recent article by Jean Caldwell in the Boston Globe (reprinted in the Chicago Sun-Times, October 17, 1982) deals with the physician's role in detecting child abuse. Ronald Reeves,

a military pathologist who specializes in child abuse cases, pointed out that many of the indications of abuse that a doctor will see will be quite subtle. As many as 40 percent of children beaten to death will show no external signs of injury. Reeves pointed out that the physician should listen carefully to the explanation of any injuries. If the explanation does not fit the injuries--for example, if there are no splash marks on a child said to have accidentally fallen into a tub of scalding water--the doctor should suspect abuse. "Children don't lie about injuries," Reeves said. The physician should listen carefully to the child's account of the injuries.

Reeves said that it is difficult to ask doctors to be suspicious every time an injured child is treated. He insists, though, that the only way to detect the more subtle cases is to pay close attention to the more subtle clues. A thorough exam with the child completely undressed should be performed when there is the slightest possibility of physical or sexual abuse. Finally, a complete autopsy should be performed whenever a child dies unattended by a doctor or under strange circumstances.

c. The Role of Law Enforcement

Commission staff also reviewed a 1976 document from the National Institute of Law Enforcement and Criminal Justice, Arnold Schuchter's Prescriptive Package: Child Abuse Intervention. The author mentions that his report is the first on the subject written from the perspective of criminal justice. It offers a model system that emphasizes medical treatment for the child and due process for both parents and children. All child abuse cases are handled as medical emergencies under this plan. Hospitals to which abused children are taken are to be licensed by the state in accordance with certain written standards that are both "medical and procedural." This hospital becomes the primary decision-making arena for diagnostic assessment of all suspected child abuse cases. The plan states that a trauma team, or multidisciplinary team, does not become involved with a case until after a petition has been filed stating that abuse did actually occur.

The local city or county attorney would receive reports of suspected child abuse. He would determine whether the information in the medical report was sufficient for a petition to be filed. Petitions would be filed whenever there is probable cause. If there is only suspicion of child abuse, a "pre-petition investigation" must be completed within three days of the report's being received by the prosecutor. No agency that could conceivably play a role in treatment or disposition of the case is to be involved in such investigation. This would, in effect, move child protective services workers and their functions from the beginning of intervention in child abuse cases to the end of the disposition of such cases, where their limited resources could be better utilized.

In the place of central registers, the author recommends implementing a "Child Abuse Information File," a tightly-restricted source of information located within the courts. Such a file would not be a part of any social welfare function.

In terms of reporting, the author states that, "A major reason for professional underreporting...is lack of confidence in the child protective law enforcement and judicial system that handles suspected abuse cases after a report is made....Consequently, at this time, we advocate improvement of services provided by the child protection system as the more effective method of increasing reporting." While on its face this plan sounds realistic, the author of the model plan also recommends eliminating any penalty for not reporting.

This proposal would require the court to appoint an attorney for every child in court as a victim of child abuse or neglect. This attorney would not also serve the normal functions of a guardian ad litem. Further, the guardian ad litem should never be a local child protective services attorney, since the interests of the parent and the child may conflict.

The thrust of this proposal is that medical institutions would become "the fulcrum for system change" rather than social service agencies or the courts. The authors argue that the system could be implemented with only minor changes in the systems now in place. In practical terms in Illinois, for instance, this system would relieve CPS workers from the burden of conducting investigations. Pre-petition investigations would be handled by the local prosecutor's office. Hospitals would take on increased responsibilities, particularly in screening of child abuse and neglect cases. This would allow CPS and other DCFS workers to concentrate their efforts on service and development of a reasonable service plan.

Multidisciplinary teams have been mandated in several states. They have been suggested as tools for the management of child abuse and neglect cases and as oversight mechanisms for social service agencies. While such teams have met with mixed reactions, generally they appear to be useful, forward-thinking cooperative groups of people genuinely interested in dealing with abuse and neglect. The many models vary considerably, but our investigation has determined that the most successful teams include volunteers, utilize as many professional disciplines as possible, and are community-based. The smaller the geographic area served, the more successful the team is likely to be. Involvement of a state social worker is essential, but this person should not be paid simply to serve on such teams throughout part of the state. The person should be a volunteer who serves on the team as a small portion of his duties as a CPS worker.

Late in 1981, we received a list of priorities from the Illinois Commission on Children. Fifth on the list of sixteen priorities was "children in need of protection." In the brief

discussion concerning this priority, the first item on the agenda of recommendations is: "Multi-disciplinary teams are needed to evaluate child abuse cases and coordinate the numerous community agencies."

All of the evidence, not the least of which includes our case studies in this report, points toward the value of M-D teams. Our specific conclusions and recommendations regarding the establishment of such teams are included in the following chapter.

Chapter 9

PUBLIC HEARINGS

During our investigation of child abuse, we often encountered references to multidisciplinary child protection teams (see Chapter 8). It became clear that such teams would help solve many problems in Illinois' child protective network, just as they had in Colorado and Virginia. Although the teams' value was manifest, some details of implementation and operation in Illinois warranted further examination. For this reason, the Commission held public hearings on multidisciplinary teams February 15, 1983.

As we explain in Chapter 8, section 7.1 of the Abused and Neglected Child Reporting Act encourages the Department of Children and Family Services (DCFS) to create multidisciplinary teams, but DCFS has not fully implemented such teams. Thus, we proposed an amendment which would require such teams, specifying their composition and duties.

Witnesses at the hearings included spokespersons from State's Attorney's offices, hospital-based multidisciplinary teams, a juvenile court, two contractual agencies, and DCFS.

A. Testimony

Co-Chairman Aaron Jaffe opened the hearings by describing the concerns which led him to sponsor House Resolution 776 and the value of multidisciplinary teams in allaying those concerns. He then called upon the first witness, the Commission's Chief Investigator.

1. Thomas Hampson

Hampson began by pointing out that DCFS does not alone bear responsibility for protecting Illinois' children; the Department must always cooperate with other agencies in detecting, counseling, and housing abused children. Unfortunately, Hampson said, we did not see the necessary cooperation during our investigation. In fact, we often heard complaints from other agencies about lack of DCFS cooperation. Hampson noted, however, that DCFS has made significant improvements in the last three years, including the statewide, toll-free child abuse hotline; the computerized central register; and policies regarding immediate notification of State's Attorneys and the Chicago Police Department. Still, further improvement is needed.

Hampson then explained our recommendation of a statewide network of multidisciplinary teams patterned after those in Colorado and Virginia (see Chapter 10, recommendation 1). He described the teams' members, saying they would be responsible for case oversight, management, and planning. Hampson emphasized that the teams "must have decision-making authority in the treatment plan and not function in only an advisory capacity," though he acknowledged DCFS' ultimate responsibility for all child abuse and neglect reports.

The multidisciplinary teams' main purposes would be "to develop model policies and procedures to be followed by all agencies that come in contact with abused children; to disseminate those policies and procedures to their colleagues, and to encourage the cooperation of all agencies and professionals in their communities."

After Hampson's prepared statement, the Commissioners asked him to clarify a few points. Regarding membership, Hampson said that each team's coordinator, the DCFS representative, would appoint members according to the community's needs. These members' salaries would be paid by the agencies they work for, not the state, and so the teams would cost the state only the DCFS caseworkers' salaries plus about 20% of those salaries for administrative expenses. Hampson said that the teams' cost would be more than justified by the saved hours and enhanced efficiency of multidisciplinary cooperation. Finally, Hampson said the teams would review unusual cases--cases that the original DCFS caseworker was unsure how to handle. He said the teams might also randomly monitor cases for procedural correctness.

2. Teresa Maganzini

The second witness was a Cook County Assistant State's Attorney and supervisor of the office's Child Abuse and Neglect Unit. In her prepared statement, Maganzini first discussed the high volume of child abuse and neglect cases in her office: "In Cook County alone as many as 350 new children per month may require the protection of the juvenile court due to the most serious forms of abuse and neglect." She said that multidisciplinary teams could not be involved in every case reported to DCFS, and recommended that the teams advise DCFS "not in those cases where the facts are clear," but when "there is a real question as to what disposition would be in the best interests of the child."

From Maganzini's viewpoint as an assistant state's attorney, the team could participate in child abuse proceedings at two stages. First, in cases where emergency protective custody is not being considered, the team could help decide whether court involvement is needed. Second, in cases where children have been removed from their homes, the team could help decide whether the children could return home safely.

Finally, Maganzini cautioned that legal mandates must be remembered when setting up the teams. The law gives DCFS primary responsibility for investigating and serving disfunctioning families, and the county state's attorney's office is mandated to prosecute the cases. Maganzini said that "careful study should be given to developing a system wherein the team concept can be incorporated within the legal framework so as to be truly cooperative and not antagonistic or competitive."

Upon being questioned by Co-Chairman Jaffe, Maganzini said she agreed that there has been antagonism between departments, and that multidisciplinary teams therefore are an excellent idea in theory. She also said she has seen such teams work to children's benefit.

Though she is not opposed to multidisciplinary teams, she is concerned that their meetings could become mere forums for airing professional differences. Co-Chairman Hastert then asked, simply, if the teams would work. Maganzini answered that they had a chance of working well if their functions and responsibilities were more clearly specified.

3. Neil J. Hochstadt and Linda L. Groetzinger

Hochstadt co-directs the Child Protection Team at La Rabida Children's Hospital and Research Center in Chicago, where he also serves as director of the Behavioral Science Department. Groetzinger coordinates the Child Protection Team at the University of Illinois' Health Sciences Center in Chicago while serving its pediatric clinic as a medical social worker.

Dr. Hochstadt called child abuse "a very complex and varied phenomenon." He said that the "complexity of the problem demands a multidisciplinary approach to adequately diagnose, plan, treat and follow-up abuse victims and their families." He then briefly described La Rabida's multidisciplinary team, saying that it was based on the following premises:

--the team provides DCFS with a comprehensive evaluation of the child and the family before decisions are made.

--"The multidisciplinary team must be involved as soon after the abuse is reported as possible."

--Because child abuse and neglect are most often chronic problems, long-term involvement and follow-up are required.

--"Child abuse victims and families often come from disorganized fragmented homes, from disorganized fragmented communities and very often are placed in a disorganized fragmented protective service and child welfare system. The multidisciplinary team must coordinate and organize all aspects of the follow-up treatment plan."

Dr. Hochstadt then gave some cautions regarding multidisciplinary teams. He said that the team's members need to have a common sense of mission gained through working together daily. He warned that he has seen "agencies misuse the multidisciplinary evaluation process, albeit inadvertently, to cover for the lack of adequate services," and that the "multidisciplinary team is only as good as the available services." Too often, Hochstadt said, "the abused child receives endless rounds of diagnostic work-ups but never receives any of the services recommended."

Hochstadt then made three recommendations:

1) "Regional multidisciplinary evaluation centers should be established in medical centers. ...[These centers] would serve as central diagnostic facilities for child abuse and neglect victims."

2) "...the regional multidisciplinary teams [should] be responsible for the long-term follow-up of all the children evaluated by the team."

3) The teams should "begin their evaluation as soon after the child abuse is reported as possible."

In closing, Dr. Hochstadt wished the Commission well in developing "this important piece of legislation."

From questioning, the Commissioners learned that Hochstadt thought multidisciplinary teams were useful for unusual or very serious cases. As examples, he mentioned children who have sustained serious injuries that may be permanent, such as head trauma; children who have failed in foster care and thus are at high risk for emotional problems; and abused children with chronic illnesses or handicaps.

Linda Groetzinger described the University of Illinois team, which has four functions:

--to review all cases reported by the Center to DCFS as suspected abuse or neglect cases, as well as all questionable cases which may require reporting;

--to provide discussion, consultation, and case planning together as a team, assisting all staff involved in such cases;

--to gather statistical data and report on child abuse and neglect cases of the health sciences center; and

--to offer education and consultation on child abuse and neglect to all areas of the center.

Groetzinger made three specific suggestions regarding the Commission's proposed legislation:

1) "While functions of the team and roles and responsibilities of each member can be defined in a general way through legislation, each community and each team must establish such definitions specifically to meet the needs and express the uniqueness of the individual community."

2) All team members should "be representing and to some degree accountable to agencies, professional associations, or citizens' groups."

3) "All members...should be trained in the field of child abuse in an ongoing fashion, including an extensive knowledge of the community's experience, agencies, and systems in this field. Such training...must be part of orientation and of continuing participation in the team."

4. Dallas Ingemunson

Ingemunson, Kendall County's State's Attorney, expressed several concerns about multidisciplinary teams.

The proposal, he said, presupposed a lack of cooperation. He said that although it was true that DCFS used to not even like to speak to State's Attorneys, it was no longer true. DCFS has sought out Kendall County State's Attorneys to train DCFS field personnel, and now DCFS is training some State's Attorneys, too. According to Ingemunson, the problem is not lack of cooperation, but lack of facilities and resources.

Ingemunson felt that creating multidisciplinary teams would incur additional General Revenue Fund costs, and doubted whether legislation can mandate cooperation. He also feared that distrust and jealousy between neighboring counties' State's Attorneys and other professionals might carry over into team meetings. In sum, Ingemunson said he would be "very cautious" in implementing such teams.

When questioned, Ingemunson reiterated the need for more facilities and resources, and discussed the need for flexibility in the teams' boundaries. In his part of the state, he explained, it would take many counties to total 200,000 people.

5. Lola Maddox

Maddox is an associate judge from Madison County's Circuit Court who has been assigned to Juvenile Court. She had several questions and suggestions about the team's operation:

--At what stage would the team get involved? After adjudication?

--Would a team have input into whether or not a court case is filed? State's Attorneys have always considered this decision to be their private domain.

--The DCFS representative should be highly experienced in child abuse and neglect treatment, a person with field experience.

--Because there are so many contractual agencies, perhaps the team's contractual representative should be chosen on a case-by-case basis.

--The team members' salaries could be very costly. Cases often come up for review in court 10 or 12 times, so team membership could be a full-time job.

--Shouldn't the child's attorney serve on the team?

--To avoid having people travel hundreds of miles, perhaps each region should decide how many teams it needs.

6. Nahman Greenberg

Dr. Greenberg serves both the University of Illinois Medical Center's Department of Psychiatry and Illinois Masonic Medical Center's Child Abuse Unit for Studies, Education, and Services in

Chicago. He is also a consultant to DCFS and the City of Chicago's Department of Health.

In his prepared testimony, Dr. Greenberg called multidisciplinary services "essential," but asked how the proposed teams would "improve on existing services and more important how do they compensate for serious gaps in clinical services. How do MD teams qualify in diagnostics and treatment planning." Dr. Greenberg wondered what professional standards the team members would have to meet.

Dr. Greenberg concluded that DCFS

> needs its own multidisciplinary teams available throughout the state that can address the wide range of assessment and interventional problems associated with maltreated children and their families.
>
> It is my professional judgement therefore that diagnostics, treatment planning, and case followup services, and resources must be strengthened, must be increased and properly remain within DCFS. The MD teams as proposed would <u>better</u> serve to educate communities and bring about their input for improved planning and programs of prevention. (emphasis added)

In response to questioning, Dr. Greenberg reiterated that clinical diagnostic work is incredibly complex and too much for a team. Instead, he felt, such teams should be used to educate the public regarding the problem. He thought that the teams could be mandated, but he wanted the members' qualifications specified. He again called multidisciplinary input "an essential concept."

7. Gregory Coler

Coler, Director of the Department of Children and Family Services, began his prepared statement by applauding the Commission's comprehensive investigation of child abuse, saying, "Seldom do government commissions or agencies have the opportunity to explore a problem in such depth over an extended period of time."

Coler expressed his pride over the Department's recent accomplishments: the State Central Register, the Child Abuse and Neglect Investigations Decision Handbook, and the specialized Division of Child Protection (DCP) teams with investigators and nurses as members. Coler said these teams were a "direct result of my discussions with the Commission." He said, in fact, that the Commission's assistance had been "invaluable" to him.

Regarding multidisciplinary teams, Coler said, "I agree wholeheartedly with the Commission that cooperation between DCFS, medical personnel, the police, state's attorneys, medical examiners, and other professionals in the community is indispensable if we are to continue our progress in dealing with the child abuse problem." However, he said he wasn't sure "you can <u>legislate</u> cooperation."

During questioning, Coler aired further reservations:

--Who serves on the teams needs to be further defined, making sure that they are policymakers with authority and responsibility.

--What exactly are the roles of the teams? Case oversight? Monitoring? Prescription? County outreach? Policy development? Resource development? Coler suggested that the best role for the teams would be to develop community resources and awareness and to develop better working relationships between hospitals, police, courts, and DCFS.

--Because he doesn't want case responsibility to be diffused, Coler is opposed to multidisciplinary teams getting directly involved in case treatment. He pointed out that these are often life-and-death situations, and DCFS is legally accountable for them.

--Regarding cost and distribution, Coler said that such teams cost about $30,000 each per year, so 60 teams would cost about $1,800,000. Because abuse and neglect are not uniformly distributed throughout the state, Coler suggested that incident reports be used to distribute the most teams to the areas with the greatest problems.

In sum, Coler thought that the multidisciplinary team concept has great merit, but that the teams' duties need to be refined.

8. Gabriella Cohen

In his testimony, Director Coler mentioned H.E.L.P., Inc., which stands for Human Effective Living Programs. Gabriella Cohen is H.E.L.P., Inc.'s Executive Director. Cohen explained that in 1981, DCFS awarded H.E.L.P., Inc. "substantial grants to develop a coordinated, cooperative effort among all relevant organizations to identify, investigate, determine and use appropriate court involvement. This model began in the Chicago Police Department's Sixth Area and in FY 83 expanded to include CPD's Fourth and Fifth area thus covering the north side of Chicago."

Cohen opened her statement by saying that "No single viewpoint or professional expertise is sufficient to address the multiproblematic nature of these families."

Cohen identified four procedural problems that the teams would have to face:

a) If the teams review <u>all</u> child abuse and neglect cases they will be reviewing many unfounded cases (45% of cases are indicated)

b) How will the teams respond to the 24 hour mandate

c) If the team acts only as a review it will depend on existing workers for input information

d) There is no current data on the case characteristics or the nature of the problems which cause an increase in the severity of the abuse or which may lead to child deaths, nor is there adequate data on what significant factors indicate that a case is a high risk case. Therefore criteria for the review of only high risk cases is subjective.

(Regarding these problems, we offer the following comments. The teams will not review all cases; they will review unusual cases. Item "d" suggests that Cohen realizes the teams will not review all cases. Because they will review only unusual cases, the teams will handle cases only after DCFS workers have already fulfilled the 24-hour response mandate. Dependence on existing workers' information does not reduce the value of interdisciplinary review. And although review criteria are subjective, this does not preclude their use in human situations, where a certain amount of subjectivity is inevitable.)

9. James Hollandsworth

Because the H.E.L.P. project operates in Area 6, our last witness was Lt. Hollandsworth, Commanding Officer of the Area 6 Youth Division. He described the Youth Division's work with H.E.L.P., Inc., and then stressed the need for immediate investigation of child abuse cases by law enforcement agents.

B. Conclusion

The witnesses all agreed that inter-agency cooperation is essential in dealing with the families of abused and neglected children, and that multidisciplinary teams would enhance such cooperation. However, several of the witnesses had specific reservations about the implementation and operation of such teams.

On March 8, 1983, Co-Chairmen Jaffe and Hastert introduced a bill in the House of Representatives calling for mandatory implementation of multidisciplinary teams. The Co-Chairmen then arranged to speak with experts in Colorado (see Chapter 8) regarding further specifics of implementation. Their conversations continue as this report is printed and the legislation is considered in the House.

Chapter 10

CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

Many changes have occurred in the child protection system since our investigation began. The Department of Children and Family Services, the state agency primarily responsible for child protection, has undergone major reorganization during the past five years. Because the restructuring occurred while we were investigating the problem, we were in an excellent position to evaluate the impact of these changes.

Overall, significant improvements have been made in Illinois' child protection efforts in the past few years, yet much remains to be done. That more improvements are needed should come as no surprise: it has been only within the last 15 years that social work and health professionals, much less the general public, have begun to recognize the extent of the problem.

The conclusions and recommendations that we present here touch on the problem of child abuse and neglect as well as the professionals who must combat the problem. We will look first at the problem, then at the system.

1. The Problem

Our investigation began at a time when a great deal of public attention had been focused on what appeared to be an alarming increase in child deaths due to abuse. The total number of reported child abuse and neglect cases not ending in death had also increased. On the surface the growing concern was warranted by the rising numbers. Why were more and more parents beginning to abuse--even kill--their own children? And what could be done to reverse this apparent trend? These were two of the questions we were to address.

These concerns were based on the apparently false assumption that there had been a significant increase both in child abuse and in child abuse deaths. The fact is that reported cases of abuse have increased steadily over the years, while reported cases of deaths resulting from abuse have been erratic from year to year.

The real extent of the child abuse and neglect problem was impossible to ascertain because we could measure, for the most part, only reported--not actual--cases. And, until Fiscal Year 1981, when certain amendments to the Abused and Neglected Child Reporting Act were effective, even records of reports of child abuse and child abuse deaths were not very reliable. The unavailability of meaningful statistics makes it very difficult not only to devise any solutions, but also, initially, to describe the problem itself. However, the expressed fear that more and more parents are killing their children should be quieted somewhat by the knowledge that pre-FY 81 death totals are questionable and the FY 82 totals are down from FY 81.

The ability to describe the child abuse and neglect problem depends on many factors. One factor is the definition, which must remain constant from one year to the next to make proper comparisons. Though most people have a common-sense understanding of what child abuse and neglect are and are not, translating this understanding into meaningful statutory or regulatory language is another matter. Consequently, in an ongoing search for a better definition, most states including Illinois have made many changes in the language defining the problem.

The changes made in the definition in Illinois have been, we believe, improvements. But because definitions have changed in the last decade, there is a certain amount of variation in abuse statistics.

Another source of variation due to the definition involves the way it is applied to individual incidents of suspected abuse. Illinois' definition is broadly constructed, leaving social workers or others wide discretion in whether or not to label a particular incident abusive. There are strong indications that DCFS caseworkers do not apply the definition of child abuse and neglect consistently. Some caseworkers are more conservative than others in making case determinations. The differences, whether the result of differences in personal philosophies, training, or experience, limit the accuracy of abuse and neglect statistics.

Another source of error in the statistics, which is more significant than variations due to the definition and its application, is our limited collective ability to detect child abuse. Until the 1960s, child abuse was not considered a particularly important problem. Except for the occasional serious case of abuse, or death resulting from abuse, neither professionals nor the general public heard much about battered children. It was believed that the problem generally was isolated to a few economically deprived families. Teachers, police, doctors, nurses, and other professionals were not aware of the scope of the problem, nor were they trained to recognize symptoms of abuse or neglect. Even if they might have suspected a child was being abused, professionals felt they had few options for intervention.

Child abuse is a hidden problem since children generally do not walk into a police station or into the principal's office to say they are being abused or neglected. This is especially true of children who are sexually abused at home. Children do not report abuse for a variety of reasons. In fact, even when asked directly they often do not respond truthfully to protect the abusive parent. It takes a skilled person to get many children to talk about their abuse.

Expanded awareness of the child abuse problem gradually has led to increased knowledge about the symptoms, allowing professionals to identify abuse more easily. Because more people know what to look for, more cases are being detected. This all leads to greater awareness, more knowledge, increased detection, and so on.

Because of these advances, increases in reports of abuse reflect, in part, incidents that previously remained hidden, not necessarily real increases in the number of abuse incidents taking place.

The degree of reporting and the quality of centralized record keeping also have a major impact on abuse statistics. We found that several years ago professionals were less willing than they are today to report suspected or detected abuse. Furthermore, in the past, professionals who suspected abuse were less familiar with reporting procedures than they are now.

The creation of the State Central Register (SCR) within the Department of Children and Family Services has led to improved reporting, more accurate central recording, and less confusion about who should be receiving reports. All must be considered part of the explanation for increases in abuse figures.

A final major factor that affects the statistics is the effectiveness of the investigation done to verify or rule out reports of abuse. In this area, too, the Commission has noted significant advancements. The quality of the initial investigations of abuse reports conducted by DCFS has improved greatly just during the period of our investigation. This is evident especially since the creation of the Division of Child Protection (DCP) within DCFS last year. Because better investigations are being conducted, the accuracy of the statistics has further improved. Additionally, far fewer cases are being "lost." That is, virtually all reports are being investigated, whereas in the past a large percentage of reports were never followed up.

In all of these areas--definition and its application, detection, reporting, centralized record keeping, and investigation--refinements have continued over the past years. Thus, we can draw no conclusions about whether or not the problem of child abuse and neglect is increasing, decreasing, or remaining relatively the same. The current increase in statistics reflects only the improvement seen in all of those areas due to increased awareness of the child abuse problem.

Although general knowledge regarding child abuse has grown rapidly, the Commission nevertheless must conclude that there remains much we do not know about the problem. Therefore, as the system continues to acquire more information and to become more effective, we should see continued increases in the number of child abuse incidents. We base this on several findings: (1) the definition of child abuse is not being evenly applied by all people who encounter the problem; (2) many professionals who come in frequent contact with children, such as health professionals and educators, still remain largely ignorant of the symptoms of abuse; (3) many mandated reporters still are not reporting their suspicions of abuse to DCFS; (4) despite improvements in publicizing the problem of child abuse and despite the elimination of much confusion by the establishment of a single toll-free number for reporting suspicions of child

abuse and neglect, much of the general public remains unaware of its ability to report and to whom, or remains reluctant to get involved; and (5) even though the quality of investigations has improved markedly, many child welfare workers still lack essential skills to gather and document credible evidence of abuse.

2. The System

No single agency bears total responsibility for protecting our state's children. Although the Illinois Department of Children and Family Services plays a central role in combatting child abuse and neglect, the responsibility ultimately is shared by literally hundreds of local and state government agencies, as well as by private organizations and private citizens. In fact, even though DCFS plays a central role in dealing with the problem, the impact of that agency acting alone will always remain severely limited.

As we have already seen, DCFS must rely almost totally on people other than its own employees to identify abuse initially. Likewise, DCFS must rely mainly on other agencies to provide treatment to an abused child and abusive parents, even though DCFS retains responsibility for placement and for monitoring progress.

For children to be protected adequately, all agencies and professionals, indeed all citizens, must work together toward that common goal. What we found during our investigation is that the agencies that should be operating in concert often work at cross purposes. The type of cooperation and coordination necessary to deal effectively with child abuse does not exist.

The Department of Children and Family Services itself must assume much of the responsibility for this. Apparently, from the time the agency was first created it established the model for non-cooperation.

When we first started our investigation, we interviewed scores of police, state's attorneys, judges, school officials, and health professionals. Many of those interviewed openly expressed hostility toward the Department. A common complaint was that DCFS would not cooperate even in providing feedback on what happened with cases referred to them, much less listen to recommendations on how to handle a case or work with the reporting agency. We were told that DCFS sometimes did not even follow up on cases referred to it.

Criminal justice authorities also complained about DCFS case-workers failing to refer serious cases of abuse to the police or State's Attorney's Office for criminal investigation and possible prosecution.

Our investigation established that all of these complaints had validity. DCFS did not try to develop a coordinated approach to deal with child abuse incidents. Hiding behind the excuse that their activities were confidential, DCFS employees often refused to reveal whether or not they even were working on a case reported to

them. Frequently, confidentiality was raised when DCFS workers wanted to hide the fact they had done nothing. The agency was accountable to no one.

The Commission also found many examples of DCFS workers failing to notify proper law enforcement authorities about serious abuse incidents. In one case we reviewed, a 12-year-old girl had been raped by her mother's boyfriend. The DCFS worker closed the case after the mother promised she would not let her boyfriend back in the house. Another case involved a two-year-old girl who was discovered to have gonorrhea. The doctor who discovered the disease called DCFS. After interviewing several people, the DCFS case-worker closed the case. She had arrived at the incredible conclusion that the girl had contracted venereal disease "from the toilet seat in a church." Neither of these cases was referred to law enforcement authorities, nor was there any other follow up.

Fortunately, while our investigation was underway, the Department began making important changes that are eliminating most of these problems. Particularly noteworthy has been the addition of the SCR. The Commission's evaluation of the register is a most positive one. People calling the central register using the single statewide phone number are told immediately whether or not there is sufficient information to begin an investigation. Mandated reporters, automatically in most cases, are now notified of DCFS's case determinations regarding reports of suspected abuse. And some mandated reporters, such as police and physicians, who are authorized by law to take temporary custody of children they believe are in danger, have full access to information contained in the central register.

Another improvement has been a DCFS policy requiring that the appropriate state's attorney be notified of certain serious abuse incidents. This has been carried one step futher in Chicago, where the Chicago Police Department is notified directly by the SCR of some reports that appear especially serious.

These major accomplishments notwithstanding, there remains much DCFS could do to promote further the cooperation and coordination necessary for effective child protection. One thing the agency has not done that we believe could help enormously is to create a statewide network of community-based multidisciplinary teams. Such teams have proved effective in several other states in fostering cooperation, identifying service gaps, evaluating treatment plans, monitoring case handling, educating mandated reporters and community members, helping to solve administrative problems, developing new services, drafting procedure for case handling, recommending referrals to juvenile or criminal courts, and coordinating the activities of multiple agencies that might become involved in complicated abuse or neglect cases.

Such teams should be especially useful in metropolitan areas where a formal method must be implemented to establish continuing cross-agency links. In less populated areas, we found that DCFS workers are much more effective in establishing and cultivating

informal ties with other agencies than are workers in the Chicago area. Yet even downstate, gaps exist; if the caseworker leaves the agency or is transferred, his contacts are lost to DCFS. Teams allow for continuity in the links between all appropriate agencies and segments of the community.

It is the intent of the current law that DCFS establish multidisciplinary teams. Unfortunately, the Department has haphazardly set up a variety of teams in only a few areas. It also has established a few teams from within its own staff. These efforts fall far short of what the legislature envisioned and what is necessary.

Aside from inadequate coordination, another major problem is the almost non-existent child abuse prevention effort. As we outlined earlier in this report, Brian Fraser identified the following factors that, together, are likely to lead to child abuse: (1) one one or both parents have been abused as children; (2) the abusive parents have no friends, neighbors, or relatives to call on in a time of crisis; (3) the parents have unrealistic expectations of their children; and (4) a crisis occurs.

These four factors imply a number of possible strategies for prevention. The first factor could lead to an educational campaign encouraging people who had been abused as children to seek counselling to help heal the psychological wounds, or one that would encourage children who are now being abused to contact DCFS. Educators, police, health professionals, and others all could become involved in similar efforts.

The second and fourth factors would seem to imply establishing more crisis intervention hotlines at the community level. The third would seem to imply educating people about the developmental stages of childhood through public service broadcasts and school curricula. These are only a few of the possibilities. There are a host of others.

The Commission found, however, that virtually nothing is being done to develop, much less implement, a comprehensive prevention strategy. There are a few piecemeal efforts. Some hospitals teach young mothers a few basics about early childhood development during their brief hospital stay and then visit the mothers a few weeks after they take their infants home. A few high schools offer elective basic parenting classes. Crisis intervention hotlines have been set up for a variety of purposes in a few communities. And some private groups as well as police departments offer brief classes to young children to help them recognize inappropriate discipline or sexual conduct and to instruct them on what to do if it happens to them.

The groups and agencies that are working hard in the area of prevention deserve our recognition and support. We applaud them. But in assessing the prevention efforts from a statewide perspective, the energy being devoted is pitifully small.

Two other problems that we already mentioned in part are the detection and reporting of child abuse and neglect. There are far too many professionals who regularly come in contact with children who remain ignorant of the symptoms of child abuse. Moreover, far too many of these professionals are untrained in how, reassuringly, to get children to talk about their abuse. Initial training and continuing education in these skills are practically non-existent for the medical, law enforcement, and education professions. Some medical specialists, especially in some hospital emergency rooms, some counsellors or teachers, and some specialists in a few police departments are experts in these areas. The vast majority have not learned even the basics. Even most welfare workers in DCFS' sister agency, the Illinois Department of Public Aid, do not know the fundamentals of detecting abuse, nor do they even look for it.

As for reporting, our investigators interviewed many mandated reporters who were not aware that they had a legal obligation to report suspicions of child abuse. Many others, we found, were aware of their responsibility but chose not to report their suspicions. In some schools we visited, policies had been set up that require teachers to report their suspicions only to the principal, who then would decide whether or not to notify DCFS. Such policies do not meet the requirements of the law, under which mandated reporters have the obligation to notify DCFS themselves.

When we started our investigation, we found that many police and medical examiners or coroners were confused about how to proceed with reports of child deaths due to abuse. Some reported these to DCFS, others did not. The confusion seems to have been eliminated, however, apparently because of the creation of the statewide hotline and attendant media campaigns.

The problem of non-reporting appears to be particularly concentrated among private physicians and dentists. Most of them are apparently aware of their obligation but do not live up to it. Perhaps one reason many mandated reporters flout the law is that Illinois, like many other states, does very little vigorously to enforce the law. In fact, no one we interviewed could think of an example of a mandated reporter being punished for not reporting.

An area that has shown significant improvement during the last five years has been the investigation of suspected cases of abuse. When we began our investigation, we were shocked by some of the poor investigations that were done by Child Protective Services (CPS) workers. Some reports of suspected abuse were not even accepted. Others were not followed up. Some might be followed up, but days later. Some were investigated, but the cases were handled in a slipshod, unprofessional fashion. Few cases were handled well.

To describe many of these investigations as incompetent would be generous. Basic facts were not recorded in the case file. Notes were often written illegibly on the back of envelopes or other scraps of paper. Even the reason why an investigation was being conducted sometimes was not recorded. Caseworkers often did not have the

vaguest notion of how to gather and document evidence, how to conduct a fact finding interview, or how to report their observations. The very idea of having to support with documented facts their final determination and recommendation in a case seemed foreign to many caseworkers. These problems were most evident in Cook County. Elsewhere in the state, the investigations were generally better but still somewhat deficient in proper documentation.

Fortunately, improvements have been made. Shortly after our investigation began we started to notice that better investigations were being done. This was primarily the result of CPS training efforts that had begun earlier. However, further improvement did not come about until the implementation of the Child Abuse and Neglect Tracking System, which centralized quality control and accountability for follow-up within the SCR. After some problems during early implementation and the initial training period, the overall quality of investigations and documentation has significantly improved.

Last year DCFS moved toward further improvement with the creation of DCP. This brought about the needed separation between the investigation and service delivery functions of the agency. Previously, CPS workers were expected to do both, which resulted in a confusion of roles. Preliminary indications are that cases are being handled more expeditiously and documented more fully.

The deficiencies have not all disappeared. Many of the DCP investigators still are not properly documenting information for possible use in courts. Some also need further training in how to testify during court hearings and trials. Many cases have been in limbo for varying periods because of a DCFS policy that workers physically see and interview every member of the immediate family. This requirement has resulted in unnecessary stagnation of cases that could be closed. Finally, there are problems in transferring cases from DCP to CPS follow-up workers. The case files do not contain adequate information to allow for a smooth transition between divisions.

Although DCFS is the agency primarily responsible for conducting investigations, it would be a mistake to focus solely on what DCP could do to improve investigations. Many mandated reporters could help improve abuse investigations by fully documenting their observations and supplying the documentation to DCFS. The police could be especially helpful in this regard because of their training and because DCFS can legally delegate an entire investigation to them. Unfortunately, not all agencies are assisting as completely as they could, even when asked.

After the investigation is completed, a decision must be made on what action to take, if any. This leads to our next major block of findings: formal intervention, treatment, and monitoring.

One option is to refer a case for criminal prosecution, depending on the seriousness of the case. HR 776 mentions that there

had been demands for stiff new penalties for parents who abuse or neglect their children. The Commission has determined that current law provides appropriate sanctions and penalties. No new criminal laws appear to be needed.

The problem is not in the laws but in the quality of the investigations conducted by DCFS workers and the absence of a continuing working relationship between DCFS and criminal justice agencies. As we said, DCFS' revised reporting policies and the creation of DCP are steps in the right direction. Mutually acceptable procedures and agreements need to be worked out between DCFS and criminal justice agencies throughout the state.

Because cooperative relationships do not exist to any great extent, children end up being victimized twice, first by their abusive parents and second by the system that subjects them to an unnecessary series of insensitive interviews by social workers, police, and prosecutors, culminating in a bewildering and frightening courtroom experience for which they rarely have been prepared. Pilot projects throughout the country have demonstrated that where a strong cooperative relationship exists between criminal justice and social service agencies, serious trauma can be eliminated.

A current DCFS-funded project in Chicago aims at creating a model for cooperative agreements between DCFS, private treatment providers, the police, state's attorneys, and the courts with respect to handling sexual abuse cases. Preliminary indications are that the program is successful. We hope that similar programs will be started throughout the state and that the focus will be expanded to cover other forms of abuse, not just sexual abuse.

In addition to, or instead of, criminal action, a case can be handled in Juvenile Court. Possible trauma to the child is not as great a problem in Juvenile Court because of the less stringent evidence requirements and the less formal nature of the proceedings. Nevertheless, here too, sensitivity to the child's needs is often lacking.

A third possible alternative is for the parents voluntarily to accept a treatment plan recommended by DCFS rather than go through the court process. This option is supposedly selected only in the least severe cases. On the surface this might appear to be the best alternative; the child is spared the need to testify, and much of the time always involved in either juvenile or criminal prosecutions is saved. We found in our investigation, however, that this option is often misused. We discovered many instances of serious cases that were not referred to court because of a voluntary agreement. Too often the parents later break the agreement. In the meantime, documentation often has not been adequately prepared and evidence has not been preserved. Thus, DCFS frequently finds itself in no position to later refer the case for either civil or criminal prosecution. Since the formation of DCP, we do not know to what extent this is still a problem.

No matter how the case is handled, if there is a finding of abuse or neglect, some kind of treatment plan is either formally or informally prepared. The plan might involve counselling for the family, homemaker or day care services, temporary out-of-home placement for the child, or a range of other services. Generally, DCFS caseworkers do not provide any of these services directly. Outside agencies are contracted to provide them. DCFS workers primarily perform a case management function.

If a person is convicted in criminal court and is placed on probation, DCFS generally will be responsible for providing services to the offender if he will remain in the home and if part of the plan involves keeping the family intact or eventually reuniting the family. This responsibility is sometimes carried out in conjunction with county probation departments.

We learned that if the offender is incarcerated, he rarely will receive treatment, therapy, or counselling of any kind. No follow-up is done by anyone once this person leaves prison.

If a case is handled by voluntary agreement or in Juvenile Court, DCFS alone is responsible for arranging services. The judge must be kept informed of progress in cases he adjudicated, but once he enters a finding and turns custody over to DCFS, it is DCFS' responsibility to arrange whatever services are appropriate.

The Commission found several problems with DCFS' function of arranging and then monitoring services. First, we found many gaps in the availability of treatment services, yet DCFS has not developed a way to identify the full extent of these gaps through a statewide needs assessment. Consequently, a full continuum of services is not available to abusive parents and abused children. This is one reason for some of the inappropriate placements that we discovered during our investigation. Another reason is that many caseworkers are unfamiliar with the services available.

DCFS' network of treatment services was built haphazardly. Rather than identifying a need, sending out a request for proposal (RFP), seeking bids to meet the need, and then entering into a contract with the agency that offered to provide the best service, DCFS' network was constructed the other way around. A private agency would approach someone at DCFS and offer to provide a specified service. DCFS would then decide whether or not to enter into a contract. Rarely were programs designed to DCFS specification or open for bidding. This also resulted in disparities in what was paid to different agencies for similar services.

A new policy of the Department that requires competitive bidding on RFPs has not been in force long enough for us to know if these problems will be eliminated soon. At least it appears to lead in the right direction.

Another problem with the services is the failure by DCFS to evaluate and monitor the performance of contractual agencies. DCFS

caseworkers may individually review the treatment provided to clients, but the agency as a whole does not. We were frequently told that such evaluations cannot be performed because "success" is impossible to define, yet this position is totally unsupported in the literature. Researchers have been evaluating such programs for years, and we believe it is time for DCFS to do so. DCFS should stop wasting money on programs that do not work or could be improved.

The monitoring of services by DCFS workers has improved considerably since our investigation began, but again more improvement is needed. Several years ago DCFS did such poor case monitoring that the agency often lost track of its wards. This should not happen anymore, not only because of the Child Abuse and Neglect Tracking System, but also because there is a case conference on each out-of-home placement every six months. The conference is chaired by a case review administrator who evaluates the case's progress. Unfortunately, cases where the child remains in the home are not subject to similar reviews.

Even with the periodic reviews, however, we found that the majority of caseworkers have too little contact with the contractual agencies providing services to their clients. Furthermore, we found that caseworkers do not properly maintain files on their clients.

The last area we will address in these findings and conclusions is the overall administration of DCFS. The Commission would like to commend DCFS Director Gregory Coler for the job he has done in engineering major improvements in his agency's operational and administrative effectiveness.

When we began our investigation of child abuse, the administration of DCFS was chaotic. There was virtually no central control. The agency functioned more as a loose confederation of independent fiefdoms than as a single department.

Resources were sorely lacking. Reports of abuse were often not investigated. Caseworkers lacked fundamental training. Files were frequently misplaced. DCFS was in worse shape than any public agency this Commission has ever investigated.

In the last few years the Department has gone through a transformation. It barely resembles the same agency. Nevertheless, several major problems persist.

The Department cites again and again budgetary deficiencies for many of these problems. At the same time, the Auditor General continues to cite DCFS for its failure to collect funds due it, its failure to make use of federal funding for which it is eligible, and its failure to explore additional funding possibilities.

Despite significant improvements, DCFS continues to mishandle cases of abuse and neglect. We have identified several reasons for this. First, many caseworkers require more training. Second, supervision of the caseworkers is poor. Routine supervisory review

of caseworker decisions is lacking. Rather than devote their time to management, supervisors--who often lack training in supervisory skills--maintain caseloads themselves or act primarily as consultants on difficult cases. And third, case files are frequently disorganized, inadequate, incomplete, and practically indecipherable. The condition of the files is inexcusable. Caseworkers complained to us that spending time on paperwork takes away from their ability to do their job. What they do not seem to understand is that proper documentation and maintenance of those files is a vital part of their job.

DCFS continues to have a disturbingly high employee turnover rate. We believe there are two major reasons. First, DCFS has no systematic way to identify internal problems, evaluate them, and devise solutions. Problems experienced at the caseworker level, we were told, often persist after repeated complaints to higher levels. To many caseworkers we interviewed, it appears as though problems are simply being ignored because their concerns frequently elicit no response.

The second reason relates to DCFS' internal investigations of cases that may have been mishandled. The Commission reviewed several reports detailing the findings of internal investigations. We also conducted our own investigation of the incidents. Frequently, there were significant factual differences in the findings. Important facts were often distorted or missing in the DCFS reports. This discovery leads us to conclude that the DCFS Director has been misled in at least some of the incidents. As a result, some caseworkers were unfairly disciplined. Such unjust treatment has repercussions far beyond the person directly involved. It inevitably leads to poor morale, poor performance, and "burnout" for many workers, and thus high turnover.

B. Legislative Recommendations

1. Mandatory Implementation of Multidisciplinary Child Protection Teams

a. Cooperation With Appropriate Public and Private Agencies and Professionals

Section 7.1 of the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. Ch. 23, ¶ 2057.1) states that DCFS "shall cooperate with and shall seek the cooperation and involvement of all appropriate public and private agencies," but only "[t]o the fullest extent feasible." This cooperation and involvement is to extend to consultation and services, planning, case management, public education and information services, utilization of facilities, staff development and other training, as well as "the creation of multidisciplinary case diagnostic, case handling, case management, and policy planning teams."

We have determined that the multidisciplinary team approach is the best method of dealing with incidents of child abuse and neglect.

Multidisciplinary teams are not only desirable, they are feasible. Their use assures the most comprehensive and coordinated care available to abused and neglected children and their families. Cooperation and communication between agencies intervening in child abuse and neglect cases are essential if the problem is to be dealt with effectively. (See Chapter 8, which discusses the purpose and functions of multidisciplinary teams, as well as their success in several of the states we visited.)

Unfortunately, despite the addition of Section 7.1 to the Reporting Act, effective July 1, 1980, DCFS has failed to begin using such teams in the manner it should be. Its failure to do so can be traced to the statutory discretion accorded the decision-makers within DCFS ("[t]o the fullest extent feasible"), as well as to the general language of the statute. These statutory shortcomings have tended to undermine the intent of the General Assembly that the issues of child abuse and neglect prevention, identification, and treatment be addressed as a joint effort.

Accordingly, we recommend that the discretionary language of Section 7.1 of the Reporting Act be deleted, so that DCFS will have an affirmative duty to implement "multidisciplinary case diagnostic, case handling, case management, and policy planning teams."

Also, the language of Section 7.1 must be made more specific to guide DCFS in the development and use of multidisciplinary teams. At the least, such teams should consist of the following permanent members: (1) a DCFS employee, who would serve as the team coordinator, (2) a representative from any other public or private agency under contract with DCFS for the provision of services, (3) a representative from the medical profession, whether it be a physician, a member of any local public health agency, a hospital social worker, a registered nurse, or a clinical psychologist, (4) a representative from the local school district, (5) a local Assistant State's Attorney, (6) a representative of a local law enforcement agency, and (7) a representative of the local lay community.

Each team would be responsible for overseeing all cases of child abuse and neglect occurring in a designated geographic area of the State. There should be no less than one team for every 200,000 population.

The minimum terms of service on such teams should be one year. However, additional consulting members could be appointed by the team to serve on a case-by-case basis.

Such teams must have some decision-making authority in the treatment plan and not function in only an advisorial capacity. To avoid confusion and inefficiency, however, DCFS must retain ultimate responsibility for overseeing all reports of child abuse and neglect.

b. Access to Statutorily Confidential DCFS Records

Section 11 of the Abused and Neglected Child Reporting Act

(Ill. Rev. Stat. Ch. 23, ¶ 2061) provides that "[a]ll records concerning reports of child abuse and neglect and all records generated as a result of such reports, shall be confidential and shall not be disclosed except as specifically authorized by this Act or other applicable law." Access to ten specifically enumerated categories of agencies and persons is authorized in Section 11.1 of the Reporting Act (Ill. Rev. Stat. Ch. 23, ¶ 2061.1).

For members of child protection multidisciplinary teams to provide the services outlined in Section 7.1 of the Reporting Act, they must have access to the records made confidential by Section 11. Accordingly, a subsection (11) should be added to Section 11.1 of the Reporting Act, to read as follows:

> "(11) All members of multidisciplinary case diagnostic, case handling, case management, and policy planning teams working in conjunction with the Department."

2. Legislative Access to Statutorily Confidential DCFS Records

House Resolution 776 directed this Commission to examine "the responsibilities, activities, and records of all agencies that deal with the child abuse problem." In our attempt to fulfill this legislative mandate, we encountered many obstacles, due to the reluctance of DCFS and child care agencies under contract with DCFS to allow us access to their records. This led to unnecessary delays in completing this investigation, which relied heavily on the use of case studies to evaluate the child abuse and neglect system in Illinois.

Clearly, the intent of the General Assembly was not to bar itself and its commissions and committees from access to such records, in that access is necessary to monitor the activities of agencies that look to the General Assembly for their appropriations.

Beyond the issue of intent, there is some confusion, and possibly even a direct conflict, between two present laws regarding legislative access to DCFS records. Section 11.1 of the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. Ch. 23, ¶ 2061.1) inexplicably omits the General Assembly from those ten categories of agencies and persons authorized access to "[a]ll records concerning reports of child abuse and neglect and all records generated as a result of such reports." However, Section 35.1 of the DCFS Act (Ill. Rev. Stat. Ch. 23, ¶ 5035.1) provides, in relevant part, that "[t]he case and clinical records of patients in Department supervised facilities, wards of the Department, children receiving or applying for other services, persons receiving or applying for other services of the Department, and Department reports of inquiry or abuse to children ... shall be disclosed by the Director of the Department only to proper law enforcement officials, individuals authorized by court, the Illinois General Assembly or any committee or commission thereof, and to such other persons and for such reasons as the Director shall designate by rule or regulation. [Emphasis added.]"

Many questions arise regarding the interpretation of these two statutory provisions, and how they are to be construed together. We can envision the necessity, at some point in the future, of seeking a court decision if the law is not amended. Because court intervention has not yet become a necessity, we feel that the law should be amended now.

Furthermore, the Model Child Protection Act (promulgated by the National Center on Child Abuse and Neglect, an agency under the United States Department of Health and Human Services), on which the Illinois Abused and Neglected Child Reporting Act is based, specifically provides that access to records concerning reports of child abuse and neglect and all records generated as a result of such reports shall be given to any appropriate state or local official responsible for administration, supervision, or legislation relating to the prevention and treatment of abuse and neglect, when they are carrying out their official functions. Illinois law has incorporated every exception to the confidentiality of child abuse and neglect records save this one. The comment to the Model Act states: "If central register and other records are to be used to improve child protective services through monitoring and research, it is imperative that the data collected so painstakingly and at such a great expense should be available to outsiders including ... legislators."

Also relevant to this discussion is the fact that Section 11.1 of the Reporting Act was amended effective January 1, 1982, to add "[l]aw enforcement agencies, physicians, courts and child welfare agencies in other states..." to the list of persons and agencies that have access to otherwise confidential records of child abuse and neglect (Public Act 82-453) (emphasis added). It is inappropriate that out-of-state officials should have access to Illinois records of child abuse and neglect, when the Illinois General Assembly is denied such access.

Accordingly, Section 11.1 of the Abused and Neglected Child Reporting Act should be amended to add the General Assembly to the list of those persons and agencies that have access to child abuse and neglect records. This amendment would add a new subsection (12) to Section 11.1 of the Reporting Act (our previous legislative recommendation with respect to multidisciplinary teams would add new subsection (11)), to read as follows:

> (12) The Illinois General Assembly or any committee or commission thereof; provided however, that individual members of the General Assembly shall not have access to the records described in Section 11 unless such member is acting as a member of a committee or commission of the General Assembly and the information is needed to advance the legislative purpose of such committee or commission.

3. Mandatory Reporting of Certain Child Abuse and Neglect Cases to Appropriate State's Attorney

During our investigation we received many complaints from officials of various police departments and state's attorney's offices about the failure of DCFS to supply them with abuse and

neglect reports of which they should have been apprised. Certainly not every case of abuse or neglect received by the DCFS State Central Register need be or should be reported to law enforcement officials; however, we have documented reluctance on the part of some DCFS workers to report any case of abuse or neglect, no matter how severe. Apparently, some DCFS workers feel -- unjustifiably -- that they, as social service professionals, are adequately equipped to handle any case of abuse or neglect without the assistance of other agencies having a different orientation.

Currently, DCFS, by its own rule, is supposed to report certain cases of abuse or neglect to the appropriate State's Attorney's office. The Commission, based upon its findings, feels that the coordination between DCFS and State's Attorney's offices is so important that reporting of certain cases should not only be required by a departmental rule but also by state statute. First, a law is less likely than an internal rule to be rescinded without debate. (This is an especially important consideration with DCFS because its directorship has changed so often.) Second, failure to report certain specified cases to the State's Attorney in violation of a law could subject the offending DCFS employee to charges for official misconduct (Ill. Rev. Stat. Ch. 38, ¶ 33-3): "A public officer or employee commits misconduct when, in his official capacity, he... (a) [i]ntentionally or recklessly fails to perform any mandatory duty as required by law...." (Any DCFS employee convicted of violating this provision forfeits his employment and commits a Class 3 felony.)

Therefore, we recommend that the Abused and Neglected Child Reporting Act be amended to add a new section 4.2 (Ill. Rev. Stat. Ch. 23, proposed ¶ 2054.2) requiring that DCFS, including but not limited to DCFS field personnel, immediately refer to the appropriate State's Attorney for consideration of criminal investigation or other action, the following types of reports:

(1) reports in which a child is dead on arrival at or dies after admission to a hospital as a result of suspected abuse or neglect;

(2) reports in which the harm to the child suspected to be abused or neglected is severe; such as, but not limited to: multiple or spiral fractures, third degree burns, and subdural hematoma;

(3) reports in which credible evidence is found that a child has been abused a second time, regardless of severity;

(4) reports of physical injury when the evidence indicates that the child has been tortured;

(5) reports in which a child is the alleged victim of sexual abuse; or

(6) reports in which the child suspected to be abused or

neglected is in need of protection beyond that which can be provided through comprehensive protective casework services.

Provision should be made in this added section that the requirement that these specific cases must be reported to the appropriate State's Attorney does not preclude the reporting of other cases if, in the caseworker's discretion, such action is deemed prudent.

4. Civil and Criminal Penalties for Mandated Reporters Who Fail to Report

We have listed, in Section C (Subsection 9) of Chapter 3, all persons required by Section 4 of the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. Ch. 23, ¶ 2054) to report to DCFS whenever they have "reasonable cause to believe a child known to them in their professional or official capacity may be an abused or neglected child." However, no sanctions for failure to report are provided in the Act itself.

During our investigation we documented the failure of mandated reporters to report even severe cases of child abuse and neglect. For example, the case study entitled "Peter" included in Chapter 5 (Section F) details how three mandated reporters (two hospitals and one medical examiner) failed to make legally required reports to DCFS after Peter's death, because each assumed--incorrectly--that the other already had reported. DCFS, consequently, did not learn of Peter's death due to suspected parental abuse and neglect until five months after the death. As a result, Peter's younger sister was in the custody of her parents all that time without even any supervision by DCFS.

Such laxity cannot be tolerated. Statutory civil and criminal penalties for failure to report, already enacted in a majority of states, would help alleviate the problem of non-reporting. Mandated reporters would be less hesitant about reporting suspected cases of abuse and neglect if they knew they would be subject to penalties for failure to report.

Presently, sanctions such as suspension or revocation of one's professional license for willful failure to report do exist for certain mandated reporters. These sanctions are provided in the individual acts relating to the licensure of such professionals. (The Reporting Act, however, makes no reference to these other acts and their discretionary penalties for failure to report appropriate cases.)

Similarly, those mandated reporters who are public officers or employees may be criminally liable for "official misconduct" (Ill. Rev. Stat. Ch. 38, ¶ 33-3), when in their official capacity they "[i]ntentionally or recklessly [fail] to perform any mandatory duty as required to law." Official misconduct constitutes a Class 3 felony, and conviction results in the forfeiture of the person's office or employment.

Not every mandated reporter falls within the purview of these

potential sanctions. Therefore, the Commission recommends that Section 4 of the Reporting Act (Ill. Rev. Stat. Ch. 23, ¶ 2054) be amended to provide certain criminal and civil penalties for mandated reporters who fail to fulfill their statutory duty to report suspected cases of child abuse and neglect. Without these penalties, the Reporting Act remains unenforceable in many instances.

5. Clarification of Interspousal Privileges

The difficulties involved in establishing guilt beyond a reasonable doubt in a child abuse case in criminal court are well known. Most states, including Illinois, have abrogated the status of one or more privileged communications, such as those between doctors and patients, social workers and clients, and husbands and wives, in order to alleviate some of these trial problems.

In Illinois criminal cases, a "...husband and wife may testify for or against each other: provided, that neither may testify as to any communication or admission made by either of them to the other or as to any conversation between them during marriage, except in cases where...the interests of their child or children are directly involved...." (Emphasis added.) (Ill. Rev. Stat. Ch. 38, ¶ 155-1.)

It came to the attention of the Commission through interviews with assistant state's attorneys that the language of this statute is a bit unclear as to whether foster children, step-children, or other children in their care, would be included by the statute above. Since the statutory definitions of "abused child" and "neglected child" appear to include foster children, step-children, children for whom a husband and wife are babysitting, etc., the intent of the legislature would be best served by adding the following clarifying language to ¶ 155-1:

> ...except in cases where...the interests of their child or children, or of any child or children in either party's care, custody, or control, are directly involved...." (Amendment underscored.)

Because the reasons for clarifying the abrogation of interspousal privilege in criminal cases applies to civil cases as well, the Commission recommends that Section 8-801 of the Code of Civil Procedure (Ill. Rev. Stat. Ch. 110, ¶ 8-801) be amended as follows:

> In all civil actions, husband and wife may testify for or against each other, provided that neither may testify as to any communication or admission made by either of them to the other or as to any conversation between them during marriage, except in actions between such husband and wife, and in actions where the custody, support, health or welfare of their children or children in either party's care, custody, or control, is directly in issue, and as to matters in which either has acted as agent for the other." (Amendment underscored.)

6. Standard of Proof in Parental Unfitness Proceedings

As discussed in Section C (Subsection 5 f) of Chapter 3, the standard of proof in proceedings to terminate the rights of parents and free a child for adoption was changed effective January 1, 1982. Public Act 82-437 amended Section 5-9 of the Juvenile Court Act (Ill. Rev. Stat. Ch. 37, ¶ 705-9) by reducing the standard of proof that must be met when seeking to terminate parental rights from "clear and convincing evidence" to a "preponderance of the evidence" (unless the parents are minors, mentally ill or mentally deficient).

The U.S. Supreme Court decision in Santosky v. Kramer (455 U.S. 745), issued in March of this year, has rendered this reduction in the standard of proof unconstitutional. In that case, a New York law requiring that only a "fair preponderance of the evidence" support a finding of unfitness in parental termination proceedings was declared invalid. It was held that the Due Process Clause requires states to support its allegations by at least "clear and convincing evidence" before the rights of parents to their natural child are completely and irrevocably severed.

Accordingly, the Commission recommends that Section 5-9 of the Juvenile Court Act be amended by requiring that a finding of parental unfitness be based upon "clear and convincing evidence."

7. Deletion of "Obscenity" Requirement in Child Pornography Prosecutions

This legislative recommendation arises not from the findings of this report, but from the Commission report entitled Sexual Exploitation of Children, published in 1980. However, because the decision of the U.S. Supreme Court in New York v. Ferber (455 U.S. 904), rendered July 2, 1982, clarified several constitutional questions regarding the proscription of child pornography, we are making this recommendation here.

That case, as well as the Illinois child pornography statute (Ill. Rev. Stat. Ch. 38, ¶ 11-20a) and other child pornography laws, are discussed in Section E (Subsection 4) of Chapter 1. For a better understanding of the implications of the Ferber case, the reader is directed to that earlier discussion.

To make prosecutions for child pornography easier, the Commission recommends that subsections (c) "Interpretation of Evidence," (d) "Prima Facie Evidence," and (e) "Affirmative Defenses" of the child pornography statute be amended by deleting all references to obscenity and the necessity of the State to prove the elements of obscenity (set forth in Ill. Rev. Stat. Ch. 38, ¶ 11-20a(c)) in child pornography prosecutions. Furthermore, it should be made clear in that statute that non-obscenity of the material is not an affirmative defense to the crime of child pornography.

8. Child Abuse Prevention Centers and Service Programs

While victims of other forms of domestic violence currently have a variety of temporary shelters and service programs available, children who are victims of abuse from both parents have no place in the community to turn.

The Commission recommends that DCFS be required to administer such shelters and service programs for abused or neglected children, or to provide for their administration by certain outside agencies. To be eligible for DCFS funding, those wishing to implement a shelter or service program should be required to provide a minimum of 20% in matching funds. In this manner, local governments and the private sector will be shown that they will receive needed support from the state if they are willing to take the initiative in this important area.

C. General Recommendations

1. DCFS should prepare a detailed statewide plan for the prevention of child abuse and neglect. The plan should identify the role that each agency, type of agency, and profession ideally should play and should include guidelines for implementing prevention programs as well as sample literature for promoting them. We recommend that DCFS extend its focus on abuse prevention beyond agencies and professionals that deal with children to include local programs and citizens throughout the state. DCFS should assess to what degree programs aimed at awareness and prevention of abuse and neglect exist, and take steps to coordinate and promulgate those efforts statewide.

2. In conjunction with the establishment of multidisciplinary teams, DCFS should develop cooperative agreements and procedures, in writing, with all appropriate criminal justice agencies regarding how cases of abuse and neglect will be handled.

3. DCFS should strengthen its in-service training program, especially for DCP investigators, CPS follow-up staff, and supervisory employees. Some of the continuing training for DCP investigators and CPS follow-up staff should be provided by experienced state's attorneys and police investigators to improve interviewing, report writing, case documentation, and case presentation skills. DCP and CPS follow-up supervisors should receive training not only in these areas, but also, along with supervisory employees throughout the Department, in performance management techniques.

4. A state-wide resource needs assessment should be conducted immediately by DCFS. DCFS should issue requests for proposals based on that assessment to establish treatment programs that would fill the many gaps in resources available to abusive parents and abused children. DCFS needs to develop, immediately, more contractual resources to handle cases of child sexual abuse and troubled adolescents.

5. DCFS should immediately revise its entire filing system. At a minimum, the documents in each folder should be filed consistently and should be well secured to prevent case data from being lost. Each file should also provide for data entry of all contacts made with the client or subject of the case file. Casework supervisors should be held accountable for ensuring that these files are accurate and complete.

6. DCFS should reestablish its unit of program evaluation to check on contractual agencies. Individual cases should be monitored, as should the operations of contractual agencies as a whole. Agencies should be required to submit appropriate reports on time or face the cancellation of their contracts. It should be made clear to DCFS workers that part of their function is to collect appropriate documentation, file it properly, and act on it promptly. DCFS should hold contractual agencies accountable for the services provided to individual clients in a systematic, review-oriented manner.

7. DCFS should develop a somewhat increased direct service capability so that it can adequately handle clients who present problems that cannot be addressed by available contractual agency services, or that could be better served by the close supervision of DCFS.

8. DCFS should develop a mechanism to deal systematically with problems identified at the caseworker level.

9. The Office of Administrative Case Review should examine periodically all open cases within DCFS. Presently, the Office reviews only those cases in which the child is placed out of the home; cases involving in-home family maintenance should also be reviewed. A review of all open cases will help prevent any cases from "falling through the cracks."

10. DCFS supervisors should function as supervisors and not as super-caseworkers. Attention must be paid to the method that caseworkers have used to resolve a case as well as to the result that they have achieved.

11. DCFS should significantly improve the quality of its internal investigations to ensure both accuracy and fairness.

12. So that cases do not languish in the system for technical reasons, DCFS should develop a case investigation procedure through which, under certain conditions, every member of the immediate family need not be physically seen and interviewed. This should not become a routine process, however; it should require, at the very least, that certain conditions be met and that supervisor approval be secured specifically in each case.

13. While DCFS' campaign to publicize the state-wide hotline for child abuse reporting has increased public awareness of the problem of abuse and neglect, DCFS should also publicize some of the major indicators of abuse and neglect in order to increase the detection of victimized children.

14. All schools that train professionals who under the law are or will become mandated reporters should teach as part of their normal curricula the signs of abuse as well as the techniques of interviewing child victims of abuse, sexual assault, and neglect.

15. Social service staff and all other mandated reporters should receive training in the detection and identification of child abuse and neglect. The responsibility for this training should be coordinated by DCFS and include the individual professional societies and associations to which mandated reporters belong.

16. All agencies employing mandated reporters such as police departments, hospitals, school districts and others, as well as all professional societies and associations whose members are mandated reporters, should design and implement a continuing information campaign to remind their employees or members of the specific statutory requirement to report all reasonable suspicions of child abuse and neglect to DCFS. Included as part of the information campaign should be a reminder of the possible consequences for failure to report.

17. The State Board of Education should examine the area of child abuse and neglect prevention and determine whether classes in parenting and similar skills should be mandatory and, if so, at what level. Individual school districts are encouraged to evaluate their programs, if any, that touch upon child abuse and neglect prevention and adopt additional or new programs as needed.

D. Funding

It goes without saying that the members of this Commission are cognizant of the harsh realities of today's economy and, in particular, the budget problems that currently confront the State of Illinois. It also goes without saying that if necessary improvements are to be made in the child protection framework established in this state, additional monies need to be expended. In terms of specific Commission recommendations made in this chapter, the implementation of multidisciplinary child protection teams (Legislative Recommendation 1) and child abuse prevention centers and service programs (Legislative Recommendation 8) will entail the expenditure of additional monies.

Therefore, even though revenue sources were not our main concern in this investigation, two points should be made:

1. Implementation of our recommendations should lead to long-term savings in that efforts currently expended in this area would become more coordinated. One of our major findings was that, while the situation has improved somewhat, child protection services still are duplicative and fragmented. At the least, the recommendations will eventually pay for themselves.

2. New sources of revenue are possible. State law currently provides that additional fees to be imposed on marriage dissolution petitions and marriage licenses (in the amount of $5 and $10, respectively) shall be used to fund domestic violence shelters ("An Act in relation to domestic relations and domestic violence shelters and service programs," enacted by the 82nd General Assembly). This law has been held unconstitutional, but only with respect to the divorce surcharge, in the Circuit Court of Cook County case of Crocker v. Morgan M. Finley, et al. (No. 82-CH-1), which is now on appeal in the Illinois Supreme Court.

Clearly child abuse and neglect are domestic problems and, as such, are closely related to marriage and divorce. It seems reasonable, then, that these fees could be increased to cover the cost of funding the implementation of our child abuse recommendations. And even if the Illinois high court upholds the finding of the circuit court that the domestic violence shelter funding law is unconstitutional, marriage license fees would be unaffected and still could be earmarked for costs incurred in improving this state's child protection system.

An alternative, or supplementary, source of funding might be specifically designated refunds of income tax. That is, a "check-off" on state income tax returns could be provided that would allow taxpayers receiving a refund to voluntarily earmark a small portion of it (such as $1, $2 or $3) for a children's trust fund.

California, Iowa, Kansas, Michigan, Virginia, and Washington all recently implemented one of these funding strategies by enacting children's trust fund legislation. Implementation of these strategies would not only provide a practical solution to the funding problem in a time of shrinking state services, but would enhance public awareness and community responsibility.

E. Introduced Bills

The Commission's legislative recommendations were put in bill form and introduced in both houses of the General Assembly on Tuesday, March 8, 1983 by the following Commission members:

Subject	Bill Number	Sponsors
Multidisciplinary Child Protection Teams (Recommendation 1)	House Bill 538	Representatives Aaron Jaffe and Dennis Hastert
Legislative Access to DCFS Records (Recommendation 2)	House Bill 732	Representatives Jeffrey D. Mays and Aaron Jaffe
Mandatory Reporting to State's Attorneys (Recommendation 3)	Senate Bill 269	Senators Bob Kustra and Emil Jones

Penalties for Failure to Report (Recommendation 4)	No Bill	
Clarification of Interspousal Privilege (Recommendation 5)	Senate Bill 290	Senators Adeline J. Geo-Karis and Frank D. Savickas
Standard of Proof in Unfitness Proceedings (Recommendation 6)	Senate Bill 299	Senators David N. Barkhausen and Jeremiah E. Joyce
Child Pornography Offense (Recommendation 7)	House Bill 539	Representatives Jane M. Barnes and John T. O'Connell
Prevention Centers and Service Programs (Recommendation 8)	House Bill 537	Representatives Aaron Jaffe and Dennis Hastert

The names of all twelve Commissioners appear on each bill as co-sponsors.

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Appendix A

RECOMMENDED GUIDELINES FOR COMMUNITY-BASED MULTIDISCIPLINE TEAMS FOR CHILD PROTECTION

[The following excerpted guidelines were issued in 1977 by the Commonwealth of Virginia Governor's Advisory Committee on Child Abuse and Neglect.]

PREFACE

The General Assembly of Virginia in session during the winter of 1975 amended the Code of Virginia by adding in Title 63.1 a chapter numbered 12.1 containing sections numbered 63.1-248.1 through 63.1-248.17. The addition established the statute of the State regarding child abuse and neglect, defined certain pertinent terms, set the framework for reporting, and encouraged the fostering of multi-discipline community and hospital-based teams within each locality.

> "The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multidiscipline teams which shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children, coordinating medical, social, and legal services for the children and their families, helping to develop innovative programs for detection and prevention of child abuse, promoting community concern and action in the area of child abuse and neglect, and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court."
>
> (Chapter 12.1, Section 63.1-248.6, E, Code of Virginia)

Although the local welfare departments were charged with "fostering" local teams, the same section suggests that public and private agencies as well as community groups and interested citizens be involved in the team.

Almost immediately, a need arose for some standards and guidelines to structure and give direction to the teams. Therefore, the Governor's Advisory Committee on Child Abuse and Neglect (also established by the aforementioned Code amendments) designated a subcommittee to perform such a function on behalf of the local teams.

Meanwhile, Region III of the Department of Health, Education, and Welfare signed a contract with the consulting firm Development Associates, Inc., to provide assistance to State groups as they began to structure programs for child abuse and neglect.

The material presented here is the result of the work of a subcommittee of the Governor's Advisory Committee on Child Abuse and Neglect consulting with representatives of Development Associates, Inc. Represented on the subcommittee were an established hospital-based team from the University of Virginia, the York County School Board, the Chesterfield-Colonial Heights Protective Services, The State Department of Corrections, the Orange County Welfare Department, a multi-discipline team in Virginia Beach, a mental health clinic in Martinsville, a health department in Abingdon, the Bureau of Child Protective Services and the general public.

Teams around the State provided advice and critical reaction as the subcommittee's work progressed.

Mrs. Elizabeth Bone
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State Department of Welfare
Richmond, Virginia

1. <u>TEAM PURPOSE, FUNCTIONS, AND ORGANIZATIONAL ISSUES</u>

A. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT CLEARLY IDENTIFYING ITS MISSION OR PURPOSE.

- This statement should include:

  1. measurable goals.

  2. priorities.

  3. specific objectives leading to the achievement of goals.

  4. action steps, members responsible and deadlines.

B. THE COMMUNITY BASED TEAM SHALL OBTAIN SANCTION AND SUPPORT FROM INFLUENTIAL GROUPS IN THE COMMUNITY.

- Sanctioning should be sought as early as possible in the team's development.

- The team should advise political leadership of its effort and submit periodic reports.

- Team members should seek sanction and support from their respective boards.

- The team should seek sanction and support from the local juvenile court and from the commonwealth's attorney, county attorney or city attorney.

- The team should develop alignments with other citizen groups and representatives of the private sector.

While the ultimate sanction for reducing the incidence of child abuse and neglect is based in law, the need for having everyone in the community understand and support the effort is obvious. Without this support, protective services and the community based team will be working in a vacuum. With the broadest community support that can be secured, everyone will become a part of the challenge, and the children will be the beneficiaries.

C. THE COMMUNITY BASED TEAM SHALL HAVE A WRITTEN STATEMENT OF OPERATING PROCEDURES.

- This statement should include:

  1. a method of electing a chairperson.

  2. responsibilities of the chairperson and members.

  3. terms of service of the chairperson and members.

  4. frequency of meetings.

  5. convenient time and locations of meetings.

  6. procedure for the conduct of meetings.

- Plans and mechanisms should be developed for continuous communication and coordination of efforts with sanctioning bodies and with other pertinent groups, public and private.

- The team may need to establish small, temporary subcommittees to undertake specific tasks.

D. THE COMMUNITY BASED TEAM SHALL BE PERMANENT SINCE EFFECTIVE SERVICE, PLANNING, AND COORDINATION ARE ENDURING PROCESSES. THE COMMUNITY BASED TEAM SHALL DEVELOP PROCEDURES TO INSURE COMMUNICATION AND COORDINATION AMONG ITS COMPONENTS.

- A firm link must exist between the Program Development Committee and the Case Consultation Committee through the core group.
- A member of the core group should serve as liaison between any temporary subcommittee and the team.
- The team members should understand how each organization represented on the team functions.
- Each member should be responsible for insuring that other members understand their professional "language."

II. COMMUNITY DEFINITIONS OF CHILD ABUSE AND NEGLECT AND STANDARDS OF CARE

A. THE COMMUNITY BASED TEAM SHALL RECOGNIZE THE COMMUNITY CONTEXT IN WHICH CHILD ABUSE AND NEGLECT OCCUR (COMMUNITY VALUES, INDIGENOUS PROBLEM SOLVING TECHNIQUES, CHILD-REARING TRADITIONS, RESOURCES AND LEADERSHIP) IN THE DEVELOPMENT OF PROGRAMS FOR TREATMENT AND PREVENTION OF CHILD ABUSE AND NEGLECT.

- The team should identify sources of leadership in both the public and private sector.
- The team should identify strengths in the community that help or could help in preventing child abuse and neglect.
- The team should identify social and economic problems and lifestyle patterns in the community that contribute to the problems of child abuse and neglect.

B. WITHIN THE FRAMEWORK OF THE STATE CHILD ABUSE AND NEGLECT LEGISLATION AND GUIDELINES OF THE DEPARTMENT OF PUBLIC WELFARE, THE TEAM SHALL DEVELOP AN OPERATIONAL DEFINITION OF ABUSE AND NEGLECT TO GUIDE ORGANIZATIONS AND INDIVIDUALS IN IDENTIFYING AND REPORTING.

- The definition should reflect community as well as professional standards and should be sufficiently broad for casework and preventive intervention. The definition should be reflective of the guidelines issued by the

State Department of Welfare. The definition should be consider the varying child-rearing practices in the community.

C. WITHIN THE FRAMEWORK OF EXISTING REGULATIONS, THE COMMUNITY BASED TEAM SHALL DEVELOP REALISTIC AND ATTAINABLE STANDARDS AND GUIDELINES FOR USE BY COOPERATING AGENCIES AND INDIVIDUAL PROFESSIONALS IN WORKING WITH CHILD ABUSE AND NEGLECT CASES.

The standards and guidelines should include:

1. joint diagnostic evaluation.
2. criteria for treatment plans.
3. criteria for format and timing of case review.
4. criteria for maximum caseload for team.
5. policies on follow-up of terminated or stabilized cases.
6. procedures for monitoring follow-up contacts.

Just as operational definitions can differ among communities, so also do the level of resources, leadership, decision-making processes, and cultural backgrounds. It is not possible, therefore, to develop standards and guidelines for service delivery that apply to every community situation. The team should bear in mind that if standards are set too low, they may be easily achieved but restrict progress. On the other hand, standards that are set too high may never be attainable in some communities, and frustration can be the result. By determining desirable patterns of services that are within the realm of reality and practicality, teams can measure needs by comparing existing patterns with the desirable ones. This process will provide the necessary groundwork for thorough program planning and development.

III. SIZE AND COMPOSITION OF COMMUNITY BASED TEAMS

A. THE SIZE AND COMPOSITION OF A COMMUNITY BASED TEAM WILL DEPEND ON THE TEAM'S FUNCTION AND PURPOSE WITHIN THE GEOGRAPHIC AREA.

The membership of the community based team should consist of a core group whose membership remains relatively permanent and a resource group whose membership varies according to the need of the team for consultation.

The core group should draw its membership from those who have given impetus to the formation and development of the community based team and who have shown regular attendance at the team's meetings. This should be a relatively stable group whose broad function is to act as a steering committee for the community based team. Specific functions of this group may include program planning and coordination as well as communication and liaison between the team's committees. It is recommended that membership of this group not exceed six.

The resource group should have an open-ended membership consisting of people who are invited to participate on the community based team for varying lengths of time determined by the core group and who function as case or program consultants to the community based team. The membership of this group need not be limited and should be comprised of people who agree to participate on the team for specific projects or tasks relevant to their areas of skill, knowledge, or community influence.

B. THE TEAM SHALL REFLECT THE RANGE OF PREVENTIVE AND TREATMENT RESOURCES AVAILABLE TO ABUSED AND NEGLECTED CHILDREN. IT SHALL INCLUDE PEOPLE INTERESTED AND WILLING TO PARTICIPATE ACTIVELY IN THE IDENTIFICATION, DEVELOPMENT AND EVALUATION OF PROGRAMS RELEVANT TO CHILD ABUSE AND NEGLECT.

- The membership of the community based team (i.e. core and resource people) shall be divided into a Case Consultation Committee and/or a Program Development Committee. The community based team may function in either one or both of these areas, depending on the continuing needs of the community in which the team is developed.

- The Case Consultation Committee should be restricted to community based team members who have the professional expertise necessary to identify and plan for treatment of child abuse and neglect cases. Individuals with knowledge of a specific case to be staffed by the Case Consultation Committee may be invited to participate on the committee for whatever length of time required for their consultation. This committee may include both agency and privately employed professionals and should involve people with a broad range of treatment and management knowledge, such as physicians, ministers, school personnel, psychologists, psychiatrists, social workers, law enforcement officials and health professionals. The specific professions represented will vary with

both availability as well as the demonstrated or expected contribution they may be expected to make to the committee. Where possible, these professionals should be drawn from local treatment agencies in order to provide a referral liaison between the committee and the agency. Agency professionals should have sufficient authority to accept referrals to their own agency as well as to represent their agencies' policies and procedures.

- The Program Development Committee should include community based team members who are agency as well as nonagency personnel. This committee should represent a cross-section community in demographic characteristics determined necessary by the Program Development Committee and may include representatives from civic groups, volunteer organizations, business and government. Members chosen for this committee should have skills, knowledge or influence necessary for contributing to program organization, coordination and evaluation as well as acquisition of funding. These members should also have demonstrated an interest and concern about child abuse and neglect in their community.

C. IF A MILITARY INSTALLATION EXISTS WITHIN THE AREA OF A COMMUNITY BASED TEAM, A REPRESENTATIVE FROM THE MILITARY SHALL BE INVITED TO BE ON THE TEAM.

IV. AREA AND COVERAGE OF COMMUNITY BASED TEAM

A. SUFFICIENT POPULATION SHALL BE ONE FACTOR IN DETERMINING THE AREA TO BE SERVED BY A COMMUNITY BASED TEAM AS WELL AS THE COVERAGE THAT CAN BE REASONABLY PROVIDED.

- The population base might differ for the Case Consulation Committee and the Program Development Committee of the team. A Program Development Committee might take as its scope an area as comprehensive as an individual welfare region; however, a Case Consultation Committee should be limited to a single municipality or a section thereof and perhaps to one or more of its neighboring jurisdictions.

B. THE AREA CHOSEN FOR COVERAGE SHALL NOT EXCEED PROSPECTS FOR ADEQUATE FUNDING TO ACHIEVE TEAM GOALS.

- Combined jurisdiction might guarantee a better financial base.

- Financial support for the team will come primarily from the budgets of participating agencies.

- Time and services may be donated by core and resource members of the team.

- There should be cooperative efforts between the public and private sectors in exploring the use of Title XX funds and other possible sources of funding.

- Supportive services may be provided by sponsoring organizations or groups. These can include such items as duplicating, clerical assistance, postage, etc.

C. COMMUNITY INTERESTS, LOCAL MORES, BUSINESS AND SOCIAL FACTORS AND TRANSPORTATION SYSTEMS ARE IMPORTANT CONSIDERATIONS OF AREA AND SCOPE OF COVERAGE.

- The team should determine whether the area has common problems amenable to solution through joint efforts.

- There should be a basic interpretation of community standards and values.

- Services should be accessible within a reasonable travel time.

- Existing transportation systems should be considered in developing services.

D. THE DISTANCE TO BE TRAVELLED BY ANY TEAM MEMBER TO ATTEND MEETINGS SHALL BE A LIMITING FACTOR ON AREA COVERAGE.

- A team member's travel time should not exceed two hours a day.

V. CITIZEN PARTICIPATION ON A COMMUNITY BASED TEAM

A. THE COMMUNITY BASED TEAM SHALL DEVELOP MECHANISMS FOR CITIZEN PARTICIPATION SO AS TO ASSURE AN ACCURATE VIEW OF AREA NEEDS, PATTERNS, AND TOTAL CITIZEN SUPPORT.

- The Community Based Team should encourage the participation of nonagency people. This will allow concerned citizens to share leadership and guidance in the planning and development of programs.

- Procedures for choosing nonagency members should reflect the community make-up, such as patterns of ethnic, racial, and economic levels. Other factors would include a willingness to serve and an interest and concern in the area of abuse and neglect.

- The Community Based Team should develop relationships with volunteer and citizen groups.

- The Community Based Team meetings dealing with community needs assessment, program planning and program evaluation should be open to the public.

- The team should develop regular communications with all segments of the community.

VI. PROGRAM DEVELOPMENT COMMITTEE

A. THE COMMUNITY BASED TEAM SHALL STUDY THE EXISTING SERVICE DELIVERY SYSTEM FOR ABUSING AND NEGLECTING FAMILIES IN ORDER TO DETERMINE THE COMMUNITY'S PROBLEMS, SIGNIFICANT GAPS OR OVERLAPS, AND OBSTACLES TO DEVELOPMENT OF A COORDINATED PROGRAM.

- Elements of the system that should be studied include:

  1. identification and reporting.
  2. investigation.
  3. diagnosis and treatment planning.
  4. long- and short-term treatment and follow-up.
  5. training of professionals.
  6. community education.
  7. prevention.

- The study should include not only those organizations and individuals currently providing services, but also any others in the community that could provide preventive or treatment services.

- Recommendations should be sought from any existing case consultation committee(s) and human services planning groups in the community.

- Information on problems and needs should also be elicited from clients, e.g., Parents Anonymous groups or Client Involvement Committees.

- The study should examine procedures for coordination within and among agencies and organizations.

- Each organization represented on the team may wish to assess its internal service capability, administrative procedures, planning and funding resources and commitment to the team process before assuming responsibilities within the team's plan.

B. BASED ON THE FINDINGS AND CONCLUSIONS OF THE STUDY, A PLAN SHALL BE DEVELOPED TO SUPPORT A COMMUNITY SYSTEM FOR THE PREVENTION, IDENTIFICATION AND TREATMENT OF CHILD ABUSE AND NEGLECT.

- The plan should establish a framework for cooperative community structures to prevent and treat child abuse and neglect.

- This plan should include:

  1. measurable goals (long-term, intermediate and short-term).

  2. priorities.

  3. operational objectives.

  4. specific action steps.

- The plan should consider adaptation of existing services as well as development of new ones.

- Recommendations for coordination at case consultation and program development levels should be included.

C. THE COMMUNITY BASED TEAM SHALL ASSIST THE COMMUNITY (INCLUDING ITS POLITICAL LEADERSHIP), THE GOVERNOR'S ADVISORY COMMITTEE, AND THE LEGISLATORS IN UNDERSTANDING CHILD ABUSE AND NEGLECT AS WELL AS IN FORMULATING AND EFFECTING LEGISLATION AND REALISTIC APPROPRIATIONS FOR SERVICES TO ABUSING AND NEGLECTING FAMILIES.

- The team should inform the community and its leadership of the results of its needs assessment study.

- The team should seek support for its comprehensive plan among various public and private organizations

as well as with political leaders.

D. THE COMMUNITY BASED TEAM SHALL SET THE DIRECTION FOR SOCIAL ACTION THROUGH THE DEVELOPMENT OF PUBLIC POLICIES THAT STRENGTHEN FAMILY LIFE, IN ORDER TO ALLEVIATE THE ECONOMIC AND SOCIAL CONDITIONS THAT CONTRIBUTE TO THE PROBLEM OF ABUSE AND NEGLECT.

A thorough study must be undertaken before an effective plan can be developed. The study should consist of a compilation of relevant statistical information as well as opinions and the analysis of these to determine problems. It is crucial that real needs based on facts be identified. The problems that appear most obvious may be those for which a solution is already known and may not reflect the more critical problems underlying the service delivery system that should be addressed in the plan. The more directly each goal can be related to a specific part of the problem, the more successful planning efforts will be. It is difficult to develop realistic long-range goals because changes in conditions upon which they are based are not always predictable. It is important, however, that teams attempt long-range planning to set the overall framework of their short-term goals and efforts. It is also essential that the team establish priorities among its goals to reduce confusion about which activity is more important and to provide direction on where scarce resources can most effectively be used. In doing this, the team should always keep in mind the interdependence of various activities.

Adaption of existing resources as well as development of new resources should be considered. Existing day-care programs might, for example, reserve a number of slots for abused or neglected children after securing training for program staff. Voluntary organizations and church groups also sponsor programs that might be adapted to the needs of abusing and neglecting families.

The plan should include a description of existing coordinating procedures, such as referrals, sharing of information, and terminating of cases, and should make recommendations for changes if needed.

VII. CASE CONSULTATION COMMITTEE

A. ANY MEMBER OF THE COMMITTEE OR HIS DESIGNEE MAY PRESENT A CASE TO THE CASE CONSULTATION COMMITTEE. THE LOCAL WELFARE AGENCY SHALL DETERMINE WHICH OF ITS CASES ARE IN NEED OF THE COMMITTEE'S ASSISTANCE. THE LOCAL WELFARE AGENCY

MUST BE ULTIMATELY RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING SERVICE ON ITS CASES.

- Appropriate cases to be brought to the Case Consultation Committee should be situations where the specific treatment needs are not clear, where it is questionable whether the child can safely remain at home, where a permanent plan of foster care or adoption is to be considered, or where numerous community resources and treatment services must be coordinated.

B. THE CASE CONSULTATION COMMITTEE SHALL ASSIST THE LOCAL WELFARE AGENCY IN MAKING A COMPREHENSIVE DIAGNOSIS AND TREATMENT PLAN FOR EACH CASE PRESENTED TO THE COMMITTEE. THE COMMITTEE SHALL ASSIST IN MOBILIZING AND COORDINATING SERVICES TO MEET BOTH SHORT AND LONG TERM TREATMENT GOALS.

- The Case Consultation Committee shall assist by:

  1. collecting relevant information on the child and family members to validate a complaint or report; to the greatest extent possible, information should be collected directly from the family.

  2. providing a forum to integrate information and identify potential problems in service delivery.

  3. assessing needs, strengths and priority problems of the child and family members.

  4. recommending short- and long-term treatment plans and matching needs with appropriate resources.

  5. coordinating referrals to available resources.

  6. promoting development of needed resources.

  7. determining when a case is to be presented for another review.

  8. developing a recall system to assure that cases will be reviewed at predetermined intervals.

  9. determining when a case can be safely terminated.

C. THE CASE CONSULTATION COMMITTEE SHALL INSURE THAT APPROPRIATE FEEDBACK IS PROVIDED TO INDIVIDUALS WHO REPORT SUSPECTED CHILD ABUSE OR NEGLECT SITUATIONS, WHERE THIS IS ALLOWED BY LAW.

- The State Department of Welfare, Social Service Manual outlines procedures for providing such feedback. In addition, the committee could determine other feedback methods; e.g., a reporting professional might attend diagnostic and/or treatment review conference.

D. THE CASE CONSULTATION COMMITTEE SHALL ENCOURAGE COORDINATED EFFORTS AMONG AGENCIES AND INDIVIDUALS WHO ARE RENDERING DIRECT SERVICES TO A FAMILY. WHEN SERIOUS PROBLEMS OF COORDINATION OR SERVICE DELIVERY OCCUR, THE CASE SHOULD BE REVIEWED BY THE COMMITTEE.

- Initially, service providers would convene to clarify their respective roles and set intervals for progress conferences. Each provider would accept responsibility for communicating with other providers whenever indicated, e.g., when a family crisis warrants concerted action. Providers will want to consider the advisability of involving family members in conferences when appropriate.

  When a conflict between providers cannot be resolved, it would be in the family's best interest for the case to be reviewed by the Case Consultation Committee.

VIII. PARENTS' AND CHILDREN'S RIGHTS

A. THE CASE CONSULTATION COMMITTEE SHALL AT ALL TIMES REMAIN AWARE OF THE NEED TO PROTECT THE RIGHTS OF PARENTS AND CHILDREN IN THE PRESENTATION OF CASES BEFORE THE COMMITTEE.

- All committee members shall become familiar with State legislation and agency regulations regarding confidentiality in child abuse and neglect cases. Minimally, the Case Consultation Committee shall adhere to the Privacy Protection Act of 1976, Section 2.1-377 through 2.1-386 of the Code of Virginia.

- Any information shared concerning the child and his/her family shall safeguard to the greatest extent possible, the privacy rights of the individual involved.

B. DUE TO THE PRIVACY PROTECTION ACT, IT IS RECOMMENDED THAT TEAM MEMBERS SIGN A WRITTEN STATEMENT THAT GUARDS THE CONFIDENTIALITY OF ALL INFORMATION REVEALED DURING TEAM DISCUSSIONS.

IX. INTER-AGENCY AGREEMENTS

A. THE TEAM SHALL OBTAIN WRITTEN AGREEMENTS OF COOPERATION FROM THE AGENCIES AND ORGANIZATIONS WITHIN THE COMMUNITY'S SERVICE DELIVERY SYSTEM.

- Local interagency agreements should reflect any agreements existing between State agencies.

- Agreements should be based on the results of the study and comprehensive community plan developed by the team.

- Agreements should include:

  1. methods for formal and informal communication among staff.

  2. referral procedures.

  3. criteria for cases to be accepted by each.

  4. the roles agencies will play in identifying and reporting cases, providing various types of treatment and day-to-day management of cases.

  5. procedures for sharing information on diagnosis and progress of cases with which more than one agency is working.

  6. mechanism for resolving conflicts that might arise among staff working on a case.

B. THE AGREEMENTS SHALL RECOGNIZE THE LOCAL WELFARE AGENCY'S NEED FOR SUFFICIENT INVOLVEMENT IN CASES TO CARRY OUT ITS LEGAL MANDATE.

- The team should insure that the local welfare agency's authority and responsibilities are observed.

  It is essential that the team insure that all agreements reflect the legal mandate of the local welfare agency; for example, the local welfare agency is given the authority to investigate all reported cases of suspected abuse and neglect.

C. THE TEAM SHOULD ENCOURAGE CONFERENCES AMONG COOPERATING AGENCIES ON A REGULAR BASIS TO DISCUSS PROBLEMS AND RECOMMEND CHANGES IN PROCEDURES AS NECESSARY.

- Administrators of cooperating agencies should meet quarterly to review progress in implementing the comprehensive community plan.

- Agreements should be reviewed and revised as necessary.

X. <u>PROGRAM EVALUATION/RESEARCH</u>

A. THE COMMUNITY BASED TEAM SHALL ENCOURAGE ALL AGENCIES TO MAINTAIN AND SHARE THE TYPES AND AMOUNT OF DATA NECESSARY FOR PLANNING AND EVALUATION OF PROGRAMS.

- This information should include:

  1. the number and sources of referrals.

  2. the number of valid cases.

  3. the type of abuse and neglect.

  4. the number of cases terminated and the reason.

  5. the number of repeated cases.

  6. the types of services provided by organization.

  7. the number of organizations providing services.

  8. the number of individuals providing services.

  9. the number of case conferences held.

  10. the number of joint treatment plans developed.

  11. the number and types of training programs.

  12. the number and types of public awareness programs.

B. THE COMMUNITY BASED TEAM SHALL REGULARLY PERFORM A REVIEW AND EVALUATION OF THE COMMUNITY'S OVER-ALL SERVICE DELIVERY SYSTEM WITH EMPHASIS ON THE EFFECTIVENESS, EFFICIENCY AND ACCEPTABILITY OF SERVICES FOR CHILD ABUSE AND NEGLECT CASES.

- Effective planning for child abuse and neglect services is based on regular evaluation of community programs and their effects on families.

C. THE COMMUNITY-BASED TEAM SHALL DEVELOP METHODS FOR REVIEWING AND EVALUATING THE EFFECTIVENESS WITH WHICH SERVICES ARE BEING COORDINATED AND UTILIZED.

- The team should designate persons skilled in evaluation methods to assist with this evaluation.

- The team should determine how a representative sample of cases is to be selected and assist with selection of cases for review.

- The team should spell out criteria for determining effective and noneffective use of services by client; e.g., number of appointments made, kept, broken, accessiblity of service, completeness of treatment plan, regularity with which treatment plan is reviewed and updated.

- The team should determine how often such reviews should be conducted.

- The team should be responsible for writing and distributing a report of findings and recommendations to improve service utilization and coordination.

D. THE COMMUNITY BASED TEAM SHALL COOPERATE WITH INDIVIDUALS AND GROUPS CONDUCTING BONAFIDE RESEARCH ON CHILD ABUSE AND NEGLECT BY PROVIDING APPROPRIATE INFORMATION.

- The teams should be assured that the purpose of research is valid.

- Only nonidentifying information should be released.

- The teams should insure that the researcher is following acceptable research standards such as those governing the protection of human subjects.

- Cooperation with appropriate research gatherers may result in valuable planning and evaluation assistance to the team.

Appendix B

SOME "DO'S AND DON'TS" OF INTERVIEWING
[for school personnel, possible child abuse or neglect]

When Talking with the Child

DO:

- Make sure the interviewer is someone the child trusts
- Conduct the interview in private
- Sit next to the child, not across a table or desk
- Tell the child that the interview is confidential
- Conduct the interview in language the child understands
- Ask the child to clarify words/terms which are not understood
- Tell the child if any future action will be required

DON'T:

- Allow the child to feel "in trouble" or "at fault"
- Disparage or criticize the child's choice of words or language
- Suggest answers to the child
- Probe or press for answers the child is unwilling to give
- Display horror, shock, or disapproval of parents, child, or the situation
- Force the child to remove clothing
- Conduct the interview with a group of interviewers
- Leave the child alone with a stranger (e.g., a CPS worker)

When Talking with the Parents

DO:

- Select interviewer(s) appropriate to the situation
- Conduct the interview in private
- Tell the parent(s) why the interview is taking place
- Be direct, honest and professional
- Tell the parent(s) the interview is confidential
- Reassure the parents of the support of the school
- Tell the parents if a report has been made or will be made
- Advise the parent(s) of the school's legal responsibilities to report

DON'T:

- Try to "prove" abuse or neglect by accusations or demands
- Display horror, anger, or disapproval of parent(s), child, or situation
- Pry into family matters unrelated to the specific situation
- Place blame or make judgments about the parent(s) or child

From The Role of Law Enforcement in the Prevention and Treatment of Child Abuse and Neglect, by Diane D. Broadhurst and James S. Knoeller, U.S. Department of Health and Human Services, User Manual Series, August 1979, p. 42.

Acronyms

ACT	Associates in Crisis Therapy, Inc.
AHA	American Humane Association
ASA	Assistant State's Attorney
CAFA	Child and Family Advocates of Evanston
CA/N	Child Abuse/Neglect
CANTS	Child Abuse/Neglect Tracking System
CAUSES	Child Abuse Unit for Studies, Education and Services
CCR	Council on Children at Risk
CHAS	Children's Home and Aid Society
CPS	Child Protective Services
CPT	Lake County Child Protection Team
CSATP	Child Sexual Abuse Treatment Program
CYCIS	Child and Youth Centered Information System
DAS	Developmental Abilities Service of Lutheran General Hospital
DCFS	Illinois Department of Children and Family Services
DCP	Division of Child Protection
DMH-DD	Illinois Department of Mental Health and Developmental Disabilities
DPA	Illinois Department of Public Aid
ECHO	Emergency Caretaker and Homemaker Outreach
EPS	Emergency Protective Services
GAP	Group Action Planning
HELP	Human Effective Living Programs, Inc.
HHS	Department of Health and Human Services
HIS	Home Intervention Systems
I & R	Information and Referral
IDDAA	Illinois Developmental Disabilities Advocacy Authority

ISOS	Illinois Status Offender Services
JSPA	Joint Service Program for Adolescents
MARS	Management Accounting and Reporting System
NCCAN	National Center on Child Abuse and Neglect
RFP	Request for Proposal
SCAN	Suspected Child Abuse and Neglect
SCR	State Central Register
SCU	Service Coordination Unit
SEDOM	Special Education District of McHenry County
UDIS	Unified Delinquent Intervention Services
VOA	Volunteers of America
YSB	Youth Services Bureau

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