Grief and Loss,
Spiritual Support
and Child Welfare:

A Handbook for Hospital Chaplains & Child Welfare Professionals

ACKNOWLEDGEMENTS

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I. INTRODUCTION

This Handbook on Pastoral Care and Child Welfare has been produced for child welfare professionals and hospital chaplains in response to each profession's desire to gain a greater understanding about the other's role and responsibilities.

Through its investigative work, the Office of the Inspector General for the Department of Children and Family Services (DCFS) has noted that both DCFS case managers and chaplains need clarification about the religious rights of children in state custody due to abuse or neglect (sometimes referred to as DCFS wards). DCFS case managers have an ethical obligation to inform wards of their religious rights and to assist them in making connections with their spiritual community. Hospital chaplains can be a valuable resource to both case managers and DCFS wards.

This Handbook provides insights and suggestions for working with DCFS wards with regard to their spirituality so that case managers and hospital chaplains can work together effectively. Its purpose is to facilitate conversations, networking, and the general establishment of better working relationships between the professions so that each may better serve children in need.

Some children and their families have religious and spiritual preferences and some do not. It is equally important to honor the religious rights of the former group and to be respectful of the preferences of the latter.

The role of DCFS as a state agency is not to promote spirituality and religion, but to protect the rights of children and provide access to religious resources for those who want them. The role of hospital chaplains is to be available to children and their family members who wish to confide in them during difficult circumstances.

Important Terms

What is DCFS?

The mission of the Illinois Department of Children and Family Services (DCFS) is to protect children who have been abused or neglected and, when appropriate, to improve their families' ability to care for them. DCFS also provides for the well-being of children in the state's custody due to abuse or neglect. These children are referred to as "DCFS wards."

How can I contact DCFS?

DCFS has hotlines and other important numbers for people wishing to report child abuse and neglect or ask questions about DCFS. Please refer to Appendix C for DCFS contact information.

Who are DCFS wards?

DCFS wards are children who have been taken into protective custody by the state due to their abuse and/or neglect by their parent(s), someone in their home, or another caregiver. Wards are often placed in foster care homes (substitute care). This separates them from their biological parents' home and places them in the home of either a relative or an unrelated person until they can be returned home or placed in another permanent home. Foster care professionals try to place children with their siblings, but sometimes it is not possible. This means that many children are separated not only from their parents but also their siblings. Some children are placed in numerous foster homes during their substitute care experience. When moving from home to home, they sometimes must also change schools, friends, families, religious institutions, and mental health and healthcare providers. Many children in foster care feel insecure and apprehensive about the future before they even enter the hospital.

The Religious Rights of DCFS Wards

Spirituality can be a very important part of a child's life. Thus, case managers have an ethical obligation to inform wards and their biological and foster families of their religious rights. DCFS Procedure 301.60(a4) states that a child aged eleven or under should be placed, when possible, in a foster placement with the same religious affiliation as that child or his/her biological parents. If the religious affiliation of the foster home differs and the child is eleven or under, the biological parents of the child will be asked to sign a consent form (included in the Appendix E) indicating parental consent regarding the child's religious instruction and attendance. Parental refusal to sign the consent form shall be documented in the child and parent case records. In the case of a child aged twelve or older, he or she has the right to choose his/her own religious preference and practice. Case managers should inform their wards, their families and foster families of these rights, and respect the decisions they make in this regard.

Chaplains and DCFS Case Managers

DCFS case managers have an ethical obligation to respect children's religious rights, but are outside their area of professional expertise when dealing with religious matters. Thus, chaplains can be an important resource for case managers with children in the hospital. Chaplains can provide comfort to hospitalized wards and help them work through the anxiety of a hospital stay. They can be especially helpful in the immediate aftermath of abuse and neglect when children are still in the process of being placed in foster care. If family members wish to talk to the chaplain, he or she can be a valuable resource for them. Since such families are usually involved in the child welfare system involuntarily, they may be resentful or angry with case managers or the DCFS system. Thus, families may be more inclined to confide in chaplains to help them cope with current circumstances. While chaplains are not medical professionals, they do have relationships with healthcare providers and may be able to mediate between healthcare providers and families so that everyone can better understand the situation.

Hospital chaplains dealing with DCFS wards should consider the special circumstances of these children. Although DCFS wards should be treated like other children in most ways, it is also important to recognize that their life

experiences can be very different. Chaplains should have a basic understanding of the child welfare system and its effects on children so that they are better able to provide appropriate comfort. Chaplains should also be aware that DCFS case managers are not the only child welfare workers they may encounter in the hospital. Many child welfare cases are handled by private agencies that have contracts with DCFS. These agencies are called Purchase of Service (POS) agencies, and they assign their own case managers that function in the same way as DCFS case managers. In addition to the case manager, the DCFS Guardianship Administrator or their designee may sometimes be present with a hospitalized ward. The Guardianship Administrator acts as legal guardian for all DCFS wards. It is the responsibility of the Guardianship Administrator, or their designee, to provide legal consent on behalf of wards, including medical consents. (In the event of the death of a DCFS ward, custody of the child's body immediately belongs to the biological parents.) It should be noted that the DCFS Guardianship Administrator is distinct from a Guardian Ad Litem (GAL). A GAL is a person appointed to represent the interests of a minor in court. Please see Appendices B and D for greater clarification of these roles.

A child abuse and neglect investigation can be very difficult for a family. Most often, parents love their children and want the best for them, but may not have the skills, knowledge, or capacity to provide a proper environment for them. Children in foster care have often lived through chaos and instability in their home environments. Therefore, an interdisciplinary team can help children experience consistency. It is important for all professionals who become involved in the process to interact in a cohesive way that does not further harm or confuse the child.

It is essential to remember that abused children's feelings about spirituality and religious institutions will vary. Thus, it is important to discover and respect each child's perspective on spirituality. **It is also important for professionals (chaplains and case managers) to operate within their own areas of competence.** Case managers should identify the religious preferences of their wards, and then refer them to chaplains or other religious personnel. Similarly, chaplains should defer to case managers on issues outside the spiritual domain.

II. EFFECTS OF ABUSE AND NEGLECT ON CHILDREN

What kinds of problems do neglected and abused children experience?

Foster children often have had extremely complicated and unstable pasts. This leads to predictable insecurity and other problems. Some abused and neglected children have problems trusting people and can experience serious behavioral problems because of their troubled history. Other problems may inlcude:

- Medical problems (sometimes stemming from abuse and/or neglect)
- Behavioral problems
- Depression
- Anxiety
- Feelings of abandonment
- Low self-esteem
- Drug or alcohol abuse
- Fear of intimacy
- Extreme shyness or withdrawal
- Pseudomaturity or overcompensation
- Sexual acting out
- Lack of trust

How can case managers and chaplains help foster children minimize the effects of abuse or neglect?

Both case managers and chaplains can provide a sense of consistency and stability for foster children. As children deal with separation from loved ones, case managers and chaplains can:

- Acknowledge the difficulties of leaving a parent (foster or biological) and/or siblings;
- Allow children to express their frustration, anger, and sadness; and
- Help children develop ways of easing the trauma of separation from their loved ones (writing a letter, drawing a picture, or talking about how hard it is).

It is important to establish links for children to connect on a regular basis with supportive adults, siblings, or communities. This can help increase a child's feelings of stability while separated from his or her family. Case managers and chaplains may have connections to a variety of supportive services and can work together to establish networks for foster children. For example, a chaplain could help the case manager make contact with the clergyperson at the child's home church.

III. CHILDREN'S SPIRITUALITY

Is there a difference between spirituality and religion?

Traditionally, there has been a distinction between the terms "religion" and "spirituality."

- **Religion** is generally defined as: an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to a transcendent reality and to foster an understanding of one's relationship and responsibility to others living together in community.

- **Spirituality** is the personal quest for answers to ultimate questions about life, meaning, and relationship to the sacred or transcendent, which may or may not lead to or arise from the development of religious rituals and the formation of community.

Throughout this Handbook, we will use both terms to address faith issues. Professionals (social workers, lawyers, healthcare providers, etc.) sometimes have a difficult time addressing the spiritual and religious needs of children. It can be difficult to draw the appropriate lines between church, state, and individual rights. However, for the welfare of abused or neglected children, it is important to address all significant issues that touch their lives.

Why is a child's spirituality important?

Many families regard spirituality and religion as an important part of their lives. People often look to their church, synagogue, mosque, temple, or other religious group to provide family behavior guidelines for both children and adults. Additionally, many religions preserve a system of values, norms, and laws for family frameworks; for example, Jewish communities view the family as the primary vehicle for transmitting and preserving the faith. Religion can also serve as a framework for strengthening and uniting families. It is not only appropriate but also necessary to allow DCFS wards to discuss their religious beliefs and preferences, and to allow them to be incorporated in their healing processes. There are some cases where religious beliefs have harmed and distorted family ideologies and systems. However, religious communities more often serve as supportive structures for keeping families intact.

Can spirituality benefit children?

Experiencing spirituality usually means feeling a connection with a higher power. This connection can be an important presence in a child's life and a way to cope with difficult circumstances. Sometimes children who have been abused have relied on their spirituality and their particular religious institution to help them survive their experiences. This can be a very important resource for children to heal, grow, and survive. Furthermore, children who are sick may receive comfort and find answers by relying on their spirituality.

Spirituality can also play an important role in children's lives by helping them develop close and important relationships. Often, children make friends and

develop positive peer groups at their regular religious institution. These support networks may protect children and lead them away from substance abuse, smoking, teenage pregnancy, and other behaviors that can have life-long consequences. Spirituality can also broaden children's life experience and provide them with mentors and healthy role models.

Can spirituality harm a child?

Spirituality, like many other aspects of life, can have negative effects when distorted. Sometimes religious rationalizations are used to justify actions that could be considered abusive. For example, the Bible contains a passage that is sometimes interpreted to justify corporal punishment of children. There have also been instances where a a trusted member of a religious institution hides under distorted view of their religion to justify abuse. However, the tenets of mainstream religious traditions do not advocate or encourage intentional harm to others. Although religious justifications have sometimes been used to promote violence and hate, religious traditions most often uphold principles of love, hope, peace, and faith. A healthy skepticism should be maintained about religions, institutions, and religious people that seem punitive in their outlook.

Are there religions that advocate the use of spiritual care instead of medical care for children?

Yes, there are some religions that prefer spiritual healing to medical care. This is a controversial topic among medical personnel who believe that all children should have medical care regardless of their parents' wishes. However, the U.S. Supreme Court has held that spiritual practices such as prayer may serve as an alternative to traditional medical treatment. If the child is in DCFS custody, the Guardianship Administrator can authorize medical treatment for the child in spite of the parents' religious preferences. Please consult Appendix A of this handbook for some of the specific medical preferences of different religious groups.

How does spiritual formation occur during a child's development?

Formation of spiritual identity occurs in parallel with a child's development. Faith development is a continuous process in life; however, children are in a very different part of their journey from adults. Children are trying to figure out not only who they are, but also what spirituality is and how it relates to

them. As children develop cognitively, their spiritual outlook will develop as well. Many children's religious and spiritual values will stem from their parents' beliefs.

Some children progress more slowly with verbal and thinking skills; this may also slow their understanding of spirituality but will not necessarily make it less important. They may just understand spirituality less abstractly than other children of the same age.

Can abuse or neglect affect a child's spirituality?

Abuse can sometimes have negative affects on a child's spirituality. For example, if a child believes in God, the abuse he suffered may result in a negative conception of God. Many children who survive abuse and neglect will have some religious questions stemming from the abuse. Rather than attempting to answer these questions themselves, case managers can introduce such a child to the chaplain, whose function is to discuss such issues.

Does sickness affect a child's spirituality?

Children with serious disease or illness may also have religious questions pertaining to their illness. It is important for chaplains, when possible, to help children deal with their questions and understand their sickness within the context of each child's own spiritual tradition. Children who are not spiritual may also benefit from the consistent empathetic listening that hospital chaplains can provide. Case managers should make sure that children are aware that the chaplain is an available resource.

CONCLUSION

While the world's religious traditions are very diverse, each tradition recognizes children as an important link to the future. The issues of children's spiritual and religious rights are complex in nature. To ensure the best exercise of these rights, it is important for chaplains and case managers to establish and maintain relationships so that they can converse and consult with one another as different situations arise. Please consult the Appendices for important information regarding religion and medicine, the DCFS system, and resources for calling chaplains and DCFS.

IV. CHILDHOOD GRIEF AND LOSS

The loss of a friend, parent (biological or foster), or other involved relative is a stressful event for any child. For those who have experienced crisis in their youth, these experiences can be particularly complex and traumatic. Children process death differently than adults and efforts to help them cope during times of grief and loss must be tailored both to their age and life experiences. Chaplin and hospice agencies can help by linking a child to Grief and Loss supportive services.

This section includes a number of techniques and resources available to those offering support to children dealing with grief and loss. In addition, a video illustrating the many issues and concerns related to helping children through these difficult times in available on the Office of Inspector General Dnet page. All are tools intended to assist those working with children during confusing and difficult times.

Supporting Grieving Children

Children are disadvantaged as grievers. They do not have the same language abilities, cognitive understanding, and experience that adults do. Children look to adults for cues on how to grieve. They are affected by the emotions of others and learn the "rules" for grieving from observing others. Professionals have an opportunity to model permission and acceptance of a variety of feelings and help in identifying support systems.

Grief is a normal response to loss. It is made up of the thoughts, feelings, and behaviors experienced when there is a loss. Grief is physical, emotional, psychological, social, and spiritual. Many events, such as death, divorce, deportation, and abandonment can create a loss for children and it seems that children are increasingly experiencing loss at a younger age.

When a death does occur, sometimes even professionals feel ill-equipped in how to support the child. Adults are often immobilized by their own anxieties and loss histories. Cultural taboos about death may also interfere with many adults ability to support grieving children. Children can not be protected from the pain of grief, but these situations

can provide unique opportunities to impact and promote healing and introduce skills that will help them throughout their lives.

Three Basic Needs

1) Honesty. Children almost always know "something." They overhear conversations, observe facial expressions, and watch people come and go. It is normal to want to "protect" them, but secrets can feel unsafe and leave children feeling more vulnerable, insecure and alone. Children will try to fill in the missing pieces and often their imaginations are worse than the truth. The goal is to create an environment where children feel safe to ask questions and to express their feelings.

Give honest and accurate information. Children need to be able to trust the adults around them and they are better quipped to cope if given what to expect.

Avoid euphemisms. Use the words death & dying. Any other words (lost, on a trip, sleeping) have other implications which only create more confusion.

Encourage consistency in language in describing the situation.

Begin with where the child is and follow their lead. Ask them what they know or understand is happening. This also allows the opportunity to correct any misinformation or check for "magical thinking."

Encourage questions. Be honest and answer truthfully, even the hard ones. But, it is also okay to say, "I don't know" or "let's find out together."

Provide as much information as they ask for but don't push more than they want or are ready for. Children at different developmental ages will need different levels of information. Try not to go past their attention span or their ability to understand. Do frequent check-ins.

Utilize drawings, pictures, puppets, dolls as tools. Children often respond to visuals and concrete explanations.

Acknowledge the loss. Use the name of the person who died. Encourage memory sharing. Provide opportunities to memorialize and remember the person who died.

2) Children are children *first* and grievers *second*. Even in very traumatic situations, children often demonstrate very typical, carefree, child-like behaviors. What may appear as indifference or a lack of feelings is actually a self-protecting measure. Children can tolerate only small dosages of grief at a time.

Children often grieve with their bodies. Somatic complaints and physiological symptoms are normal. Anticipate eating and/or sleep disturbances and some change in behaviors: tiredness, lack of concentration, nervousness, separation anxiety are normal.

Respond with nurturance to complaints of physical aches and pain. It often represents anxiety and other emotions connected to their grief

Regression is normal. Bedwetting, baby talk, tantrums, separation anxiety are common. With support, children often quickly regain their developmental milestones.

Encourage and utilize play as an opportunity for the child to communicate and express themselves. In an attempt to master what they have seen, children will often play it out.

Behaviors are functional. Be a good observer. Children often communicate through their behavior. "Listen" to all levels of communication.

Provide a variety of tools for the children to express themselves. Art, music, play, games, and books can be wonderful tools for expression and communication.

3) Reestablish Safety & Routine. Children need limits and boundaries. When a death occurs, it shatters their sense of safety and security. There is a loss of trust and protection. At a time when everything is changing and unpredictable, they need to know that someone is going to keep them "safe," physically and emotionally. Rules feel safer than the unknown.

Maintain as much of their routine as possible and where there is change, empower the child with as many choices as appropriate.

Explore with the child what they need when they are having difficulty. This may be different when at home, when at school, or when with friends.

Help the child identify who they perceive as supportive and helpful within the family, peer group, school and other situations.

Allow the child to direct how others are told and what they are told.

Encourage consistency in their day to day routine.

Be Present. Listen and listen some more. Don't force a child to talk. If the child is initially resistant, offer again and again. Continue to be available. They may not be ready. Or may still need to develop trust and reclaim a sense of security first.

Become familiar with community resources and support groups.

Three Influencing Factors

Children's needs will be influenced by their developmental age, loss relationship, and personality. Each child is a different individual with a different personality with a different life experience.

1) **Developmental Age:** The child's age at the time of death will significantly affect their ability to understand death and finality. Children will also respond with behaviors that are typical for their age. Certain awareness should be given to how their age influences their needs and relationship with others. Children may also revisit their grief years later at different development milestones as their understanding and questions change.

2) **Loss Relationship:** A child's grief experience will be influenced by who died. There are specific dynamics related to the death of a parent, grandparent, sibling, or friend. Children can also be affected by deaths within the community or in the media. There should also be certain sensitivity to the quality of that relationship and how it may influence their grieving process.

3) **Unique Personality:** Every child is unique and different. Children will utilize similar coping skills they have used in the past. If a child was very verbal before, they will probably be more verbal in their grief. If they

didn't like to talk, they probably won't now. But this is also an opportunity to draw upon their strengths. Explore their interest and help them identify how they can use art, music, sports, etc. to express themselves now.

Three Universal Concerns

1) **Did I cause it?** Children will suspect that somehow, by something they did, or didn't do, that they "caused" the death. Young children believe in their omnipotence- what happens around them happens because of them. They may believe thoughts cause actions. This can create an overwhelming feeling of guilt for a situation totally outside their control. Explore with them their perceptions and beliefs about what happened. Children need to know nothing they did made this happen. They may need to be reminded of this over and over again.

2) **Can I catch it? Can this happen to me?** Children may be afraid the illness is contagious or that the same disease could happen to them. Beware of somatic complaints. Many children take on the symptoms they witnessed from the person who died. They will need to be told that they can't "catch" the disease. They can't catch it by kissing the person, touching the person, eating their food, breathing their air, etc. Some children may need to talk with a physician to believe they are healthy. If the disease is contagious, the children will need to know what is safe.

3) **Who will take care of me?** Regardless of who died, their world is no longer safe. When one family member dies, suddenly children realize others can die. Children will need to know who is going to take care of them. Encourage parents to talk openly about this fear and involve the children in developing a care plan.

SUMMARY

Most important to remember is that there is no timetable on grief. Children and families will experience it in their own way, in their own time. Hopefully, with time, the intensity and the frequency will decrease but their needs continue. In particular, be aware of special dates and holidays. They may trigger emotions even years later. The loss may also be magnified at different

events throughout their lives; first day of school, graduation, weddings, birth of a child, or some days will just be more difficult than others. Their loss will be remembered and be a part of who they are.

What children report as most important is that others acknowledge their loss. Do not let your anxiety or fear stop you from offering support to the child. Respect their need for time, their need to play, and their ability to heal. Let children "teach" you what they need and show you how they feel. The gift to bring is your presence, without judgment, and a commitment to help.

For Grief and Loss support services:

- Contact the social work department or the chaplaincy office at your local children's hospital. See Appendix C for a list of children's hospitals with contact information.

- Contact Rainbows. Rainbows is an international not-for profit organization that uses peer support groups to assist children and families who are grieving.

  Contact information:
  Rainbows Headquarters
  1007 Church Street, Suite 408
  Evanston, IL 606201
  P: 847-952-1770
  F: 847-952-1774
  http://rainbows.org/

Childhood Reaction to Illness and Death

Infant Reaction to Illness			
Age	**Reactions**	**Symptoms**	**Interventions**
Infant	During this age, children are most affected by separation from those who normally provide comfort and nurture. They are aware and affected by intense emotions of their primary caregiver.	Crying Clinginess Loss of appetite Sleep disturbances	Provide a consistent caregiver. Minimize separation from primary caregiver. Decrease parental anxiety, which is projected on the infant. Maintain the crib as a safe place where no invasive procedures are performed.
Infant Understanding of Death			
Age	**Infant Understanding**		**Symptoms**
Infancy	Infants have no understanding of death yet are directly affected by separation from their nurturer or their caregiver's emotions, especially anxiety. Distress is a visible when an infant is suffering a loss, although infants can usually be soothed.		Crankiness Crying Clinging

Toddler & Preschool Reaction to Illness			
Age	**Reactions**	**Symptoms**	**Interventions**
2 – 5 years Toddler & Preschool	This is a time when a child is beginning to develop a sense of autonomy and independence from their primary caregiver. An illness interferes with their sense of control and independence. Children may develop a fear of being alone.	Regression Separation anxiety Bad dreams Temper Tantrums Magical Thinking	Minimize separation from primary caregiver. Keep security objects available for child. Explain and maintain consistent limits Encourage it in daily care of child. Use words, pictures, drawings actual equipment and medical play. Provide simple and repetitive explanations.
Toddler & Preschool Understanding of Death			
Age	**Toddler & Preschool Understanding**	**Symptoms**	
2 – 5 years Toddler & Preschool	Death is seen as temporary. It can also been interpreted as a punishment, violent, and sudden. Young children have magical thinking powers and fantasize about the return or healing of the person who has died (Sleeping Beauty). Children may think that they can catch the same illness and die. They may also need to talk often about the illness or death in an effort to understand the words and concepts.	Regression Separation Anxiety Bed wetting	Bad Dreams Baby Talk Clinging Temper tantrums

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5-12 School Age Reaction to Illness			
Age	**Reactions**	**Symptoms**	**Intervention**
5-12 years	During this age, children begin to have logical thought. They begin to understand and fear death. The illness can potentially cause feeling of inadequacy and inferiority when independence and autonomy are compromised	Somatic problems Anxiety Hostility towards others Guilt Crying	Allow children to make choices whenever possible. Encourage contact ant interactions with peers. Use pictures, diagrams, and models to help explain the illness and procedures. Emphasize "normal" things that a child can do to avoid feeling different. Reassure children that the illness is not their fault or something that they caused.

5-12 School Age Understanding of Death			
Age	**School Age Understanding**	**Symptoms**	
5 – 9 years	Children in this age group may hide their feelings to avoid appearing babyish, to protect others from feeling sad, or because they are unable to tolerate the pain of loss. Death is seen as possible, but the child continues to see themselves as invincible. The children often seek out very concrete information about the death, although they also have a strong fantasy life that they use to make everything as it was before the death.	Regression Crying Anxiety Headaches Bad dreams	Stomach aches Denial of death Hostility toward the Deceased School problems Inability to concentrate
9 – 12 years	Children in this age group begin to truly understand the irreversibility of death. Children may seek information about the details of the illness or death and need explicit explanations. The child's independence is fragile and when threatened, the child may respond with anger towards the deceased, themselves, or other survivors. New fears and phobias are common.	Anxiety Physical pain Hostility towards others Guilty feelings Lack of attention	Day dreaming School problems Fear of additional loss Fear of dying

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Adolescent Reactions to Illness and Death

12-18 years (Adolescence) Reaction to Illness			
Age	**Reactions**	**Symptoms**	**Interventions**
12-18 years Adolescence	During this age, adolescents begin to develop abstract thinking and strive for independence and self identity. They fear loss of their identity, loss of control, an altered body image, and separation from their peer group, (Physical and emotional separation).	Withdrawal Acting Out Risk-taking behavior Preoccupation with death Regression Difficulty maintaining relationships with others	Allow adolescent to be integral part of decision making regarding their care. Give information carefully, adolescents are affected by the content and delivery of the information. Allow adolescents as much control and choices as possible. Assist in maintaining contact with peer group. Stress what the adolescent can do for him/herself and the importance of compliance

12-18 years (Adolescence) Understanding of Death		
Age	**Adolescent Understanding**	**Symptoms**
12-18 years Adolescence	Many adolescents would like to retreat to the safety of childhood, yet society does not permit it. They are compelled to act like adults, where their coping mechanisms and ability to understand death may be more similar to a child's. Often they assume different roles to maintain balance within the family. They are overly concerned with acceptance by others and often suppress their own needs in order to fit in. The main goal of this age group is to feel normal.	Withdrawal, acting out, assumption of adult roles, regression, preoccupation with death or the details of the death, anger, and difficulty maintaining relationships with family. Often they assume different roles to maintain balance within the family. They are overly concerned with acceptance by others and often suppress their own needs in order to fit in. The main goal of this age group is to feel normal. Adolescents are often more susceptible to unresolved grief. They use denial as a means to avoid losing control.

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Ways to Help a Grieving Child

1. Listen … and then listen some more.
2. Let the children ask questions. Be honest and answer truthfully, even the hard ones. But, it is okay to say, "I don't know."
3. Keep explanations short, simple, and truthful.
4. Encourage everyone to use proper words, such as dead/ dying. Avoid euphemisms, such as "sleeping", "lost", or "long trip."
5. Be a good model of grieving and share your feelings with your child. If you hide your grief, they will learn to hide it, too.
6. Talk about and remember the person who died. Use their name!
7. Expect and allow all kinds of emotions…sadness, numbness, anger, fear, guilt, frustration, happiness.
8. Don't misunderstand what may appear to be a lack of feelings when a loved one dies. Children are children first and often can tolerate only dosages of grief at one time.
9. Get out the crayons, pens, pencils, paint and chalk; Children often express their grief through artwork. Provide opportunities for the children to express themselves. Art, Music, play, games, and books can be wonderful tools for expression and communication.
10. Run! Jump! Play! to release energy and emptiness.
11. Try to keep routines as consistent as possible.
12. Set limits/ rules and enforce them.
13. Give the child choices whenever possible.
14. Realize that children's bodies react when they experience grief. Anticipate eating and/ or sleep disturbances and some changes in their behavior.
15. Be especially supportive at bedtime; Sleep can be different for grieving children.
16. Respond with nurturing to physical aches and pains that often represent emotions connected to grief.
17. Hug with permission.
18. Practice patience.
19. Inform teachers and all important people in the child's life about the death.
20. Don't force children to talk.
21. Resist being over-protective.
22. Remember special days that are important to the child (holidays, birthdays, etc.) and expect a variety of feelings on those days.
23. Plan family days together.
24. Seek additional professional help for the child if needed.
25. Remember that "playing" is "grieving" for children.
26. Make each child feel SPECIAL and IMPORTANT.

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Healthy v. Unhealthy Grief Responses by Students

HEALTHY GRIEF RESPONSES BY STUDENTS INCLUDE:

- Emotional pain, most commonly expressed through crying
- Difficulty concentrating
- Apathy about school work and relationships at school
- Memory loss
- Problems controlling anger
- One moment appearing "OK" and yet very distressed a short time later
- Difficulty sleeping or eating
- Reflection
- Desire to talk about the person/ incident over and over again
- Difficulty maintaining interest in extra-curricular activities
- Dwelling on things they used to enjoy doing with the deceased or before the incident
- Concerned about members of his/ her family and becoming fearful of their potential death
- Disruptive behavior in class, either in an aggressive or humorous way

UNHEALTHY GRIEF RESPONSES BY STUDENTS INCLUDE:

- Major drop in grades and student effort
- Symptoms of depression (apathetic, difficulty sleeping, change in eating that becomes physically noticeable, and fatigue)
- Chronic stress related illnesses which persist even after thorough exam by a MD
- Anger which becomes expressed as rage on oneself or onto themselves
- Use of drugs/ substances
- Withdrawal and social isolation from peers as well as adults
- Excessive expression of intense emotion
- Remain preoccupied in thought and action with the lost person/ object
- Deny the loss by organizing life as though the person/ event is recoverable
- Past losses that were not resolved emerge and are not dealt with
- Display of great dissatisfaction and ill temper with friends and self
- Display/ absorb the deceased symptoms/ situation

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Factors that Influence Acting Out in Bereaved Children

1. **Feelings of Insecurity**
   The family is often the most stable influence in a child's life. Parents are "supposed to" protect and keep children safe. When a family member dies, it is natural for a child to experience an increased sense of insecurity. Suddenly, the world doesn't feel safe anymore. And the child learns that if one person can die, they can die and so can a parent, a sibling, a friend… Acting out behaviors may provide the child with a temporary sense of power. While such behaviors may appear "out of control" they are, in fact, the child's environment. This fear response can contribute to the child's sense of control.
2. **Feelings of Abandonment**
   Bereaved children may feel like their loved one has abandoned or "died on them." They may act out, in part, because they feel unloved. The acting out behaviors in turn drives people away and may create a self-fulfilling prophecy. Also, children are motivated to behave largely due to parental reinforcement. A bereaved child might think, "Why should I behave? Even when I do, Daddy is not here to praise me." And often times, bereaved parents are often unavailable due to their own grieving.
3. **Provoking Punishment**
   Some bereaved children may wrongly assume that it is their fault the person died. Many children express guilt and fear they are to blame for the death. Some feel they must have been so bad, that they caused the death and deserve to be punished. This may be an unconscious process that contributes to acting out behaviors. A child may also reason, "If I am bad enough, then the person who died may come back to make me behave."
4. **Protecting oneself from future losses**
   A bereaved child reasons (often unconsciously) that it is better to abandon than to be abandoned. They don't want to hurt again. "If I don't care about them, then it won't hurt if they die, too." Acting out behaviors also serves to keep others at a distance and thus protect the child from intimacy. In this way, the child is in control of the relationship and is not the passive victim left by others.
5. **Externalizing internal feelings of grief**
   Acting out is often seen in the children who have had a difficult time expressing their feelings. As grief-related thoughts and feeling continue to be expressed, they build inside the child and eventually, come out one way or another, usually destructively. "Explosions" usually occur when feelings are trapped inside. Children may not have learned healthy, more adaptive ways of expressing their feelings will often act them out through inappropriate behaviors.

How to respond when a bereaved child is Acting Out

Remember that while a child's behavior may be bad, the child is loveable and good. Be clear that it is their behavior that is unacceptable, not the child. Try understanding the meaning behind the child's behavior. Assist them in setting external controls, and teach them that mistakes are a part of growth. There are two parts to children's acting out behaviors: explosive feelings and explosive acts. Children's feelings need to be identified and expressed while their behaviors need to be limited and redirected. Let them know that "mad" feelings are okay, but hurting others or themselves is not. Help the child find new way of expressing themselves. Be open to using a variety of "tools" (are, writing, music, sports, etc). Each child has their own interest and abilities and will have different coping styles.

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Preparing Your Child to Return to School
Following the Death of Someone Significant

1. **Talk to your child**. Help them understand how difficult it is to return to school and yet while it is hard you will assist them until they feel more comfortable. Tell them, "We will make it through this together."

2. **Reassure your child**. Give them instructions on how they may reach you during the day and permission to call you when they need encouragement. Tell them where you will be while they are at school. Your child is learning about mortality issues. With this concern for your well being they need to know that you are safe and in familiar surroundings. At first they may need to phone you frequently but over time they will adjust. Be patient with this process and do not force it along.

3. **Talk to your child's principal, teacher and counselor.** Give clear information about the death and what understandings the child has about those details. Determine a plan for emotional safety with their teacher. Teens may be resistant to this step but for their well being it is imperative that they have a plan of action.

   This plan should include permission for your child to leave the classroom if necessary and go directly to a safer place. Children are easily embarrassed by their "grief bursts" and need to establish control. Through a prearranged signal with their teacher, your child will understand they have permission to leave the classroom, go to the nurse or counselor's office. Self-esteem is increased as children learn to manage their emotions in appropriate ways. Leaving emotional reactions unaddressed teaches children that being resistant, unresponsive and acting out is the acceptable way to get attention or removal from the classroom.

   Note: Teach your school administrators and faculty about how children grieve differently from adults. Remember that children take breaks from grief and appear to be "going on with their lives." Often when playing and laughing they appear to not be thinking about the death. Children contain and express their grief in different ways; therefore they may react more strongly to disappointments (low grades, reprimands or playground injuries), crying inconsolably or louder for long periods of time. When your child reacts to their loss we call this a "grief burst." This is normal behavior and may be a pattern for months and years following the death and can be overwhelming at times for those caring for your child. As children learn to manage their grief, the deep emotional pain changes.

4. **Be patient.** Children have difficulty concentrating and focusing on schoolwork following the death of someone significant. There is no magic timetable to determine when your child will have more energy to devote to the rigors of academics. Some children improve after 3 months while many more are still experiencing difficulty 1-2+ years after the death. This is normal just as it is for adults who have trouble finding a new routine at work or in their daily lives.

Many daily triggers remind children that their loved ones are dead. Often classroom work and subject matter, conversations or playground activities serve as painful reminders sending a child plummeting with these thoughts and memories. Listen carefully to what your child is telling you about their school day.

5. **Teach your child about your grief.** When you do not cry in front of your child or share with them how difficult your day has been they feel isolated in their grief. They make false assumptions about your love for the person who died and often get mixed signals about normal grief reactions. This is a difficult time for all family members and rarely will all the family be sad at the same time. Use this as a positive way to reach out for support or to open yourself to assist another. The pain will not be this intense forever; patient encouragement and support will promote healing.

6. **Young adults need support.** While young people are eagerly establishing a place for themselves, in the adult world often away from home, it can also be a very painful, isolating and difficult process. Fears and worries intensify when your child is not home or around familiar faces. Some common thoughts and questions are: not feeling as connected to family and friends; increased loneliness; wondering if my loved ones will be okay while I'm away; trouble concentrating or going to classes or work. Be sure to establish a routine of initiating contact with your young adult. Expect this to be a one-way communication for a while. They will appreciate your encouragement.

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GUIDED PARTICIPATION QUESTIONS

- I am wondering… what you know about why your brother is sick? What you know about why your dad died?
- I am wondering… what you need from me today? From your parents? From your teachers?... and what you think you might need for tomorrow?
- I noticed…
- Your mom shared that… What do you think?
- How are things different than you expected today? How are things different than you were hoping for?
- What are you thinking about right now?
- What did you notice when…?
- What do you think happens when…? What do you want to happen next?

RHYTHM AND FLOW OF THE CONVERSATION

- Ask… Listen… Pause… Ask again…
- Pause and Center yourself before answering their questions
- Reflect back
- Clarify… assess the child's understanding of the answers
- Be on the same level of the child
- Observe behavior.
- Do not overload! Only answer what is being asked. Only ask as much as they have an attention span for.
- "I don't know" is an answer. But you can offer to help find out together.
- Repeat.
- Be present. Be patient.

Child:

C Consider their age and developmental stage

H Honesty

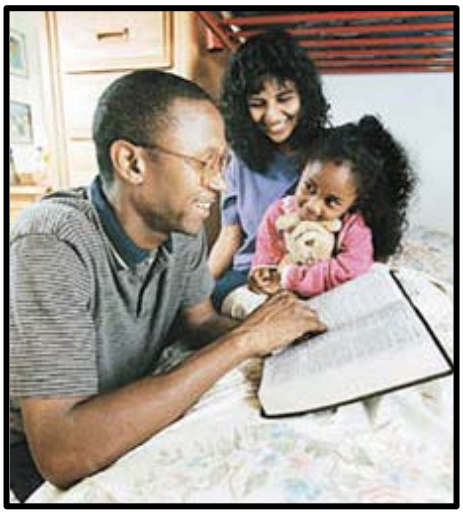
I Involve them

L Listen

D Do it again. and again.

V. CHAPLAINS

What are the requirements for becoming a chaplain?



Most chaplains are required (by hospitals, church denominations, and pastoral care associations) to have a minimum of three years of graduate education (the Master of Divinity). The Master of Divinity is typically a three-year scholastic program including a full year internship at a hospital (in a chaplain role) or at a church (in a ministerial role). In addition, chaplains are required to undergo a rigorous certification process. Much like doctors, chaplains spend their first year in a residency program called Clinical Pastoral Education (CPE). CPE requires the chaplain to spend 40 hours a week in the hospital seeing patients and their families. In addition, participants spend several hours a week with an experienced supervisor to discuss their caseloads and their responses to patients. At the end of CPE, the chaplain is reviewed by the Association of Professional Chaplains (APC), which decides whether the chaplain will be certified. Certification is required for chaplainry in hospitals, long-term care facilities, hospice care, prisons and juvenile detention facilities.

What are a chaplain's roles and responsibilities?

The hospital chaplain's role is to serve the spiritual needs of the patient. A hospital chaplain's primary mission is to provide comfort and a calming presence. The patient sets the agenda and can decide what he or she wants to discuss. Furthermore, patients have the choice of whether to see a chaplain. Many times, even non-spiritual or non-religious people decide to see the chaplain. Chaplains may also spend time with patients' families, bringing a consistent empathetic presence to both the patient and family. Many chaplains sit with families as the patient is suffering or dying; sometimes nothing is said during these times, but the presence of a spiritual person brings comfort to the patient and family.

Some of the chaplain's roles specific to religion include:

- Listening to patients' spiritual or religious concerns
- Coordinating with churches and other religious/spiritual organizations that are already part of the patient's life or that the patient desires to have as part of her/his life
- Discussing spiritual needs with the patient's religious leader (when appropriate)
- Administering sacraments
- Presiding at prayer and worship services (in patients' rooms or in the chapel)
- Coordinating bible studies and/or other study groups
- Performing last rites and/or confession
- Performing baptisms
- Performing rituals with the family and patient (i.e., gathering the family to affirm or confess their life with the patient, helping the family process death and sickness)

Some of the chaplain's roles not specific to religion include:

- Listening to patients' non-religious concerns
- Participating as a member of multidisciplinary teams within the hospital
- Discussing the option of organ donation with patients and their families
- Advocating on behalf of patients with other professionals
- Attending to patients and their extended biological and foster families during difficult times
- Helping with peaceful negotiations between stressed families and other professionals
- Reconciling professionals (chaplains will sometimes help professional teams of social workers, physicians, nurses, etc. reconcile their conflicting viewpoints about patient care)
- Coordinating, recruiting, and training volunteers to visit patients
- Grief and Loss counseling

Do chaplains proselytize and try to "convert" patients?

Chaplains are professionals and have a code of ethics like many other professions. The chaplains' ethical code strictly prohibits proselytizing, as does the Association of Professional Chaplains. Thus, it is not ethical for chaplains to try to convert patients. Also, chaplains are specifically trained to work with patients from many different denominations and religious groups. They are trained not to prefer one group to another.

What can chaplains do to help DCFS wards in the hospital?

Chaplains working with foster children in the hospital can advocate follow up spiritual care and connections to spiritual resources. Many children feel isolated and lonely in the hospital. It is important for them to maintain linkages to their personal lives while there. Discussing a child's spiritual background and finding out if he or she would like to see a spiritual leader (minister, rabbi, etc.) is important. Chaplains can help children develop and work through questions they may have about their abuse or illness. Expressing themselves on these topics can be hard for children; devices such as art projects and story telling can be used to help them communicate their thoughts and feelings. Furthermore, linking children to trusted adults and other helping professionals (counselors, ministers, advocates, etc.) is critically important if their questions are out of the range of expertise of the chaplain.

Chaplains should:

- Know and understand the religious rights of foster care children
- Have important DCFS numbers readily available
- Make connections with DCFS or POS workers and know whom to contact with questions regarding foster children
- Help foster children establish important spiritual/religious resources if needed and keep in contact with their case managers when appropriate
- Help biological families make contacts regarding funeral arrangements in the event of a child's death

VI. DCFS CASE MANAGERS

How does one become a case manager?

A bachelor's degree (four years of college) is the minimum level of education for a case manager. Many case managers also hold master's degrees. In all cases, DCFS supervisors have master's degrees in social work. Furthermore, case managers must pass the Illinois licensure exam. This exam tests them on their knowledge of casework skills, children's developmental phases, stages of grief, medical requirements (visits, immunizations, etc.) for all age groups, and other similar material.

What are the responsibilities and roles of case managers?

Case managers, like chaplains, have a variety of different roles, including:

- Intervening in families who are the subjects of indicated reports. A report is "indicated" when credible evidence of abuse or neglect is found.
- Visiting families regularly (intervening through case management and documenting progress)
- Attending court sessions (hearings); often serving as a witness
- Facilitating adoption and substitute care (permanent and temporary)
- Providing services that help prevent the maltreatment of children and/or help to heal the effects of abuse or neglect

What is the difference between a case manager and a DCP worker?

A Division of Child Protection (DCP) worker performs the initial investigation into an allegation of abuse or neglect. The investigator interviews the child and other witnesses and makes a determination whether credible evidence of abuse or neglect exists. If it does, the report is "indicated" and case managers step in to coordinate the necessary services.

How do DCFS case managers differ from social workers in other settings?

The most striking difference between DCFS case workers and social workers in other settings is that the involvement of wards and their families is usually non-voluntary, while the involvement of individuals served by social workers

is often voluntary. DCFS case managers are mandated by the state to intervene in troubled families and provide services for them. Their tasks are directed towards protecting the children who have been abused or neglected and providing services to families to eliminate the factors that caused the abuse or neglect. Social workers, on the other hand, can be involved with clients under many different circumstances and encounter clients in many different settings including social services, medical services, education services, and psychiatric or substance abuse treatment. A social worker's sole responsibility is to their client, whereas the DCFS case manger has duties to the state, the public and the court. Like DCFS case managers, all social workers are mandated reporters.

What is the case manager's legal obligation to DCFS wards regarding their religious rights?

DCFS Policies and Procedures, Rule 402.18 and Procedure 301.60(a4) state the guidelines for the religious rights of DCFS wards:

Rule 402.18 Religion

a) The religious beliefs and rights of children shall be legally protected.
b) Each child shall be given religious instruction in his own faith, or that of his parents, unless there is written consent of the parent or guardian (if residual parental rights have been legally terminated) for the child to participate in religious instruction and to attend the facility of another faith. This shall include consent to baptism or confirmation.
c) Children shall be permitted to participate in religious services either singly or in groups.

Procedure 301.60(a4) Same Religion

A child placed in a foster family home, relative home, group home or residential facility shall be placed, when possible, in a placement where the religious affiliation is the same as that of the child or the child's parents. When the religious affiliation differs and the child is 11 or under, the parents shall be asked to complete and sign the CFS-589, Consent For Religious Instruction/Church Attendance, indicating parental consent regarding the child's religious instruction and church attendance. Parental refusal to sign the CFS-589 shall be documented in the child and parent case records.

A child age 12 or older shall be allowed to choose his/her own religious preference and church attendance. The rationale for placement in a setting with a religious background, which differs from the child or that of the parents shall be documented on the CFS 497.

How should DCFS case managers help protect a child's religious rights?

Since DCFS is acting as a substitute parent for children in state custody, case managers play a critical role in the child's life. It is the obligation of the case manager to ensure that the child's spiritual needs are recognized and respected.

DCFS case managers should:

- Discuss children and families' religious rights with children, biological parents, and foster parents.
- Insure that the foster family is aware of the child's beliefs and will make the appropriate religious institution available to him or her.
- Be informed about children's religious beliefs and observances.
- Encourage and respect children's religious practices (observations of holidays, prayer, dress, and food).
- Keep children linked with their community of faith (church, synagogue, mosque, etc.).

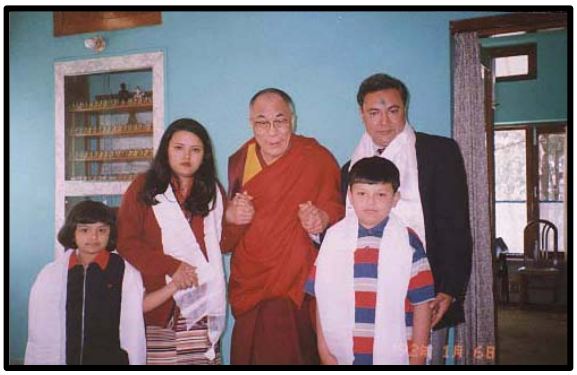
How should DCFS case managers handle their ward's spiritual needs?

Many children view spirituality as important in their lives. Thus, it is probable that DCFS case managers will have to address spiritual issues. Case managers should be careful not to let their own spiritual beliefs intrude on the situation and should defer to religious professionals who are trained to deal with these issues.

Case managers should:

- Be aware of their own spiritual position and how it may affect their dealings with wards. They should be careful not to impose their own religious beliefs on a child and only seek out spiritual resources for a ward at his or her request
- Ask children what role spirituality and religion plays in their lives.
- Use children's own language to help them articulate their beliefs.
- Acknowledge that a child's religious beliefs are important and never criticize a child's belief system.
- Support children who gain strength from their faith.
- Include a spiritual component in assessments, remembering that beliefs can act as both assets and deficits for patients.
- Explore and discover spiritual resources and linkages for children, including referring them to the hospital chaplain or contacting their religious institution.

It is interesting to note that the age at which DCFS allows wards to make their own religious decisions, twelve, is also the age that most religions consider a child mature enough to take responsibility for his or her faith. For example, most Christian faiths confirm children in the church when they are around twelve or thirteen, some as late as fifteen. In the Jewish faith, a child will make his or her bar mitzvah (male children) or bat mitzvah (female children) when he or she is thirteen. The Islamic faith considers males to reach intellectual maturity at age twelve, and females to reach it as young as nine. Once wards reach the age of twelve, case managers should encourage them to continue with their faith practices and support them through the above-mentioned practices, should they decide to participate in them.



VII. Confidentiality and Consent

What is confidentiality?

In professional settings, the confidentiality of information received or exchanged is a primary concern. However, different kinds of professionals are bound by differing standards of confidentiality, based on the reasons for their professional involvement. For example, most people realize that attorneys representing private individuals have a responsibility to keep information told to them by their client about the case confidential, and they cannot be compelled to divulge the information in court (attorney-client privilege). The reasoning behind this privilege is that the lawyer's obligation is to represent the interests of his client in an adversarial setting, and that the client will be more forthcoming with the lawyer if confidentiality is assured.

On the other hand, professionals such as clergy and child welfare workers have professional roles that are different from attorneys, and those differences help define their responsibilities regarding confidentiality. In addition to the need for confidentiality that is based on the nature of professional relationships, there are laws that protect information based on the substance of the information itself. For example, information concerning the results of an AIDS test is highly protected, as is some information related to mental health or substance abuse treatment.

What are child welfare professionals' responsibilities regarding confidentiality?

The substance of a child welfare worker's job is handling intimate familial situations that have led to the abuse or neglect of a child. The reason for the state's involvement with the family is protection of the child. Consequently, information about the child and the family must sometimes be shared so that the child is kept safe and appropriate services are provided to insure a permanency plan in the child's best interest. At the same time, private information about the family or child should be protected when sharing it is not necessary for the protection of the child or provision of services. The family is involved in the state system involuntarily and has a right to

confidentiality when that is consistent with the state's other obligations. State law and DCFS Rules therefore include guidelines about the limits on confidentiality of wards' personal information. (See DCFS Rule 431). In general terms, child welfare personnel can share information with another individual dealing with or providing services to a minor for the purpose of coordinating efforts on behalf of the minor.

What information can a child welfare worker share with a chaplain?

Sharing information with a hospital chaplain involves a delicate balance between privacy, religious rights and preferences of children and families, and beneficial outcomes for wards. Since the proper role of DCFS as a state agency is to honor clients' spiritual preferences, not to impose religious practice upon them, the agency should allow clients to decide whether or not to talk to the chaplain and how much the chaplain should know about the family situation.

Case managers should take active steps to make the child, foster family, and birth family aware that the chaplain is an available resource. The case manager can attempt to clarify the client's understanding of what a chaplain's role is and how the chaplain might be helpful in their case. The child or family can then choose to take advantage of the chaplain's services if they wish. Case managers should obtain consents from children older than eleven or from the parent or Guardian in the case of younger children before disclosing any personal information to the chaplain. The case manager should also notify the chaplain that any information that is disclosed to him or her is confidential and should not be further released without the client's consent.

Are religious professionals bound by confidentiality?

In the context of ministry, most religious professionals respect the privacy of the parishioner so that private conversations remain confidential and privileged information. Religious professionals are usually bound by principles of confidentiality under their particular tradition, and the law endeavors to respect each tradition's religious rights. Like in therapeutic

relationships, confidentiality is important in religious settings to encourage members of the congregation to speak openly with clergy in a safe and protected space without fear of repercussions. However, confidentiality does not always insure complete secrecy; members of the clergy can sometimes be obligated, either by law or their own ethical values, to break confidentiality.

What are the laws governing confidentiality for religious professionals?

The laws governing clergy confidentiality can be very confusing. First, it is often unclear, under both civil law and religious tradition, who falls under the category "clergy". Furthermore, while the tenets of religions often specify how clergy should respect confidentiality, they do not all do so in the same manner. The many denominations of Christianity, for example, take widely different approaches. Some Protestant denominations (Southern Baptist or Lutheran) hold confidentiality as a sacred privilege, but allow for certain information to be divulged. On the other hand, the Anglican Church and Catholic Church state that clergy may never break confidentiality with regard to information heard in confession. Some Jewish denominations require a breach of confidentiality if someone confesses to abusing a child (Conservative Synagogues), while other Jewish synagogues do not have a set law on confidentiality. Finally, many states have differing laws regarding clergy confidentiality and child abuse or neglect reporting. For instance, in the state of Texas, all clergy persons must report child abuse or neglect or face severe penalties. Each state also decides its own limits on clergy/parishioner privilege. For example, Illinois law states:

> *5/8-803 Clergy*
>
> 8—803 Clergy. A clergyman or practitioner of any religious denomination accredited by the religious body to which he or she belongs, shall not be compelled to disclose in any court, or to any administrative board or agency, or to any public officer, a confession or admission made to him or her in his or her professional character or as a spiritual advisor in the course of the discipline enjoined by the rules or practices of such religious body or of the religion which he or she professes, nor be compelled to divulge any information which has been obtained by him or her in such professional character or as such spiritual advisor.
>
> P.A. 82—280, 803- eff. July 1, 1983.

What and who are mandated reporters?

Mandated reporters are professionals or caring helpers who are required by law to report suspected child abuse and neglect that they encounter in their professional capacity. Many kinds of helping professionals (physicians, nurses, teachers, social workers, etc.) are required to report child abuse to authorities. The laws with regard to clergy as mandated reporters vary from state to state. Although some states require clergy to report all forms of child abuse and neglect, **under current Illinois law, members of the clergy, including hospital chaplains, are mandated reporters only with respect to child sexual abuse, and not with respect to other forms of abuse and neglect. Even in the case of child sexual abuse, Illinois clergy can still assert the "clergyman-penitent privilege" quoted above.** According to this privilege the clergyperson does not have to report confidential information he or she receives in a professional capacity when the rules or practices of his or her religious denomination require that the information be kept confidential. A good example would be information that a Catholic priest hears in the confessional. It should be noted in general, however, that even though clergy may not be required to report abuse and neglect in all circumstances, many clergy may nevertheless feel a moral obligation to do so.

How does confidentiality affect hospital chaplains?

Several different bodies govern chaplains' confidentiality rules, which further confuses the issue of confidentiality. Most hospital chaplains are considered clergy, and thus, are bound to the laws of the state and their professional organizations. Some chaplains must also follow their denominations' guidelines for clergy confidentiality. Thus, it is very difficult to sort out which laws (state, church, or hospital) bind individual chaplains. Generally speaking, it is safe to assume that chaplains will keep conversations with children or family members confidential unless they decide there is a compelling need to break confidentiality. It is within the professional discretion of the chaplain to decide when to share information learned from the child or family members. It is wise to ensure that the chaplain articulates his or her own confidentiality dictates to the ward at the outset of any relationship.

Who can consent for medical treatment for DCFS wards?

The DCFS Guardianship Administrator ("DCFS Guardian") or designees of that office are the only members of DCFS staff who can consent to a ward's medical treatment. Sometimes there are restrictions on the type of medical care the DCFS Guardian can consent to, depending on the status of parental rights. Because the DCFS Guardian can consent for wards, the guardian also has the power to withhold consent. The child's case manager's input is very important in consent situations, since the case manager often has the most familiarity with the child's circumstances, but the authority to consent rests with the Guardian.

What involvement do DCFS wards have with their medical treatment?

"In all cases the minor shall be consulted by casework staff regarding the nature of the proposed medical procedures to the extent that the child's age and understanding of the situation allow." The final decision, however, rests with the DCFS Guardian. DCFS Rules 327.5

When can DCFS wards consent to their own medical care?

DCFS wards can consent to their own medical care if they have reached age 18, unless they have a court-appointed adult guardian. Female wards that are pregnant may consent to their own medical care while pregnant. Once the baby is born, a mother under age eighteen may consent for her child's care, but not her own. A ward may also consent to an abortion. If the hospital requires guardian consent for an abortion, the DCFS Guardian will consent to it within the first two trimesters if the ward has been fully informed of her options. Finally, wards over age twelve can consent to treatment for a venereal disease or drug or alcohol abuse, and obtain birth control.

APPENDIX A: RELIGION AND MEDICINE

This section provides brief explanations of some religious traditions' concerning medical practices. Traditions have been listed only when they have specific beliefs related to medicine that a caseworker or hospital chaplain should be aware of. **These summaries are not intended to fully explain the beliefs of the major religious traditions. They are intended to provide guidance for respecting the religious beliefs of clients, and are specific to those concerns that arise in a hospital setting.** One should also contact a representative of the particular faith or do other research for additional information regarding any of the religious practices. Not all faith groups or traditions could be covered in this brief appendix. The five religious traditions covered in this appendix have been identified because many of the DCFS-involved families who are religious may practice one of the following religious traditions.

Note: Hospital chaplains can asssit caseworkers to connect with a minister, pastor, priest, rabbi or other religious representative to learn more about specific religious practices.

I. **Buddhism**

Buddhism originated as a spiritual movement in northern India around 500 BC by followers of Siddhartha Gautama. Siddhartha became known as the "Buddha" (the Enlightened One) and Buddhist traditions and teachings are known as dharma. Currently, it is most widely practiced in India, China and Tibet. Buddhists traditionally practice holistic medicine, and historically were instrumental in the development of such practices. Buddhists also practice meditation and yoga to promote well-being.

Death and Dying

Buddhists believe in reincarnation. Human life is nevertheless highly valued. Dying Buddhist patients may experience anxiety about being reborn into less desirable human circumstances or even as a lower life form. Buddhist's beliefs about impermanence and multiple lifetimes tend to create a stoic regard for the passing of a person from the present existence. Upon death, many Buddhists choose to have a person cremated, after a three-day waiting period. Departed ancestors are periodically remembered by family, especially in Asian cultures influenced by Chinese traditions.

Discussion of impending death is not typically avoided, though positive thoughts and encouragements are preferred over sadness or grief, to encourage the patient to have a positive mindset about their transition. Buddhist clergy often chant bedside blessings or protective rituals, and dying patients may wish to meditate or contemplate Buddhist teachings.

II. Christianity

There are many different denominations of Christianity, with large areas of agreement between them. While most denominations allow cremation, many prefer burial, and a few forbid cremation altogether. Most Christians prefer their priest, pastor, or minister to conduct baptisms or funerals. Additionally, many denominations have rituals for sick and hospitalized congregants. Hospital chaplains can help caseworkers connect with the minister, pastor, or priest from their client's particular denomination to learn about its particular practices. A list of some Christian denominations is provided below:

1. Anglican Christianity
    a. The Episcopal Church
    b. The Church of England
2. Catholic Christianity (The Roman Catholic Church)
3. Church of Jesus Christ of Latter Day Saints
4. Orthodox Christianity
5. Protestant Christianity
    a. Christian Church (Disciples of Christ)
    b. Church of God in Christ (COGIC)
    c. Missouri Synod Lutheran Church
    d. National Baptist Convention, U.S.A., Inc.
    e. Southern Baptist Convention
    f. The African Methodist Episcopal Church (AME)
    g. The Christian Methodist Episcopal Church (CME)
    h. The Evangelical Lutheran Church in America (ELCA)
    i. The Presbyterian Church, USA
    j. Seventh Day Adventists
    k. Unitarian Universalists
    l. United Church of Christ (UCC)
    m. United Methodist Church

In addition, there are a few denominations that have very specific beliefs regarding medical care:

1. Christian Scientists

Christian Scientists have unique beliefs regarding medical care, and believe that healing comes through scientific prayer and spiritual communion with God. There are Christian Science nurses and nursing facilities that provide physical and spiritual care such as praying, diet modifications, and dressing wounds. No medical treatments such as pharmaceuticals or therapy are used. Christian Science believes that all ailments are caused and cured by spirituality. Their healings are not considered to be faith healings, but are healings that have come from God's scientific principles of healing.

2. Jehovah's Witnesses

Jehovah's Witnesses take a literal view of the Bible and because of the Biblical demand to "abstain from blood" (Acts 15:29) do not believe in using any blood or products made from blood (e.g. homologous or autologous whole blood, packed red blood cells, plasma, and platelets). Clinicians treating Jehovah's Witnesses should discuss, in detail, the types of blood products and the specific procedures within which the individual Witness is comfortable.

Please note: DCFS Procedures 327.5, section e.2 states "Organ donations/anatomical gifts shall <u>not</u> be approved for any child who subscribes to the beliefs and practices of the Jehovah's Witnesses or the Christian Science faiths."

III. Hinduism

There are two major sects of Hinduism: Vaishnavaism and Shivaism. Meditation and yoga are two important aspects of the Hindu religion, which are designed to encourage both spiritual and physical well-being. Hindus do not practice circumcision. Many Hindus are wary of drugs, as holistic medicine is traditionally practiced. Many Hindus are vegans (they do not consume meat, eggs, or dairy), as their faith advocates non-violence. Hindu patients should be informed if a particular medicine contains ingredients made from animals.

Death and Dying

Hindus believe in reincarnation. Hindus have specific rituals for those who are dying—a patient's religious leader should be contacted regarding these rituals. Many Hindus choose cremation as soon as possible after death. Hindus believe the deceased body should not be washed, and can only be handled with disposable gloves.

IV. Islam

Like Christianity and Judaism, Islam is a monotheistic religion and Muslims believe there is only one God. The Islamic tradition began with the birth of Mohammed, the Prophet (≈570-632 AD). There are different traditions within Islam: the Sunni and the Shiite. Many of their practices are similar. After birth, boys are circumcised. At approximately age nine, some girls begin wearing a head covering. A physician may remove the head covering when absolutely necessary, such as during an examination. Prayer is the fundamental religious expression of Muslims. It carries the same spiritual potency as Christian sacraments. Observant Muslims pray five times each day. The Muslim celebration of Ramadan is well-known: during this month, believers abstain from food or drink from dawn until dusk. Only able-bodied adults undertake this practice—young children and others are not required to fast.

Death and Dying

The Qur'an is forthright about death as a major passage to another life. In Islam, the belief is that death is the cessation of life, and that the life one receives at birth is preparatory for the life after death. Traditionally, a Muslim does not die alone, segregated from relatives or friends. Muslims place an emphasis on community, and a supportive network of relatives and friends surrounds a dying Muslim, who can help the patient recite their confession of faith. Given the need to recite a confession before death, Islam stresses the importance of retaining consciousness until this has been accomplished. Islam does not accept cremation. The dead are carried by relatives and friends to the mosque for a final prayer and are immediately buried. Attending a funeral is considered meritorious, even if one does not know the deceased. On third and fortieth days after death, services of remembrance are held, featuring readings from the Qur'an, and gifts of food to attendees.

The Nation of Islam

The Nation of Islam was started by Master W. Fard Muhammad in Detroit during the 1930s. Please note that the Nation of Islam and the Islamic religion are <u>not</u> identical and have different practices. Please contact a local Nation of Islam mosque for more information.

V. Judaism

There are a number of major sects of Judaism, including Orthodox, Conservative, Reform, and Reconstruction. Jews traditionally circumcise boys shortly after birth, in a ceremony (called a "bris") that usually takes place at home or in a synagogue instead of a hospital. Some Jews keep kosher, and have particular rules about what they can eat (e.g., not eating pork or shellfish, or not consuming meat and dairy products together), and how food must be stored and prepared (e.g. meat products and dairy products require different plates and silverware when served).

Death and Dying

Traditional Jewish burial practices require burial as soon as possible, with the deceased wrapped in a plain sheet and placed in a plain, simple coffin. Many Jews are opposed to cremation. After a Jewish person dies, close family members traditionally gather together every evening for seven evenings to observe a mourning period called "Shiva." At these gatherings, family and friends come to pay their respects and offer their condolences.

<u>Material Adapted From:</u>

Babacan, Hurriyet and Obst, Patricia. *Death, Dying and Religion: An Examination of Non-Christian Beliefs and Practices*: A Guide For Health Care Professionals Including Those Working in HIV/AIDS. [South Brisbane, Qld.] : Ethnic Communities Council of Queensland, 1998. http://www.multiculturalaustralia.edu.au/doc/babacan_death_dying_religion.pdf.

The Park Ridge Center For the Study of Health, Faith, and Ethics. *Religious Traditions and Health Care Decisions: A Quick Reference To Fifteen Religious Traditions and Their Application in Health Care.* Chicago, Illinois. 1999.

Quick Reference Chart for Non-Christian Faiths

	Buddhism	**Hinduism**	**Islam**	**Judaism**
Attitude Toward Death	Strong acceptance: Reincarnation.	Strong acceptance: Reincarnation.	Acceptance of God's will.	Various attitudes toward death.
Medical Procedures	Pain relieving drugs may be refused.	No religious objections.	Objections to autopsies, euthanasia and organ donation.	Objections to autopsies, euthanasia, and some organ donation.
Dietary Practices	Many vegetarians. Fasting on special days.	Many vegetarians. Some vegans-no meat, eggs, or dairy products. May want to fast as part of practice .	Meat must be prepared according to halal standards. No pork products. No alcohol. During Ramadan holiday, fasting may be required.	Meat must be prepared according to kosher standards. Meat and dairy must be prepared and consumed separately. No pork or shellfish. Fasting on special days .
Handling of the Deceased	Leave the deceased body undisturbed as long as possible.	Do not wash body. Touchwith disposable gloves.	Only same-sex Muslims can touch the body; otherwise, disposable gloves must be used. The body is believed to feel pain after death	Wrap in a plan sheet and bury in a plain coffin. There is a seven-day mourning period after a death.
Burial Practice	Mainly cremation, some burial	Cremation as soon as possible	Burial within 24 hours	Burial as soon as possible

Adapted from: Babacan, Hurriyet and Obst, Patricia. *Death, Dying and Religion: An Examination of Non-Christian Beliefs and Practices*. http://www.multiculturalaustralia.edu.au/doc/babacan_death_dying_religion.pdf

APPENDIX B: THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The following appendix has been compiled to provide hospital chaplains with a basic understanding of the workings of DCFS. It is not intended to fully explain DCFS, but to provide a general overview of the system.

The Children and Family Services Act that established the Department of Children and Family Services as a state agency mandates the provision of services to certain populations of abused and neglected or at-risk children and provides the framework for public child welfare services in Illinois. The operations of DCFS consist of a broad range of prevention, investigative, and treatment services. The Act requires DCFS to provide family preservation and direct child welfare services, such as foster care, adoption, subsidized adoption and guardianship, counseling, and homemaker services. The Act also provides for licensure of specified child welfare workers and investigators.

For updates and other information regarding DCFS services or statistics please see the following website: www.state.il.us/dcfs/index/shtml

What services does DCFS provide?

DCFS provides a broad range of services such as:

Child protection

Family maintenance

Substitute care (foster care)

Adoption services

Intact family services

Day care services for DCFS clients

Licensing for all facilities that care for state wards including living facilities and private child welfare agencies.

Permanent homes for children who cannot return to their families.

Does DCFS handle all the child protection cases in Illinois?

No. DCFS has too large a caseload to manage on its own. Consequently, DCFS contracts with private agencies to provide services to children and families. One private agency also conducts abuse and neglect investigations. These agencies are sometimes referred to as "POS" (Purchase of Service) agencies. Eighty-percent of DCFS cases are

handled by private agencies (86% of the cases in Cook County and 69% of the cases Downstate). There are more than 90 private agencies that provide case management services for the Department. Law and DCFS Rules, Procedures and Policy bind the agencies to the same extent as the Department. DCFS monitors private agencies through Agency Performance Teams.

Is DCFS accredited?

Yes. DCFS is the nation's largest child welfare agency to receive accreditation from the Council on Accreditation for Children and Family Services. Accreditation helps ensure that DCFS services to clients meet national standards.

Where is DCFS located?

The Department of Children and Family Services is divided into four geographical regions in the state of Illinois, each containing a regional headquarters. The regions, along with their headquarters are as follows:Cook/Chicago;Northern/Aurora;Central/Peoria;Southern/East St. Louis. In addition, Cook/Chicago is divided into 3 sub-regions: Cook North, Cook South and Cook Central. More than 80% of the children served by the Department live in Cook County. As of October 31, 2014, there were approximately 4,000 Department employees statewide and 22,000 children who were wards of the Department.

The Organizational structure of DCFS

The Department is organized into the following main divisions: Placement/Permanency, Field Operations, Monitoring/Quality Assurance, Guardian & Advocacy, Clinical Practice, Service Intervention, Budget & Finance, Planning & Performance Management, Communications, and Child Protection.

The State Central Register and the Division of Child Protection

The State Central Register (SCR) maintains a toll-free 24/7 hotline that accepts calls alleging child abuse or neglect. Once a call is taken by the hotline, the allegation is then passed on to The Division of Child Protection (DCP), which investigates it. A DCP investigator (Child Protection Investigator (CPI)) must make initial contact with the alleged victim within 24 hours.

Allegations are determined to be either "indicated" or "unfounded." An indicated report is a report of child abuse or neglect where credible evidence exists that abuse or neglect occurred. Indicated perpetrators can appeal indicated findings administratively and then to the circuit court.

DCFS Service Provision

If an allegation has been indicated, the Department may transfer the case to "follow-up" for service provision. If the Department determines that it is safe to maintain the child or children in the home, services will be provided and the family will be monitored as an intact case. If children are removed from the home, the follow-up worker develops a case plan with the family that identifies services that must be provided and progress that must be achieved before the child or children can safely be returned home. The worker will also monitor the foster home. There are two types of foster homes: traditional foster homes (non-relative) and relative foster homes. Relative foster homes may be licensed or unlicensed. Services may also be provided when a court makes a finding of dependency and refers the case to DCFS for services. Dependency is when a parent or guardian is found to be unable to care for a child, but has not abused or neglected that child. DCP may also refer a case to follow-up when the allegations were unfounded but the family could benefit from child welfare services. When cases are referred after an unfounded allegation, compliance with services is strictly voluntary.

The Court System

The State cannot remove children from their parents without court approval. Therefore, whenever a child welfare worker determines that a child must be removed from home, the worker must "screen" the child's case into court. Screening a case consists of presenting the evidence and reasoning to the local State's Attorney. If the State's Attorney agrees that there is an "urgent and immediate necessity" to remove the child, the State's Attorney will file a petition in the appropriate juvenile court, alleging abuse, neglect or dependency. If temporary protective custody of a child has been taken, the court will hold a hearing within 48 hours, exclusive of weekends and holidays, to determine whether there is "probable cause" to believe that the child

was abused or neglected, and, if so, whether there is urgent and immediate necessity to remove the child (the Shelter Care or Temporary Custody Hearing). The next stage of the court process is called the adjudicatory hearing that determines, by a preponderance of the evidence, whether abuse or neglect occurred and who was responsible for it or whether dependency exists. The final stage is called the dispositional hearing, where the court determines whether the child should be made a ward of the court and whether DCFS should become the guardian of the child.

Guardianship Administrator

The Guardianship Administrator is the acting legal guardian for DCFS wards. Once the Guardianship Administrator has been appointed guardian, only she or a designee can provide legal consent for a ward. Some of the tasks of this office include consenting to adoption, aiding wards in important decisions and arranging for representation for wards in litigation.

APPENDIX C: CONTACT NUMBERS FOR DCFS AND HOSPITAL CHAPLAINS

Statewide Hospital Chaplaincy Resources

Pediatric Hospitals with Chaplaincy Services	Phone Number	DCFS Regions
Carle Foundation Hospital Urbana, IL	(217) 388-3311	Central
OSF St. Francis Medical Center Peoria, IL	(309) 655-2000	Central
Riley Hospital for Children Indianapolis, IN	(317) 944-2060	Central
St. John's Hospital Springfield, IL	(217) 544-6464	Central
Advocate Christ Medical Center, Advocate Children's Hospital Oak Lawn, IL	(708) 684-8000	Cook
Advocate Illinois Masonic Medical Center Chicago, IL	(773) 975-1600	Cook
Advocate Lutheran General Hospital, Advocate Children's Hospital Park Ridge, IL	(847) 723-2210	Cook
Ann & Robert H Lurie Children's Hospital Chicago, IL	(312) 227-1200	Cook
John H. Stroger Jr. Hospital of Cook County Chicago, IL	(312) 864-6000	Cook
Loyola University Medical Center Maywood, IL	(708) 216-9000	Cook
Mount Sinai Medical Center Chicago, IL	(773) 524-2000	Cook
Rush University Medical Center Chicago, IL	(312) 942-5000	Cook

University of Chicago Comer Children's Hospital Chicago, IL	(773) 702-1000	Cook
University of Illinois Medical Center Chicago, IL	(312) 996-2901	Cook
Advocate Good Samaritan Hospital Downers Grove, IL	(630) 275-5900	Northern
American Family Children's Hospital University of Wisconsin Madison, WI	(608) 262-2398	Northern
Cadence Central DuPage Hospital Winfield, IL	(630) 933-1600	Northern
Children's Hospital of Wisconsin - Milwaukee Milwaukee, WI	(414) 266-2000	Northern
Edward Hospital Naperville, IL	(630) 527-3000	Northern
Presence St. Joseph Medical Center Joliet, IL	(815) 725-7133	Northern
Rockford Memorial Hospital Rockford, IL	(815) 971-5000	Northern
St. Alexius Medical Center Hoffman Estates, IL	(847) 843-2000	Northern
St. Mary's Hospital Madison, WI	(608)251-6100	Northern
Meriter Hospital Madison, WI	(608) 417-6000	Northern
Cardinal Glennon Children's Hospital St. Louis, MO	(314) 577-3600	Southern
St. Louis Children's Hospital St. Louis, MO	(314) 454-6000	Southern

Other Hospitals with Chaplains in Cook County

Other Hospitals with Chaplains in Cook County	Phone Number
Evanston Hospital	(847) 570-2330
Loretto Hospital	(773) 854-5055
Oak Park Hospital	(708) 660-5658
Schwab Rehab Hospital	(773) 542-2000 x6736
Weiss Memorial Hospital	(773) 564-5738

DCFS Numbers

Child Abuse Hotline: 1-800-25-ABUSE (22873)
Adoption Hotline: 1-800-572-2390
Advocacy Office for Children and Families 1-800-232-3798
Day Care Information Hotline: 1-877-746-0829
Foster Parent Hotline: 1-800-624-KIDS (5437)
Office of the Inspector General Foster Parent Hotline 1-800-772-9124
Youth Hotline 1-800-232-3798

APPENDIX D: GLOSSARY OF TERMS

These definitions have been taken from DCFS Rule and Procedures. DCFS defines these various terms pertaining to medical care and religion as follows:

Casework: The process of needs assessment, provision of and/or arrangement for services required by the client (family) in order to achieve objectives and permanency goals; includes client contact and the coordination/evaluation of a wide variety of client services.

Child Protection Investigator (CPI): A DCFS employee who investigates hotline reports and makes the initial determination whether an allegation is indicated or unfounded.

Consent or Consenting: A legally binding commitment resulting from an informed, deliberate process in which the consulting party signs a formal document. Depending on the circumstances, the consenting party may be the Department's Guardianship Administrator, or designee, parents or caretakers. Permission is given on behalf of the child for changes in the child's living arrangement or legal status, or in order to provide medical treatment or other services or safeguard the rights of the child.

Custodians: Caretakers designated by the Department of Children and Family Services to be responsible for the day to day care of children for whom the Department is legally responsible. Caretakers include: foster parents, administrators of group homes, institutions, child welfare agencies, and relative caretakers.

Dependency: A situation where a parent or guardian is not capable of taking care of a child, but has not abused or neglected that child.

Designee: Department staff who have been appointed by the Director and authorized by the Guardianship Administrator to authorize and consent to matters concerning children for whom the Department has legal responsibility.

Division of Child Protection (DCP): The division of DCFS that investigates allegations of abuse and neglect.

Elective medical treatment: Measures other than ordinary medical care that may be delayed for 72 hours or more without jeopardizing the life, health or safety of the patient or subjecting him to probable physical harm.

Emergency medical treatment or surgical procedure: Extraordinary measures deemed necessary to preserve the life or health of a patient.

Foster Home: The residence of a family that provides full time family care for DCFS wards unrelated to them. Foster family homes are limited to a maximum of 8 children including the foster family's children unless all of the children unrelated to the foster family are of common parentage.

Guardian ad Litem (GAL): A person who is appointed to represent the interests of a minor in litigation. A GAL is generally an attorney appointed in a dual capacity: to represent the child as his or her attorney and to represent the best interests of the child in court. Illinois law requires that a GAL be appointed in every case in which a minor is alleged to be abused, neglected or dependent; the GAL must either be an attorney or be represented by one. In Cook County, the Public Guardian is generally appointed as both the GAL and attorney for the child.

Guardianship Administrator: The person designated by the Director of DCFS to serve as guardian or legal custodian of children accepted by DCFS. The Guardianship Administrator is appointed legal custodian of a child after the termination/surrender of parental rights, after the child has been taken into temporary protective custody, or if the child's parent(s) or guardian cannot be located.

Indicated Report: A finding by the Child Protective Investigation that credible evidence exists that abuse or neglect occurred. Once a report has been indicated against a caretaker, the record will be kept for 5, 10 or 50 years depending on the allegation.

Intact Family Services: DCFS services provided to a family where there has been an allegation of abuse or neglect, but the children have not been removed from the home. These services aim at improving family relations and caretaker skills. Intact family services can be provided whether or not the allegation was indicated.

Intake: Casework activities which begin at the point of initial referral for service and end with a decision regarding service eligibility and the initial mode of service delivery.

Major medical treatment or surgical procedure: Extraordinary measures deemed necessary to preserve the life or health of a patient.

Mandated Reporters: Those individuals required by law to report suspected child abuse or neglect to the Department. Examples of mandated reporters are doctors, teachers, and police officers.

Medical treatment or procedure: Any medical or surgical procedure which is intended to alleviate, ameliorate, prevent, or correct physical illness, injury, disability or disfigurement. The term does not include psychological or psychiatric counseling, therapy or treatment.

Ordinary medical care: Medical procedures which are administered or performed on a routine basis and which do not involve hospitalization, surgery or use of anesthesia and include, but are not limited to inoculations, physical examinations, and treatment for minor illnesses and injuries.

Permanency Goal: The continuous living arrangement that the Department deems desirable for and available to the child. A permanent legal status is usually a component of the permanency goal. The means for attaining a permanency goal as well as the goal itself can change, as the child's developmental or emotional needs change or as the child's and family's circumstances change. Examples of permanency goals are: return home within 1 year, adoption, and substitute care pending termination of parental rights.

Religious Institution: An entity which has declared its intent to operate for religious purposes in securing its tax exempt status pursuant to 26 U.S.C. 501(c)(3) of the Internal Revenue Code.

State Central Registry (SCR): The specialized Department unit that receives and transmits reports of alleged child abuse and neglect. Additionally, the Register maintains information concerning confirmed reports of abuse and neglect.

Substitute Care: The care of children who require placement away from their families. Substitute care includes foster family care, care of a child for whom DCFS is legally responsible in a relative family home, care provided in a group home and care provided in a child care or other institution. [See DCFS Rule 301]

Temporary Protective Custody: Custody within a hospital or other medical facility or a place previously designated by the Department, subject to reversal by the court. Temporary Protective Custody is taken by an investigative worker and cannot exceed 48 hours.

Unfounded Report: Any report of child abuse or neglect for which it is determined, after an investigation, that no credible evidence of the alleged abuse or neglect exists. These reports can be retained from 60 days to three years, depending on the severity of the allegations.

Unusual Incident Report (UIR): Report required to be filed by DCFS or private agency about any occurrence that is out of the ordinary and non-routine with regard to Department affairs. Examples of such events are: fire, robbery or burglary, riots, extreme weather occurrences resulting in damage to the facility or injury or death of persons on the premises; the death of any child, whether a Department ward or not, which is reported to the State Central Registry; serious illness or injury which requires hospitalization of a child for whom the Department is legally responsible; death under suspicious circumstances, homicide or suicide involving a child for whom the Department is legally responsible; alleged or verified act of wrongdoing or corruption by a Department employee; action in which Department staff press charges

against Department clients, and any incident which could have media importance.

Victim Sensitive Interview (VSI): A specialized interview procedure used in cases of suspected child abuse, both physical and sexual. The interview process is designed to encourage children to speak freely about what happened to them, without traumatizing or upsetting them. The primary goals of this type of interview are minimizing trauma for the child, maintaining the integrity of the investigative process, maximizing the information received about the event(s), and minimizing the contamination of the child's memory of the event(s).

APPENDIX E: CONSENT FOR RELIGIOUS INSTRUCTION/ CHURCH ATTENDANCE

IL 418-589
Rev. 9/98

State of Illinois
Department of Children and Family Services

Consent for Religious Instruction/Church Attendance

I/WE, the parent(s), legal guardian/custodian _____

A minor, whose birth date is _____ hereby consent for him/her to participate in religious instruction and to attend religious services if he/she wishes.

☐ I prefer that these services be in the _____ faith.

☐ I prefer that religious instruction be in the _____ faith.

☐ I do not object for him/her to participate in religious instruction and to attend religious services in another faith, excluding baptism and confirmation unless approved by me.

☐ I do not wish for him/her to attend religious services or participate in religious instruction.

_____
(Signature)

_____
(Signature)

_____ _____
(Date) (Relationship to Child)

Rev. 10/2014