2016 IL App (1st) 153378
No. 1-15-3378
Opinion filed April 19, 2016

Second Division

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

In re BLUE F., a Minor.	)	Appeal from the Circuit Court
	)	of Cook County.
(THE PEOPLE OF THE STATE OF ILLINOIS,	)	
	)	
Petitioner-Appellee,	)	No. 14 JA 1492
	)	
v.	)	
	)	The Honorable
TANYA F.,	)	John L. Huff,
	)	Judge, presiding.
Respondent-Appellant).	)	

JUSTICE HYMAN delivered the judgment of the court.
Presiding Justice Pierce and Justice Neville concurred in the judgment.

ORDER

Held: The circuit court's findings that minor child was dependent for lack of proper care and it was in the child's best interest that she be made a ward of the court held not against the manifest weight of the evidence.

¶ 1 Respondent Tanya F. is the mother of at least two minor children, Blue F. and her older sister, Tanya (Tanya, Jr.). Before Blue was born, the Illinois Department of Children and Family Services took custody of Tanya, Jr. because, at the time of her birth, hospital personnel reported

Tanya was acting erratically. Tanya was assessed for services aimed at reuniting her with Tanya, Jr., but having failed to complete the services or consistently visit Tanya, Jr., her parental rights were terminated and Tanya, Jr. was adopted. Shortly after Tanya, Jr.'s case was closed, Tanya gave birth to Blue. DCFS was contacted because Tanya, again, behaved erratically at the hospital. The State filed a petition for adjudication of wardship and later amended its petition so as to proceed solely on a dependency allegation. After an adjudication hearing, the trial court found Blue dependent for lack of proper care due to Tanya's mental disability. After a disposition hearing, the trial court found that respondent was unable to care for Blue, adjudicated Blue a ward of the court, and appointed DCFS as Blue's guardian. While the trial court noted "serious deficiencies" in DCFS's efforts to prevent or eliminate Blue's removal from the home, it found DCFS met minimal standards.

¶ 2 Tanya argues (i) the trial court's finding of dependency was against the manifest weight of the evidence because the court misapplied the theory of anticipatory neglect, and (ii) the trial court's disposition order was against the manifest weight of the evidence because DCFS did not make reasonable efforts to prevent or eliminate Blue's removal from the home. We affirm. The trial court's dependency finding was not against the manifest weight of the evidence based on Tanya's prior mental health issues, her refusal to acknowledge those issues, and her history of involvement with DCFS. Also not against the manifest weight of the evidence is the trial court's dispositional determination that it was in Blue's best interest to be made a ward of the court and that DCFS met the minimal standards in its efforts to prevent or eliminate Blue's removal from the home.

¶ 3 BACKGROUND

¶ 4 Blue was born on December 14, 2014. Her mother is Tanya F. but paternity was never established. The father, who Tanya identified as "Little Rickey," Rickey D., or Rickey S. was served by publication and defaulted for failing to appear. He is not a party to this appeal. On December 17, 2014, DCFS took Blue into protective custody and the State filed a petition for adjudication of wardship and a motion for temporary custody on December 19. The petition alleged Blue was abused and neglected due to an injurious environment (705 ILCS 405/2-3(1)(b) (West 2014)) and was at a substantial risk of physical injury (705 ILCS 405.2-3(2)(ii) (West 2014)). The facts supporting the allegation were that Tanya had two other minor children in DCFS custody with findings of neglect, dependency, and unfitness and that Tanya was not complying with reunification services including a psychological evaluation, parent coaching, parenting classes, and follow-up with psychiatric monitoring. Tanya had been diagnosed with paranoid schizophrenia but denied she had any mental health issues. She also denied having other children. After a hearing, the trial court found Tanya's prior mental health history and her failure to take her medication were grounds for removing Blue from the home and placing her in the temporary custody of DCFS.

¶ 5 At the adjudication hearing, the State asked to voluntarily dismiss the neglect injurious environment and abuse substantial risk of injury allegations and proceed on dependency grounds only. No one objected, and the trial court granted the request.

¶ 6 Jamie Myers, a caseworker for Lutheran Child and Family Services (LCFS), testified she began providing services for Tanya and Tanya, Jr. in September 2012. Myers conducted an updated integrated assessment because the case had been transferred to her from another caseworker. (The purpose of an integrated assessment is to obtain background information to

develop a services plan for the family.) After the assessment, Myers referred Tanya for a psychological evaluation, a psychiatric assessment, and parenting classes and asked Tanya for documentation from prior psychiatric programs she had completed. Myers referred Tanya for a psychological evaluation because Tanya told her she had been diagnosed with schizophrenia and was receiving supplemental security income (SSI) benefits for this disability, and Myers wanted to make sure the diagnosis was correct. Tanya gave Myers documentation from social security listing the schizophrenia diagnosis and medications. Myers referred Tanya for parenting services because Tanya was not parenting Tanya, Jr., and she had another child who was adopted and had been taken from her care.

¶ 7 Myers testified that Tanya, Jr. was adjudicated abused or neglected based on a lack of care and an injurious environment. The order stated that Tanya had one other minor child not in her care, was delusional and acting in an irrational and bizarre manner, and, according to family members, had a history of mental health issues and was not compliant with treatment. The order further stated that attempts to assess Tanya were unsuccessful due to her refusal to cooperate and difficulties in determining her whereabouts. After a dispositional hearing, the court found Tanya to be unable and unwilling to care for Tanya, Jr., and her parental rights were terminated. Myers testified Tanya Jr.'s case was closed in December 2014 and about two weeks later, she received a call informing her that Tanya had given birth to Blue.

¶ 8 Joy Osayande, the DCFS child protection investigator assigned to investigate Tanya and Blue's case, spoke to Tanya on December 15, 2014, at South Suburban Hospital, shortly after Blue was born. Osayande testified that when she asked Tanya about her history with DCFS, Tanya became upset and said she did not know what Osayande was talking about. When Tanya calmed down, Osayande asked her how many children she had, and Tanya gave several different

answers. First, Tanya said she had four children who lived with their father. Then she said the four children were her nieces and nephews, and they lived with their father, but she did not know where he lived. Then Tanya said she had only one child, a newborn baby, and she did not know who the father was. Tanya told Osayande she lived by herself in Harvey and received SSI benefits, but she did not say why. She also said her family lived out of state and she did not have any siblings.

¶ 9 Osayande said Tanya became increasingly upset. Osayande tried to explain to Tanya that she was from DCFS and was trying to determine what to do with Blue but Tanya told her she did not want to hear it and that if "you take my baby, I'm gonna make another one." At one point, Tanya called the police, who came to her hospital room and saw that Tanya was upset. Osayande said that a social worker also came to the room because Tanya was out of control.

¶ 10 Osayande testified that she believed Tanya understood her but was upset, unstable, and uncooperative. She said Tanya's demeanor was disturbing and she appeared to be mentally unstable. Tanya told Osayande, "I'm going to leave this hospital. You can't tell me what to do." She walked in and out of the hospital room while Osayande and the social worker questioned her. Osayande said Blue was in a crib in Tanya's hospital room and looked clean, healthy, and well cared for. But Osayande asked a nurse to remove Blue from the room because Tanya would not let anyone near the baby.

¶ 11 Tanya's medical records show that two psychiatrists visited Tanya's hospital room on December 15, 2014, because of Tanya's bizarre conduct. Dr. Mary Belford went to Tanya's room at about noon, and reported that Tanya put tape on her face to help her pain go away and had disorganized thoughts and speech. Dr. Pradeep Thapar was also called to Tanya's hospital room at about 4:30 p.m., because Tanya was "psychotic, labile, agitated at times, thinks people are out

to take advantage of her, putting tape on her mouth, and calling people rude." Dr. Thapar reported that "she is definitely psychotic, but not to the point that she need to go to inpatient psych." Dr. Belford reported that Tanya calmed down later in the evening and was more cooperative but denied any history of mental illness.

¶ 12 Osayande said she checked for prior indicated reports for Tanya and found an indicated report showing Tanya had a baby in 2011 and that DCFS had been involved in that case. Osayande said prior indicated reports help determine possible risk to a respondent's children. Osayande tried to find a family member or someone else to take care of Blue but could not find anyone.

¶ 13 After leaving the hospital, Osayande went to Tanya's home in Harvey. Osayande said it was largely an abandoned apartment complex, that doors were missing on some of the apartments, and garbage was everywhere. Osayande called Tanya to get the name of Blue's father so that she could inform him about the case. Tanya told her his name was "Little Rickey," and gave her his phone number. Osayande called Little Rickey on December 15 or 17, 2014. He acknowledged he knew Tanya but denied being Blue's father and said he would not come to court. Osayande gave him her phone number, her work address, and court information but he never contacted her or appeared in court.

¶ 14 On December 18, 2014, Osayande completed a Child Endangerment Risk Assessment Protocol (CERAP), which is used to assess the safety of children who come into the system. In the CERAP, Osayande made an "unsafe" determination as Tanya has mental health issues and was residing in an abandoned apartment building.

¶ 15 After arguments, the trial court found by a preponderance of the evidence that Tanya is disabled and that Blue was dependent because she was without proper care due to Tanya's

physical or mental disability. The court stated, "It is certainly not the strongest case I've seen" but decided the finding was warranted based on the evidence. The court noted that Tanya was acting bizarrely, was psychotic, labile, agitated, and thinks that people are out to get her and take advantage of her. She was observed acting strangely at the hospital by, for instance, putting tape on her face to make the pain go away, and her thoughts and speech were disorganized. Also, when hospital staff asked Tanya if she had a cough, she said she needed a hair perm. She also said someone in Tinley Park was trying to get her and that she had been kidnapped several times. The trial court found that she had "a flight of ideas" and would not admit to any psychiatric issues.

¶ 16 The disposition hearing was held immediately after the adjudication hearing. The trial court took judicial notice of all of the evidence and the dependency finding. The court admitted several exhibits into evidence including an integrated assessment for Blue dated February 5, 2015, integrated assessments for Tanya dated June 12, and July 10, 2015, a service plan dated June 2, 2015, a psychological evaluation for Tanya dated June 19, 2015, and a comprehensive assessment conducted by LCFS.

¶ 17 The integrated assessment for Blue stated that Tanya:

> 1) Appeared to have cognitive delays and could not follow through with a conversation.
>
> 2) Said she had another child, who was in the child's father's care for unknown reasons.
>
> 3) Had difficulty bonding with Blue— they had no physical contact in the hospital.
>
> 4) Had a circumstantial and tangential thought process, delusions, and grandiose beliefs.

5) Said she had 87 children with four partners; that she was in the Army, Navy, and Air Force between the ages of seven and ten; and received a master's degree at the age of seven and a doctorate degree at the age of ten from Dakota North University in Mississippi.

6) Received SSI disability benefits with regard to her schizophrenia.

7) Had been charged with assault five times and appeared to be at high risk to be a victim of intimate partner violence.

8) Had a history of noncompliance with mental health treatment and was ambivalent about participating in mental health services, stating that she did not think she needed to see a psychiatrist or therapist.

9) "[P]resents with delusional beliefs, problems with her thinking, poor insight, poor judgment, problems with her mood, possible problems with aggression, and reluctance to engage in necessary treatment."

10) Will not be consistently able to protect and provide a safe environment for Blue due to her mental health and lack of follow-through with services, although she has some knowledge of parenting.

¶ 18 The integrated assessment recommended these services for Tanya: (1) a review of her psychiatric and mental health treatment records; (2) a psychiatric evaluation; (3) individual therapy; (4) a consultation with a psychologist on a parenting capacity assessment; (5) the Nurturing Parenting Program (NPP) when her treatment providers deem her ready; and (6) supervised visitation with possible parenting coaching. The prognosis for reunification between Tanya and Blue was deemed poor because of Tanya's chronic mental health concerns, her reluctance to engage in treatment, lack of follow through with recommendations, emotional

dysregulation, risk of aggression, questionable decision-making and understanding of her issues, inconsistent use of services, inconsistent parenting, and lack of stable income and safe housing.

¶ 19 Blue's service plan stated that Tanya does not understand Blue's medical needs based on her diagnosis of severe acid reflux and asthma, and she is difficult to redirect about the proper way to care for Blue. On visits, Tanya insisted on giving Blue milk she packed in a bag with dirty blankets and toys though Blue needed special milk, and she tried to over-feed her contrary to doctor's instructions. Tanya also tried to cover Blue despite her breathing issues. The service plan stated that Tanya received satisfactory ratings for the NPP and the parenting capacity assessment but that services were not in place in a timely manner due to technical problems at the agency and not due to Tanya's non-cooperation. Tanya had two psychiatric assessments and was deemed not to need medication. She was scheduled for a psychological evaluation and a third psychiatric assessment. She received a satisfactory rating for individual therapy, which was not recommended at that time because Tanya had not completed other services.

¶ 20 Tanya's psychological assessment from Dr. Paul Linden dated June 19, 2015, stated that Tanya had two older children whom DCFS took from her care, but that she denied any prior involvement with DCFS. Dr. Linden reported that Tanya was delusional, made inconsistent and disorganized historical reports, and exhibited psychotic thinking. Tanya had poor judgment and may have been experiencing auditory or visual hallucinations that she was unwilling to acknowledge. Dr. Linden diagnosed Tanya as having schizophrenia and borderline intellectual functioning. He recommended a psychiatric assessment, individual therapy, and a referral to Thresholds or a similar psychiatric rehabilitation program. He also recommended supervised visitation with Blue as long as Tanya behaves appropriately. He did not recommend a parenting

capacity assessment until Tanya was stabilized on medication. Dr. Linden reported that Tanya had a poor prognosis for addressing the concerns that brought the case into the system.

¶ 21 Tanya had two psychiatric assessments that were admitted into evidence. On the first, dated June 12, 2015, the psychiatrist wrote that it was unclear why DCFS was involved and that Tanya denied any symptoms or treatment history. The psychiatrist diagnosed her with adjustment disorder and recommended counseling. The psychiatrist wrote that Tanya was not forthcoming about her involvement with DCFS and "[i]t is unclear if she is aware what is expected of her regarding parenting and future needs of her child." The second psychiatric assessment stated that Tanya was unclear about why the appointment was scheduled, and she denied any symptoms or treatment history. The psychiatrist did not make a diagnosis and recommended "clarification from case manager regarding expectations/services patient needs to be engaged in to pursue reunification with child."

¶ 22 A comprehensive assessment diagnosis by LCFS clinician Samantha Williams-Smith dated October 26, 2015, also was admitted into evidence. It stated that Tanya presented with impairment in functioning, unusual behavior, delusions, disorganized thinking and speech, detachment, limited insight, and cognitive deficits. In therapy, Tanya stated that she obtained a PhD when she was seven years old and that she had twins that were born six weeks apart and were conceived by two different fathers. Tanya was psychiatrically hospitalized in December 2011, and was diagnosed with paranoid schizophrenia and was prescribed risperidone and hydrochlorothiazide. Williams-Smith reported that Tanya was unable to address the concerns that brought the case to DCFS's attention and agreed with Dr. Linden that Tanya should be referred to Thresholds or another psychiatric rehabilitation program.

¶ 23 Jamie Myers, Tanya's LCFS caseworker again testified. She stated that since leaving the hospital on December 23, 2014, Blue has been living in a traditional non-relative foster home, that her placement is safe and appropriate, and that there have not been any unusual incidents, signs of abuse, neglect, risk of harm, or corporal punishment. Myers said Blue was almost a year old and that her shots were up to date but that there were some concerns regarding Blue's health, because she was diagnosed with asthma and severe acid reflux. Blue sees a pediatrician for regular care, a pulmonologist for asthma, and a gastro-pediatrician for acid reflux. The pulmonologist recommended albuterol every four hours and Blue was prescribed special milk for her reflux, although solid food was being introduced. Myers said Blue was only able to take four ounces of food in her mouth at once or else she becomes ill. Myers had concerns about Blue's physical and developmental needs and believed Blue likely would need physical therapy.

¶ 24 Myers testified that Tanya needed several services before reunification with Blue could be considered: a psychological evaluation, the NPP, individual therapy, and a parenting capacity assessment. Tanya was referred for all services except for the parenting capacity assessment, because the psychologist recommended that Tanya first participate in individual therapy to address why the case came into the system and psychiatric issues. Also, although a referral was made for the NPP, the therapist recommended that Tanya be therapeutically cleared before starting it. Myers acknowledged, however, that Tanya signed up for parenting classes on her own.

¶ 25 As of the date of the hearing, Tanya had been in individual therapy for about two months with Samantha Smith-Williams at LCFS but was discharged pending further psychiatric evaluation. Myers said Tanya had two psychiatric evaluations in the year before the hearing, in June and July 2015, and was found not to need medication. Myers asked Tanya to go for a third

psychiatric evaluation, which was scheduled for December 2015. Myers said she also recommended that Tanya be referred to Thresholds, a psychiatric facility, for more intense work, but Tanya was on a three to six month waiting list.

¶ 26 Myers testified that Tanya had supervised visits with Blue twice a week for an hour and a half, and the agency was recommending that the visits continue. Case aides were trained on feeding Blue and administering her albuterol treatments and helped Tanya with both. Myers said Tanya does not understand when Blue needs a treatment or anticipate when a treatment is necessary but there were no concerns about her administering treatments while she is being monitored. Myers said Tanya once brought milk that was brown in color and did not look appropriate for Blue and brought blankets that smelled of gasoline. She said that the case aides could redirect Tanya and were working with her on Blue's special dietary and health needs.

¶ 27 Myers testified that Tanya missed a couple of visits with Blue. She missed one because she said she had been raped but that she did not report it to the police. She missed another visit because she did not have bus fare, even though Myers said she gives Tanya a 30-day bus pass every month. Tanya told her that she lost the pass. Tanya also was unable to visit Blue in July 2015, because both case aides were on vacation at the same time. Also in July, Tanya's visits were reduced to one day a week because of caseworker availability and she missed those visits because she did not confirm them in advance. The visits returned to twice per week when another caseworker became available, and the agency was making up for the missed July visits by adding an extra hour on to the twice per week visits.

¶ 28 Myers said that she staffed the disposition recommendations with her supervisor and that the agency was recommending that it would serve Blue's best interest to be made a ward of the court and that DCFS be appointed her guardian.

¶ 29 After argument, the trial court found that the State had met its burden of proof by a preponderance of the evidence that it was in Blue's best interest that she be made a ward of the court and that Tanya was for some reason other than financial circumstances alone unable to care for, protect, train, or discipline Blue. The trial court found that appropriate services aimed at family preservation and reunification had been unsuccessful but it had "some concerns about the reasonable efforts of the agency" and that there “appears to be somewhat of a breakdown in the services that have been offered.” Although the court found "they've not been the best" and that there were “serious deficiencies, particularly with regard to visitation, it concluded that they met minimal standards. The court also found the father was unable and unwilling to care for the child, as he failed to come forward. Thus, the court vacated the temporary custody order and entered an order appointing DCFS as Blue's temporary guardian.

¶ 30 ANALYSIS

¶ 31 Tanya argues (i) the trial court's finding of dependency in the adjudicatory hearing was against the manifest weight of the evidence because the court misapplied the theory of anticipatory neglect; and (ii) the trial court’s finding in the dispositional hearing that DCFS made reasonable efforts to prevent or eliminate Blue’s removal from the home was against the manifest weight of the evidence.

¶ 32 Adjudicatory Findings

¶ 33 The Juvenile Court Act of 1987 (Act) is intended to secure for minors the care and guidance that will best serve the minor's safety and moral, emotional, mental, and physical welfare, and the best interests of the community. 705 ILCS 405/1-2 (West 2014).

¶ 34 After the State files a petition for wardship and placement in temporary custody, the trial court conducts an adjudicatory hearing to determine whether the allegations of the petition that a

minor is abused, neglected, or dependent are supported by a preponderance of the evidence. 705 ILCS 405/1-3(1), 2-21 (West 2014). If the State satisfies its burden of proof, the circuit court proceeds to a disposition hearing to determine whether it is consistent with the health, safety and best interests of the minor and the public to make the minor a ward of the court, and to determine what order of disposition should be made in respect to the minor so adjudged. 705 ILCS 405/1-3(6), 2-22 (West 2014).

¶ 35 A dependent minor includes any minor under 18 years of age "who is without proper care because of the physical or mental disability of his [or her] parent, guardian or custodian." 705 ILCS 405/2-4 (West 2014). Unlike a determination of neglect, the determination of whether a minor is a dependent child focuses on the parent rather than the child. *In re J.J.*, 246 Ill. App. 3d 143, 151 (1993). "Specifically the focus is on whether the disability of the parent is such that it impairs the abilities necessary for the care and parenting of the minor. *** [T]he scope and extent of the disability may be determined from other evidence, including *** observations of the parent in other contexts, and medical or other evidence regarding the parent's limitation due to the disability." *Id.*

¶ 36 The State must prove by a preponderance of the evidence that the parent's disability significantly impairs the abilities necessary to the care and parenting of a child. *Id.* A preponderance of the evidence requires "proof that makes the condition more probable than not." *In re N.B.*, 191 Ill. 2d 338, 343 (2000). A trial court's determination on dependency will not be overturned unless manifestly erroneous. In other words, it is clearly evident the proper disposition is the opposite of that reached by the trial court. *J.J.*, 246 Ill. App. 3d at 151. We give great deference to the trial court due to its superior position to observe the witnesses, assess

credibility, and weigh the evidence. *In re T.B.*, 215 Ill. App. 3d 1059, 1062 (1991). The paramount consideration in adjudicatory proceedings is the best interest of the child. *Id*.

¶ 37 The trial court's adjudicatory finding of dependency was not against the manifest weight of the evidence. Tanya has a history of mental illness, having previously been diagnosed with schizophrenia for which has been prescribed antipsychotic medication. Tanya acknowledged she receives SSI based on this diagnosis (although she also continually denied any mental health issues). Before Blue was born, Tanya lost custody of Tanya, Jr., whose case came into the system when Tanya exhibited odd behavior in the hospital, as she did after Blue's birth. An integrated assessment on Tanya, Jr.'s case, dated September 4, 2012, stated that Tanya's whereabouts were unknown, that she has a history of mental illness, including psychiatric hospitalizations in 2003 and 2011, and that prognosis for reunification was poor because she denies having mental health issues and exhibits erratic behavior. She "presents with delusional beliefs, problems with her thinking, poor insight, poor judgment, problems with her mood, possible problems with aggression, and reluctance to engage in necessary treatment." The integrated assessment also stated that although she has some knowledge of parenting, due to her mental health and lack of follow-through with services, she will not be consistently able to protect and provide a safe environment for her child.

¶ 38 After Blue was born, Tanya again was observed exhibiting unusual behavior and thoughts. One psychiatrist, Dr. Belford, said Tanya was making disorganized statements and acting bizarrely by, for instance, putting tape on her face to make her pain go away. Another psychiatrist, Dr. Thapar, described Tanya as psychotic, labile, agitated, and paranoid. Dr. Thapar opined that Tanya likely could not care for Blue because of her erratic behavior.

¶ 39 Joy Osayande, the DCFS investigator testified that at the hospital Tanya was upset and agitated and refused to answer questions. At one point, Tanya called the police and told Osayande that if her baby was taken away, she would just have another one. Osyande described Tanya's demeanor as disturbing. Tanya refused to answer questions, paced the room, and threatened to leave the hospital. Osayande said that a social worker was asked to come into the room and that Blue was removed from the room because of Tanya's erratic behavior.

¶ 40 Tanya argues that since the case came into the system, she has been evaluated by two psychiatrists, in June and July 2015, and that neither doctor diagnosed her with schizophrenia or prescribed medication for her. She asserts that the agency has asked her to undergo a third psychiatric evaluation, "hoping that the third doctor would find *** her unable to care for her child." While it is true that neither made the schizophrenia diagnosis, the first psychiatrist diagnosed her with adjustment disorder, stated that Tanya was not forthcoming about her involvement with DCFS, and may not have been aware of what is expected of her as a parent or the future needs of her child. Moreover, in June 2015, Paul Linden completed a psychological assessment of Tanya, concluding Tanya met the criteria for schizophrenic spectrum disorder and exhibited disorganized, incongruent, and delusional thinking.

¶ 41 Tanya also argues that the trial court misapplied the doctrine of anticipatory neglect. Under the anticipatory neglect theory, proof of neglect of one minor applies on the issue of the neglect of any other minor for whom the parent is responsible. 705 ILCS 405/2-18(3) (West 2014). But, “the mere admissibility of evidence does not constitute conclusive proof of the neglect of another minor.” *Arthur H.*, 212 Ill. 2d 441, 468 (2004). “There is no *per se* rule that the neglect of one child conclusively establishes the neglect of another child in the same household.” *Id.* “Rather, ‘such neglect should be measured not only by the circumstances

surrounding the sibling, but also by the care and condition of the child in question.' " *Id.* (quoting *In re Edward T.*, 343 Ill. App. 3d 778, 797 (2003)); see also *In re Edricka C.*, 276 Ill. App. 3d 18, 29-31 (1995). Nevertheless, the Illinois Supreme Court recognizes that "when faced with evidence of prior neglect by parents, 'the juvenile court should not be forced to refrain from taking action until each particular child suffers an injury.' " *Arthur H.*, 212 Ill. 2d at 477 (quoting *In re Brooks*, 63 Ill. App. 3d 328, 339 (1978)).

¶ 42 Although Tanya contends the trial court incorrectly relied on the doctrine of "anticipatory neglect," in making its adjudicatory findings, it does not apply because the State withdrew its neglect allegations and proceeded solely on a dependency theory. The court did hear evidence about Tanya's prior involvement with DCFS and her past mental health history. Both are relevant to her ability to care and parent Blue, particularly because she was exhibiting similar behavior that resulted in the removal of Tanya, Jr. from her care.

¶ 43 Tanya correctly points out that the trial court stated that this was "not the strongest case" of disability it had seen. But, the court nonetheless found that Tanya was disabled because of a history of untreated mental health issues and that Blue was dependent under section 2-4(b) of the Act. Based on the evidence and testimony, this finding was not against the manifest weight of the evidence.

¶ 44 Dispositional Findings

¶ 45 After a trial court makes a finding that the State has satisfied its burden of proof in an adjudicatory hearing and makes findings of abuse, neglect, or dependency, the court proceeds to a dispositional hearing. "A minor may be made a ward of the court if the court determines the parents are unable, for some reason other than financial circumstances alone, to care for, protect, train, or discipline the minor. 705 ILCS 405/2-27(1) (West 20[10])." *In re D.W.*, 386 Ill. App.

3d 124, 139, (2008). The trial court's decision must be supported by the preponderance of the evidence, and we will not disturb a dispositional finding unless it is against the manifest weight of the evidence. *Id*.

¶ 46 Tanya contends we should reverse the trial court's dispositional finding because the court's finding that the agency made reasonable efforts to prevent or eliminate the need to remove Blue from her care was against the manifest weight of the evidence. First, as a threshold matter, we note, as the public guardian does in its brief, Tanya did not object to the trial court's finding when it was entered as part of its dispositional ruling. (Tanya did not file a reply brief and thus did not respond to the waiver argument.) To preserve a question for review, a party must make an appropriate objection in the trial court and failure to object constitutes a waiver. *In re Lakita*, 297 Ill. App. 3d 985, 991 (1998). By failing to object to the trial court's finding that the agency made reasonable efforts to eliminate the need for Blue's removal from Tanya's home, she waived the issue.

¶ 47 Second, issues regarding whether a minor should be adjudged a ward of the court are not related to issues regarding reasonable efforts on the part of DCFS toward reunification. These concepts are on two wholly different planes and, significantly, Tanya provides us with no case law or statute to the contrary.

¶ 48 The Act provides that, once a trial court determines a minor has been abused or neglected, it must conduct a dispositional hearing to decide "whether it is consistent with the health, safety and best interests of the minor and the public that he [or she] be made a ward of the court." 705 ILCS 405/2-21(2) (West 2014). It is this "best interest" analysis, which we will discuss in more detail below, that is key to a wardship decision, not a finding regarding whether reasonable efforts toward reunification were employed by an agency involved in the cause. See

In re Violetta B., 210 Ill. App. 3d 521, 533 (1991) (“paramount consideration in all guardianship and child custody cases is the best interests of the child”); accord *In re Austin W.*, 214 Ill. 2d 31, 49 (2005); *In re S.J.*, 364 Ill. App. 3d 432, 442 (2006) (child's best interest takes precedence over any other consideration). Third, even if Tanya were correct that a lack of reasonable efforts requires the reversal of a wardship determination, the evidence supports the trial court's decision that reasonable efforts had been employed in Blue's case.

¶ 49 The trial court found "some concerns about the reasonable efforts of the agency" and "serious deficiencies" regarding visitation. This finding is likely based on the missed visits due, in part, to the lack of available case aides. (Other missed visits were not the fault of the agency but were caused by Tanya's inability to get to them.) At the time of the hearing, the agency was in the process of making up the missed visits by adding an additional half hour to Tanya's twice weekly visits. Although it would have been preferable not to have any missed visits, this alone is not grounds for finding that reasonable efforts at reunification were not made, particularly in light of the agency's effort to make up for them.

¶ 50 Aside from the visitation issue, the record shows the agency was recommending another psychiatric assessment and a referral to Thresholds or a similar psychiatric rehabilitation facility. Tanya's ongoing psychiatric issues, including her diagnosis of schizophrenia, her delusions, disorganized thinking, and cognitive deficits were a hindrance to her reuniting with her daughter. The agency was attempting to address those issues, because they were the primary impediment to reunification. For instance, although a referral was made for the Nurturing Parenting Program, the therapist recommended that Tanya be therapeutically cleared before beginning the NPP. To that end, Tanya had two psychiatric assessments that conflicted somewhat with the findings of prior assessments, the psychological evaluation, and with Tanya's observed behavior. Thus,

Tanya was asked to undergo a third psychiatric evaluation, which was to occur after the dispositional hearing. We commend the mother for seeking parenting classes on her own, but also find that the agency was taking the necessary steps to obtain parenting training and other services for her. Thus, the trial court's assessment of the reasonableness of the agency's efforts to provide reunification services was not against the manifest weight of the evidence.

¶ 51 The trial court's best interest finding also was supported by the evidence. The integrated assessment, psychological evaluation, and therapy report found that Tanya had disorganized thoughts, delusions, poor insight, poor judgment, and mood problems. Moreover, Tanya had a history of mental illness, with a prior diagnosis of schizophrenia for which she was prescribed an antipsychotic medication. Several witnesses testified about Tanya's erratic and unusual behavior immediately after Blue was born.

¶ 52 Witnesses also testified about Tanya's conduct during visits with Blue illustrating she was not ready to have the child returned to her care. For instance, she brought brown milk and blankets that smelled of gasoline to a visit, despite knowing of Blue's special dietary needs and her asthma diagnosis. She also did not demonstrate an ability to properly care for Blue absent supervision by case aides. She was not able to anticipate or understand when Blue needed breathing treatments for her asthma or administer them without assistance. We will defer to that court's determination. *In re Lakita B.*, 297 Ill. App. 3d 985, 994 (1998). Thus, the trial court's finding that it was in Blue's best interest to be made a ward of the court was not against the manifest weight of the evidence.

¶ 53 We affirm the trial court's orders.

¶ 54 Affirmed.