State of New Hampshire

Office of the Child Advocate

RSA 170-G:18

2018 Annual Report

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TABLE OF CONTENTS

State of New Hampshire Office of the Child Advocate

Annual Report

Executive Summary

2018 was a remarkable year for children in New Hampshire. The Office of the Child Advocate was operationalized and Governor Chris Sununu appointed Dr. Moira O'Neill as the first director of the agency "*established to provide independent oversight of the Division for Children, Youth and Families to assure that the best interests of children are being protected.*" NH RSA 170-G:18, II(a). The New Hampshire General Court passed momentous legislation reinstituting voluntary services for families at risk for abuse and neglect. The Legislature allocated $1.5 million to fund those services for the first time in a decade. In a promising commitment to prevent children from ever being abused or neglected, $1 million was allocated for prevention services, such as empirically-based home visiting programs, child care, and parenting assistance. The men and women who endeavor to protect children on the front lines of child welfare gained some relief with 33 new positions approved for the agency. Helping children and reforming DCYF were front and center on political agenda throughout campaign season. This is all good news. The reality though, is that it is just the beginning. There is much more work to do. This past year's accomplishments are testament to New Hampshire's commitment to children for the long term.

In the tradition of agency annual reports, this inaugural report documents the activities, findings and recommendations of the Office of the Child Advocate's (OCA) first year. The conceptual framework explains OCA perspective, point of view in analysis, and ultimately, advocacy for children's best interest. In its first year of operation, the OCA worked to define and shape its role in protecting New Hampshire's children. The OCA spent considerable time meeting with, and listening to, stakeholders in New Hampshire's child welfare and juvenile justice community to best understand how to accomplish its work. Three themes pervaded our work: children's interests, system capacity, and early action.

The very essence of child welfare and juvenile justice is the interest of the child. We know children need protection because they cannot protect themselves. We invest in children because they are the State's future. Yet the law and its interpretations stop short of children's best interest. We defer to the interests of other parties. The definitions of abuse and neglect are themselves vague and disempowering of caseworkers seeking to protect children. In the interest of children, that must change.

The capacity for the DCYF system has been exhaustively reviewed in the past two years. The shortcomings of the agency's capacity are clear: insufficient workforce, insufficient training and expertise, and insufficient resources to purchase services that actively, actually help children heal. If

DCYF workers are going to intervene effectively for children, they must have manageable workloads, support from experts like nurses and substance use counselors, and an array of services to offer families in need.

Finally, the time has come to stop waiting for children to appear bruised and battered before we step in to help. It is fundamentally unsound to expect parents to file petitions in court to access mental health services for their children. Other states have proven the benefit of building a widely available, comprehensive system of care that takes action early before the risk of abuse or neglect arise or delinquency takes hold. The federal Family First Prevention Services Act of 2018 (P.L. 115-123) (Family First Prevention Services Act) is a looming reminder that to fully capitalize on federal funding New Hampshire must shift to early action prevention. A community-based, empirically derived, rapid-response system of care is in the best interest of children and their families.

In the past eight months, the OCA established an office, hired a dedicated professional staff, created procedure, built a case management system and review process, drove over 4,500 miles to assess the landscape, engaged the legislature, and got to work responding to citizen concerns, monitoring critical incidents, tracking missing children and investigating the care and protection of children. This report includes summaries of observations and recommendations in nine major areas of concern and opportunity.

- **Intake and Assessment**
- **Persistent Psychological Maltreatment**
- **Residential Treatment**
- **Juvenile Justice**
  - **Child in Need of Services (CHINS)**
  - **Sununu Youth Services Center (SYSC)**
- **Incident Surveillance**
- **Child Deaths**
- **Children in Court**
- **System of Care**
- **Children's Best Interest**

Intake & Assessment Recommendations

Intakes and assessments of reports of suspected abuse and neglect have persistently been identified as an area for improvement in DCYF reviews. The overdue assessment backlog remains at 2,000 cases. As the opioid epidemic impacts unintended high risk pregnancies and births, the burden on assessment workers intensifies.

- **Legislative Action: Allocate funding for 104 positions as recommended in DCYF's prioritized budget needs to ensure DCYF has sufficient staff to meet the standard of safe assessments.**
- **Legislative Action: Allocate funding for 15 nurses within DCYF to serve as a health resource on assessments, targeting medically complex assessments such as drug exposed infants.**
- **DCYF: Provide families of infants born substance-exposed with extended home visiting programs.**
- **DCYF/DHHS: Monitor long term outcomes for substance-exposed infants.**

Psychological Maltreatment Recommendations

The legal definition of psychological abuse is vague. Yet psychological maltreatment is pervasive and devastating. Inattention to children's exposure to psychological maltreatment persists, even when a child is in protective care.

- **Legislative Action: Amend definitions of abuse and neglect in RSA 169-C:3 to better reflect psychological maltreatment as an action known to cause harm.**
- **DCYF: Incorporate educational content regarding psychological maltreatment in parent education programs.**

Residential Treatment Recommendations

There are no assurances that children's needs are being met in residential care, or even that they are safe. The Family First Prevention Services Act represents an opportunity to realign residential services with quality, clinically necessary, scientifically reliable, and therapeutically effective care.

- **Legislative Action and DCYF: Allocate funding for 15 nurses to be distributed throughout DCYF district offices by population ratio.** Assign nurses to monitor the health of children in residential treatment.
- **DCYF: Shift to contracting with residential treatment facilities for specific services with specific expectations.**
- **Legislative action and DHHS: Expand RSA chapter 135-F System of Care for Children's Mental Health to include an independent care coordinating entity that would conduct standardized, evidence-based child needs assessments, match children for placement, and evaluate progress as required.**
- **DCYF and DHHS: Create a reimbursement mechanism to reimburse for services of behavioral psychologist.**

Juvenile Justice - CHINS Recommendations

Reliance upon court-ordered mental and behavioral health care for children is a symptom of system failure. Resources would be better spent on prevention of delinquency with a statewide system of care that is responsive to children's behavioral and mental health needs.

- **Legislative Action, DHHS and DCYF: Allocate funds and fully implement the 10-year mental health plan, including expansion of the RSA chapter 135-F System of Care for Children's Mental Health so as to meet the mental and behavioral health needs of children and relieve parents of the burden of filing petitions in court to access necessary services.** Place priority on mobile crisis response and coordination of ongoing services.

Juvenile Justice - Sununu Youth Services Center Recommendations

The majority of children detained or committed at the Sununu Youth Services Center (SYSC) have considerable mental and behavioral health needs, yet emphasis on their risk of violence drives daily routine. The array of clinical supports available at the facility are not integrated and therefore reinforced in a therapeutic milieu. Unmet mental and behavioral health needs translate to risk of injury for children and staff.

- **DCYF/SYSC: Administer the CANS assessment to every child admitted to SYSC.**
- **DCYF/SYSC: Commit to an evidence-based, trauma-informed therapeutic milieu with complete integration across all domains of children's' routines in the facility.**

Incident Surveillance Recommendations

DCYF is not monitoring children in residential care for safety. Children continue to be missing each day, alone and exposed to risks. When children are under DCYF care, DCYF becomes the parent. Parents are expected to monitor children for safety and progress.

- **DCYF: Develop and implement a system for tracking and monitoring incidents in in-state and out-of-state facilities.**
- **DCYF: Establish an internal review system for regular review of critical incidents and RSA chapter 126-U restraints and seclusions.**
- **DCYF: Allow for regional, quarterly participation of 8-10 staff members in the OCA's System Learning Reviews.**
- **DCYF and DHHS: Incorporate an expanded statewide system of care targeting psycho-social and physical health assessment and treatment for children identified at risk for going missing.**
- **DCYF: Provide training to SYSC staff on evidence-based alternative behavior management techniques with the goal of eliminating the use of physical restraint and seclusion.**
- **DHHS: Adopt administrative rules for review of restraints as mandated by RSA 126-U:9.**

Child Death Recommendations

The deaths of Brielle and Sadie cannot be forgotten. Five more children known to DCYF died this past year and neither DCYF nor the Child Fatality Review Committee undertook child death reviews for learning and system improvements.

- **Legislative Action: Codify the Child Fatality Review Committee.**
- **DCYF: Conduct internal death reviews.**
- **DCYF: Review compliance and outcomes of enhanced assessments.** Monitor all enhanced assessment-involved infants for long term outcomes.
- **Legislative Action and DCYF: Expand voluntary services to reach more families at risk of abuse and neglect.**

Children in Court: Recommendations

In an atmosphere of competing interests, children must be adequately and actively represented and heard in court. A relationship of mistrust and low expectations between DCYF and the Court affirms the need for children to have strong, child-informed representation. Training, obligations of time spent with, and duration of representation are inconsistent among GAL, CASA/GAL and public defenders.

- **Public Defender: Establish specialized juvenile defense unit and extend period of representation to allow attorneys to remain on a juvenile delinquency case even after the conclusion of the dispositional hearing.**
- **DCYF: Initiate a systems learning dialogue with the Court about expectations and perceived areas of improvement.**
- **GAL Board: Mandate training on child development, trauma, adverse childhood experiences, and resiliency for GAL representing children.**
- **Courts: Support a mechanism allowing the OCA to provide information, as necessary, in complicated abuse and neglect cases.**

System of Care Recommendations:

DCYF performance, complicated by an opioid epidemic, has made clear that waiting for children to be abused, neglected or delinquent is waiting too long. The science of brain development and identified long-term impact of maltreatment confirms that prevention is the only moral and practical approach to intervening for children. Prevention is also paramount as shifts in federal funds make creating a statewide, comprehensive system of care unavoidable.

- **Legislative Action and DHHS: Allocate funds for the Bureau of Children's Behavioral Health identified prioritized needs.**
- **Legislative Action and DHHS: Create and allocate funds for DHHS's 10-Year Mental Health Plan.** Place priority on mobile crisis response units to reach every family in need, community care, standardized strengths based assessments, and an independent single portal of entry and provider of quality assurance.
- **Legislative Action: Create a child abuse specialized medical evaluation program with on-call specialists.**

Children's Best Interest Recommendations:

The State has a responsibility to protect children. This should not be secondary to another party's rights or interests. It should be paramount.

- **Legislative action: Amend RSA chapter 169-C to put the child's safety and best interest as the paramount purpose of the statute.**
- **DCYF: Support and establish policy that empowers caseworkers, supervisors, and attorneys to take the necessary actions in each case so as to interpret the statute as intended to protect the safety of children.**

Summary and Next Steps

The work of the Office of the Child Advocate is only begun. We look forward to 2019 with an infrastructure in place and a process to oversee DCYF and ensure the best interests of children are protected. There will be follow-up to the major areas of concern identified here with hope that opportunities are taken. New issues will be unearthed and examined. The OCA will work hard to continue building a collaborative and thoughtful approach to DCYF transformation.

With all systems in place, the OCA embarks upon a new year with the following expectations:

- Children will be heard and responded to
- The OCA will have a formally organized, responsive, and timely process for receiving complaints and investigating DCYF actions
- A critical incident review process will commence that is based in safety science and informed by the principles of child development
- Communication will be open and accessible with reporting and accounting of OCA investigations made available for immediate system reform
- In January 2019, the Child Advocate's Work Group on Juvenile Justice will commence with the task of developing a 10-year vision for juvenile justice

It is a great honor to serve the children of New Hampshire as the first staff of the Office of the Child Advocate. We pledge to hold true to our mission in all we do.

The mission of the Office of the Child Advocate is to provide independent and impartial oversight of the New Hampshire child welfare and juvenile justice systems to promote effective reforms that meet the best interests of children.

To achieve our mission we:

Listen to all concerns about the Division of Children, Youth and Families (DCYF)

Respond to complaints with a credible review process

Respect the importance of every person in a child's life

Build collaborative relationships for reform

Promote practices that are proven to be effective to help children and families

Maintain independence and impartiality in all aspects of our oversight of DCYF

Karen Kimel, Program Specialist

Emily Lawrence, Esq., Associate Director and Counsel

Moira O'Neill, PhD, RN, Director

HISTORY OF THE OFFICE OF THE CHILD ADVOCATE

In less than a year, two young girls died at the hands of their mothers: Brielle in 2014 and Sadie in 2015. Both families were known to the New Hampshire Division of Children, Youth and Families (DCYF), the state agency responsible for child protection and juvenile justice services. A call from a grieving grandmother constituent prompted then Senator David Boutin to sponsor legislation to form the Commission to Review Child Abuse Fatalities (SB 244, 2015). Early commission hearings unearthed two prevailing themes: a lack of transparency in child welfare and a lack of public trust in DCYF.

Senator Boutin formed a subcommittee to explore the idea of an independent children's ombudsman. The subcommittee met throughout 2015-2016, examining the response to the child deaths. Significantly, the subcommittee noted the length of time and lack of transparency in investigations, and that these factors contributed substantially to lack of public trust in DCYF. Criminal investigations take years to prosecute. DCYF internal reviews are not made public. The extant Child Fatality Review Committee is precluded from reviewing a death until criminal investigations are completed. The subcommittee concluded that the public expects and deserves to know that publicly funded programs are effective and, when they fail, that explanations are made known, information is gleaned, and improvements are underway within a reasonable amount of time.

> ***"While the wheels of justice are intentionally slow, public confidence does not follow the same time table."***
>
> **-Children Ombudsman Subcommittee, Report to Chairman Boutin, Commission to Review Child Abuse Fatalities, 3/28/16**

The subcommittee also noted contributing systemic factors to failures in public trust. Chiefly, the intensity and complexity of protecting New Hampshire's children requires a well-resourced and supported system. Negative outcomes such as child deaths impact public confidence, but they also have irreparable impact on caseworkers. Chronic understaffing and excessive caseloads were observed to contribute to high staff turnover and consequently an impeded ability to effectively manage the intricacies of child protective work. The subcommittee therefore concluded that DCYF required "a fresh set of eyes" to enhance quality improvement processes.

The subcommittee's assessment led to the recommendation of independent oversight through an Office of the Child Advocate. There are a number of ombudsmen or advocate offices across the country empowered to receive citizen complaints and investigate state actions. Some are independent and have general jurisdiction over all state services. Others, including the Office of the Ombudsman in New Hampshire's Department of Health and Human Services (DHHS), are internal to an agency. They provide

an important service to citizens with concerns about the state agency or who need assistance navigating complicated service channels. A growing number of states, however, are recognizing the need for independent, impartial reviews of child-serving systems to promote public trust in the problem solving process and increase transparency in the system. By establishing an Office of the Child Advocate, New Hampshire would join 13 other states with independent offices established specifically to oversee children's services. Similar to those other states, the subcommittee's rationale for establishing the New Hampshire Office of the Child Advocate included means for:

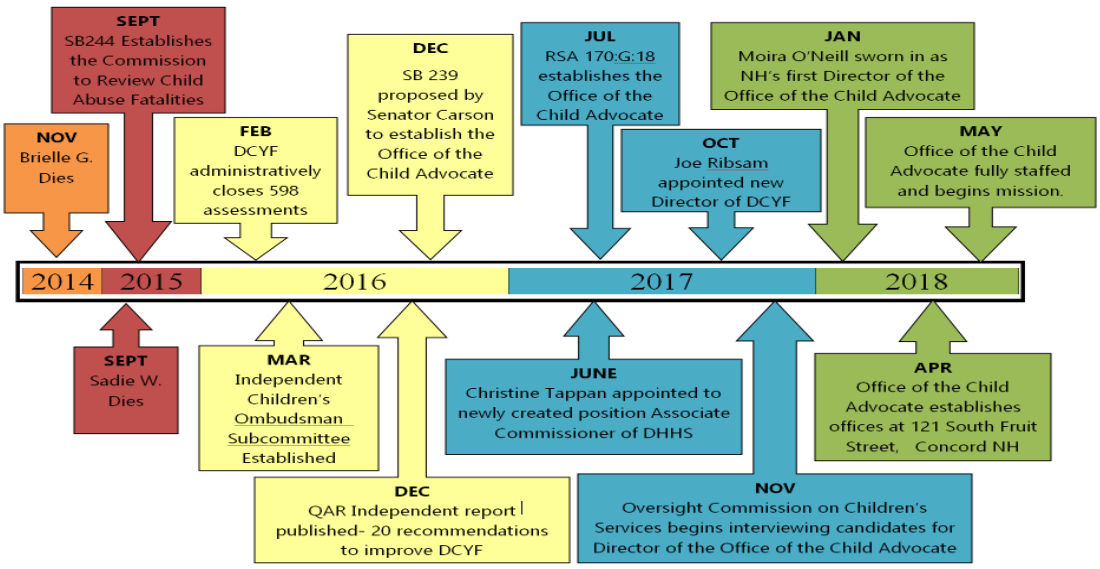
- Increasing transparency
- Improving public trust of DCYF
- Providing timely, credible case review

The subcommittee sought to achieve these goals by creating an office independent from all other state agencies and departments.

> ***"Independence is a fundamental and essential characteristic of an effective and credible Ombudsman. The Ombudsman, in structure, function, and appearance, should be free from outside control or influence to the greatest degree practicable. Being independent enables the Ombudsman to function as an impartial and critical entity that makes findings and recommendations based solely on the facts and law, in the light of reason and fairness."***
>
> **Robin K. Matsunaga, Ombudsman, State of Hawaii, and President, United States Ombudsman Association**

In December 2016, Senator Sharon Carson introduced a bill to establish the Office of the Child Advocate (SB 239) that was eventually blended into the state budget bill (HB 517) and codified as New Hampshire RSA 170-G:18. The Oversight Commission on Children's Services was duly codified in New Hampshire RSA 170-G:19 to, among other things, oversee the Office of the Child Advocate. In December 2017, Governor Chris Sununu chose Moira O'Neill, PhD, RN as the first Director of the Office of the Child Advocate. Director O'Neill was confirmed by Executive Council, and sworn in on January 30, 2018.

Establishing the Office of the Child Advocate



STATUTORY AUTHORITY

The Office of the Child Advocate (OCA) was established as an independent and impartial state agency to reform New Hampshire's child welfare and juvenile justice system. RSA 170-G:18 is the OCA's guiding statute. RSA 170-G:18, III mandates that the OCA shall:

> (a) Provide independent oversight of the division for children, youth, and families to assure that the best interests of children are being protected.
>
> (b) Regularly consult with the department of health and human services and the oversight commission established in RSA 170-G:19.
>
> (c) Have access to all case records, all third party records, and all records submitted to the courts, and maintain confidentiality pursuant to RSA 169-C:25 and RSA 170-G:8-a.
>
> (d) Have prompt electronic access to records within the scope of its mission, except for department of justice records that are part of a pending criminal investigation or prosecution, and judicial branch records to the extent that such access does not violate the constitutional separation of powers.
>
> (e) Have the authority to subpoena witnesses and/or records.
>
> (f) Have the authority to review and investigate any aspect of the department's child protection policies or practices.
>
> (g) Provide information and referral services to the public regarding the department's child protection services; provided that case specific complaints shall be handled by the department.
>
> (h) Perform educational outreach and advocacy activities in furtherance of the mission and responsibilities of the office.
>
> (i) Upon its own initiative or upon receipt of a complaint, review and if deemed necessary, investigate actions of the division for children, youth and families, or any entity that provides services to children under contract with and at the direction of the division, and make appropriate referrals. Findings of all investigations and responses to all complaints received shall be summarized in the annual report of the office of the child advocate.

RSA 170-G:18, IV further mandates that

> (a) The department of health and human services shall provide the office with a copy of all incident or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department not later than 48 hours after the occurrence; provided that any child fatality or serious injury shall be immediately communicated to the office by telephone.
>
> (b) The department of health and human services shall provide any records or reports requested by the office, subject to the exclusions in this section.

RSA 170-G:18, V requires that, each November 1, the OCA

> shall submit an annual report of its activity and findings and present his or her recommendations to the oversight commission on children's services established pursuant to RSA 170-G:19. The report shall also be provided to the commissioner of the department of health and human services, the governor, the speaker of the house of representatives, the senate president, and the state library. The director shall make the annual report available to the public on a state Internet website.

WHAT IS THE OFFICE OF THE CHILD ADVOCATE?

The OCA is mandated to oversee DCYF's care and protection of children that come into the child welfare and juvenile justice system. In addition to oversight of the system, policy and procedure, a key part of the role is to hear citizens' complaints about DCYF.

The OCA was designed to complement and extend an already existing infrastructure of assuring quality services and responsiveness to complaints about children's care. Complaints about a child or family with an open DCYF case may be brought to the child's caseworker, the casework supervisor, the court, and the DHHS Office of the Ombudsman.[1] The Office of the Ombudsman is an internal office within the Department of Health and Human Services mandated to take and assist with resolving complaints.[2] The OCA is also a type of ombudsman, but its creators delineated its role from the existing DHHS ombudsman, by instilling it with independence and the authority to advocate for children's best interest. Where an ombudsman, by definition remains impartial and takes no position, the advocate is tasked with ensuring that children's best interests are served, including advising on policy changes.

Independence is fundamental to the role of the OCA. It protects against any appearance of undue influence from DCYF or other executive authority. Independence is integral to ensuring public trust in a process that seeks to increase transparency of government processes while still protecting confidentiality of the children served or citizens bringing grievances against a government agency. In one sense, transparency of DCYF actions occurs by proxy through the eyes of the OCA, (e.g., reviewing case records or observing practice). Trust in the OCA's impartial, credible review process is essentially achieved through reporting and a clear review process. As the OCA accomplishments contribute to system improvements, and collaboration amongst relevant stakeholders flourishes, the aim is for better DCYF performance and emergent trust with the community.

[1] DCYF Form 1172, *Family's Rights Brochure*

[2] RSA 126-A:4, III provides that DHHS "shall establish an office of the ombudsman to provide assistance to clients and employees of the department by investigating and resolving complaints regarding any matter within the jurisdiction of the department including services or assistance provided by the department or its contractors. The ombudsman's office may provide mediation or other means for informally resolving complaints."

A NEW STATE OFFICE: GETTING STARTED

OCA Staff

The OCA has 3 full-time staff and an operating budget of approximately $350,000. The staff is multidisciplinary, comprised of health, legal, public health, education, and public administration professionals to reflect the varied nature of its work. The OCA staff endeavor to ensure the best interests of children are served by the most child-centric, developmentally responsive, evidence-based, adequately resourced state intervention.

Setting Up the OCA

In just a few short months, the OCA secured modest office space with assistance from Department of Administrative Services (DAS), designed and filled 2 staff positions, negotiated a generous arrangement with the Department of Information Technology (DoIT) to pilot case management software at no cost to the office, and procured significant financial and technical support from Casey Family Programs, a charitable child welfare assistance organization, to implement an evidence-based review process grounded in safety science.

The OCA case management system is designed to store and manage all levels of case information and serves as an incident monitoring system. From July through September OCA staff worked diligently to develop and test the system. Next the OCA manually entered 134 cases and 211 incidents into the system. The system is now operational and with some further refinements will provide rich reporting capacity in the coming year.

The OCA is the first independent oversight agency that Casey Family Programs has supported in its work to assist reform in child welfare and juvenile justice systems across the country. Casey Family Programs contracted with Collaborative Safety, LLC, child welfare and safety science consultants, to create a review instrument specific to the OCA's oversight needs in conducting incident reviews. A safety science approach aims to reduce human error through system learning. The OCA's uniquely designed System Learning Review (SLR) instrument will guide examination of incidents and provide an independent systemic review that is supportive of staff and focused on systems change. These methods depart from blame and surface level understandings of how systems fail to seek out the complex interplay of systemic factors. Collaborating with DCYF personnel, the OCA will use the SLR process to identify learning opportunities in practice for system improvement. By utilizing safety science, the OCA seeks to create a "safety culture" conducive to active reflection, problem solving and learning, all necessary for improving practice and outcomes.[3,4] The first live SLR is scheduled to take place in early February 2019.

Accessing Information

The ability of the OCA to carry out its mandate is anchored in its access to information.[5] To its credit, DCYF has been diligent to ensure compliance with New Hampshire law did not conflict with the agency's

[3] Vogus, TJ, Cull, MJ, Hengelbrok, NE, Modell, SJ & Epstein, RA, (2016). Assessing safety culture in child welfare: Evidence from Tennessee. *Children and Youth Services Review*, 65: 94-103.

[4] Cull, MJ, Rzepnicki, TL, O'Day, K, & Epstein, RA, (2013). Applying principles from safety science to improve child protection. *Child Welfare*, 92(2): 179-195.

[5] RSA 170-G:18, III(c), (d), (e), (f).

federal obligations for confidentiality. This was a time consuming process and there are still some sources of information the OCA has yet to access, the limits of which are discussed below in findings. However, information required for OCA investigations has been made available.

The purpose of the OCA's access to information is as a means of checks and balances on a government system. The office's access should not be confused as an alternative route to discovery in criminal or civil litigation. The OCA has no enforcement or prosecutorial authority. Its purpose is not to find guilt or build claims against DCYF, but, rather, to unearth opportunities for improvement within the system of child protection and juvenile justice. Therefore, while the OCA's access to information creates opportunity for independent oversight, information gathered in the course of oversight and investigation is exempt from disclosure to comply with extant confidentiality laws and reinforce trust with persons who bring complaints against the agency. To counter the public's access to that information the OCA will use reports and publicly available procedure to promote transparency of actions.

RSA 170-G:18, III(f) mandates the OCA review and investigate all DHHS policies and procedures. Having access to department policy and procedure facilitates understanding of the agency's actions. DCYF has provided a computer disc with what they view as relevant policy and procedure and they periodically send updated documents. The OCA has learned that all policies and procedures are contained on the DHHS "Intranet" or "R-Drive." Although the OCA has yet to gain access to the drive, the Commissioner has informed the OCA that all policies and procedures will be stored on the DCYF website, available for public inspection, starting in January 2019. This is a good step towards transparency.

Gaining Knowledge

In addition to setting up systems for oversight, the OCA staff also capitalized on available resources for building expertise in relevant topics and the process of independent oversight. OCA staff participated in:

- Court appointed special advocate/guardian ad litem CASA-NH training
- Annual colloquium of the American Professional Society on the Abuse of Children for content expertise on child abuse, psychological maltreatment, the latest in trauma-informed models of care, and federal law
- Regional conference on Child Death Review with representation from New England and Canada.
- Annual conference of the United States Ombudsman Association (USOA) to enhance the unique skills required for independent oversight
- 2018 New Hampshire Juvenile Court Diversion Network Summit
- NH Human Trafficking Collaborative Task Force Human Trafficking Training

All of the training in which the OCA has participated netted excellent resources for a growing network of support in a vast array of children's services and government agencies.

GETTING THE LAY OF THE LAND: ORIENTING TO THE SYSTEM

In the first months of its existence, the OCA undertook an assessment of the "lay of the land." In less than 8 months, OCA staff travelled approximately 4,500 miles around the state and engaged in nearly 300 activities and events locally, regionally and nationally. The OCA conducted a mix of interviews, listening sessions, site tours and field observations with DCYF frontline staff and administrators. Periodic meetings include DCYF administrators and program specialists. There is established a monthly DCYF/OCA directors' meeting for purposes of reviewing OCA findings and concerns. The OCA also meets monthly with the governor to provide updates on DCYF progress towards reform and general findings.

The OCA's lens of observation is also tuned to system reform under way and its progress. The OCA reviewed a series of recent reports assessing performance of DCYF and condition of the child welfare system. Review findings are useful as performance measures for OCA oversight, including the findings and recommendations of the 2016 Center for the Support of Families (CSF) *Quality Assurance Review of the Division of Children, Youth and Families* (2016 CSF Report*).*[6] The OCA attends meetings of the New Hampshire Child Welfare Systems Transformation Interagency Team convened to contribute to and monitor progress on the review's 20 recommendations. The OCA also observed meetings of DCYF's Safety Program Improvement Plan addressing issues identified for improvement by the federal 2018 Child and Family Services Review.

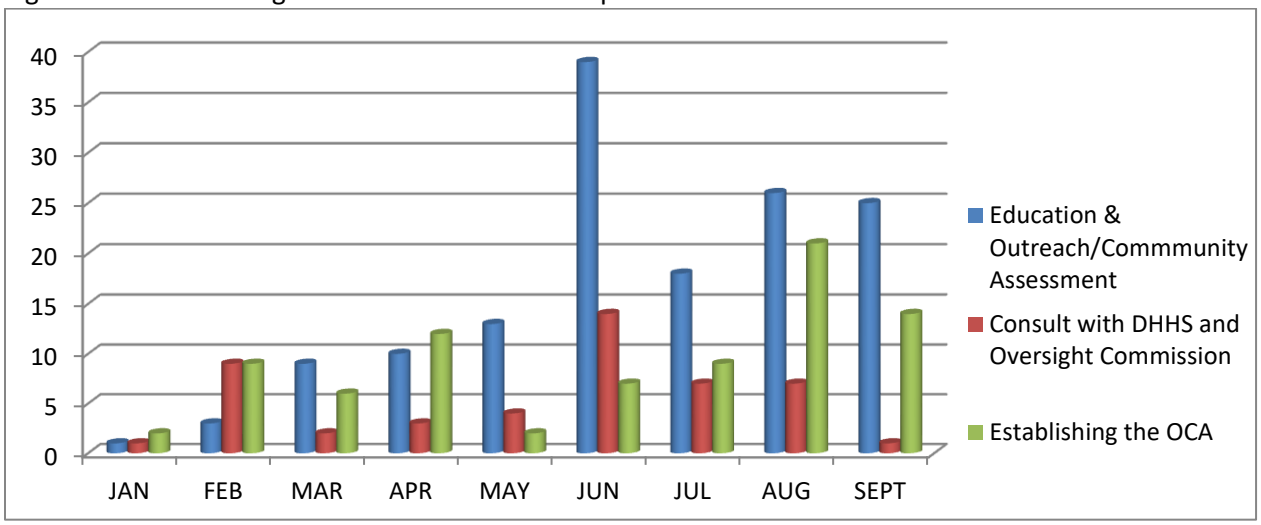
OCA staff visited and toured in-state facilities where children are placed by DCYF, including foster homes, group homes, residential treatment programs, transitional living spaces, hospitals, and the SYSC. OCA staff have met and observed children in most of those settings. OCA staff have also met with children and foster parents at community support group meetings and Youth Advisory Board events.

The OCA has established a wide network of resources and allies for children while attending meetings and events with many professional organizations, advocacy organizations, and academic programs dedicated to social work, nursing, public health and public administration. The OCA has also begun sponsoring capstone learning opportunities for graduate students of the Carsey School of Public Policy, and established paid internship opportunities for interested students or recent graduates.

The OCA regularly meets with legislators and members of child-interested legislative committees. OCA staff attend meetings of the Children's Caucus and are working with members to establish a clearing house of information on adverse childhood experiences, resiliency, and related events, trainings, and work being done around the state and region. The OCA is a member of the DHHS Bureau of Housing Supports for Homeless Youth Subcommittee, contributing to a statewide strategic plan to prevent and end youth homelessness. The OCA is also an active member of the board of the Granite State Children's Alliance's KNOW AND TELL initiative that trains mandated reporters all over the state to know the signs of abuse and to tell DCYF when appropriate.

[6] The Center for Support of Families, *Quality Assurance Review of the Division of Children, Youth and Families* [hereinafter CSF Report], December 19, 2016, available at https://www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf.

Figure 1. OCA Orienting Activities and Office Set Up



GETTING TO WORK: WHAT THE OCA DOES AND HOW

Six ways the mandate is implemented

- **Inquiries and complaints.** The Office of the Child Advocate receives inquiries and complaints about children who are in, were in, or were screened out of the care, supervision, custody, or control of DCYF. Complaints are submitted by phone, in writing, in person. The OCA will be able to take complaints from its website in the near future.
- **Investigation and systemic review.** Some complaints or inquiries need further in-depth review. In those cases, the OCA will initiate an investigation to gather additional information, conduct research and analyze the situation. Upon conclusion of the investigation, the OCA will issue an investigatory report with findings and recommendations. Systemic issues are practices, policies or cultural paradigms that affect more than one child in a universal way.
- **Incident surveillance.** The OCA tracks all reported incidents. The OCA reviews each incident report, looking for trends, gaps in the system, and issues of concern. Identified areas of systemic concern may prompt an investigation.
- **Child fatality review.** The OCA reviews all DCYF-reported child fatalities and, as necessary, conducts further in-depth investigations.
- **Education and Outreach.** The OCA engages with children, families, public leaders, advocates, stakeholders, providers and the general public to provide education about the OCA, DCYF, child abuse and neglect, child development and the interest of children.
- **Legislative action.** The OCA meets and collaborates with legislators to educate and inform on necessary systemic change in the child welfare and juvenile justice systems. The OCA may provide testimony on legislation that will impact children and their best interests.

Inquiry and Complaint Procedure

The OCA processed 134 citizen contacts in the first nine months of operation. OCA staff are committed to making every effort to provide accurate, prompt information and referral to every contact received, whether or not the inquiry is about DCYF. Every request is reviewed to determine whether it meets criteria for an OCA assist or investigation. In making this determination, the OCA assesses the following factors:

- **Jurisdiction.** Does the complaint or inquiry have to do with DCYF or a DCYF contracted service?
- **Premature**. Has the complainant exhausted all available avenues of assistance? For example, has the complainant addressed the concern with a caseworker, supervisor, district administrator, or the DHHS Ombudsman?
- **Timeliness**. Is the complaint about a recent DCYF action or action within the past three years?
- **Appropriate for systems review**. Is the complaint about DCYF actions, programs, processes and not about personal gripes, personnel actions, or unrelated to DCYF services to children?

If the complaint is clearly outside the jurisdiction of the Office of the Child Advocate, the complainant is so informed within 15 days of receipt of the complaint and a referral may be made if appropriate.

Accepted complaints are comprehensively reviewed as to match office priority, office resources, availability of relief, investigative value of policy issues, and potential issues to be investigated. Those cases that warrant further examination are assigned to an investigator for preliminary investigative review. After preliminary review, there are two ways in which the OCA will investigate a complaint.

- **Assistance** – For a relatively uncomplicated complaint that can be quickly resolved, the OCA will work informally with the complainant and DCYF and resolve the problem without conducting a formal investigation. In handling an assist, the focus of the OCA is on solving the problem and ensuring the safety and best interests of the child are being met, rather than determining the correctness of an action.
- **Investigation and systemic reviews** – For relatively complicated complaints, the OCA conducts a more formal investigation. The OCA begins by reviewing the information garnered from the complainant and conducting a preliminary review of the DCYF database for relevant or confirming information. The OCA then will develop an investigation plan, gather information and, if necessary, conduct interviews, research relevant statutes or rules, analyze and review data, make findings, identify remedies, and make recommendations. Beginning in 2019, if an investigation is warranted, but will take more than 60 business days to complete, the OCA will issue an Investigative Briefing. The briefing will explain why the investigation will not be completed within 60 business days and requires additional time, resources and/or research. The briefing will also explain how the investigation will proceed and an estimated completion date. Additionally, starting in 2019, once an investigation is completed, the OCA will issue an Investigation Report with its findings, recommendations, outcomes and/or DCYF response. The OCA will then follow-up to see that recommendations were followed.

THE WORK OF THE OFFICE OF THE CHILD ADVOCATE: Complaints & Incidents Received

Figure 2. OCA Cases & Incident Reports

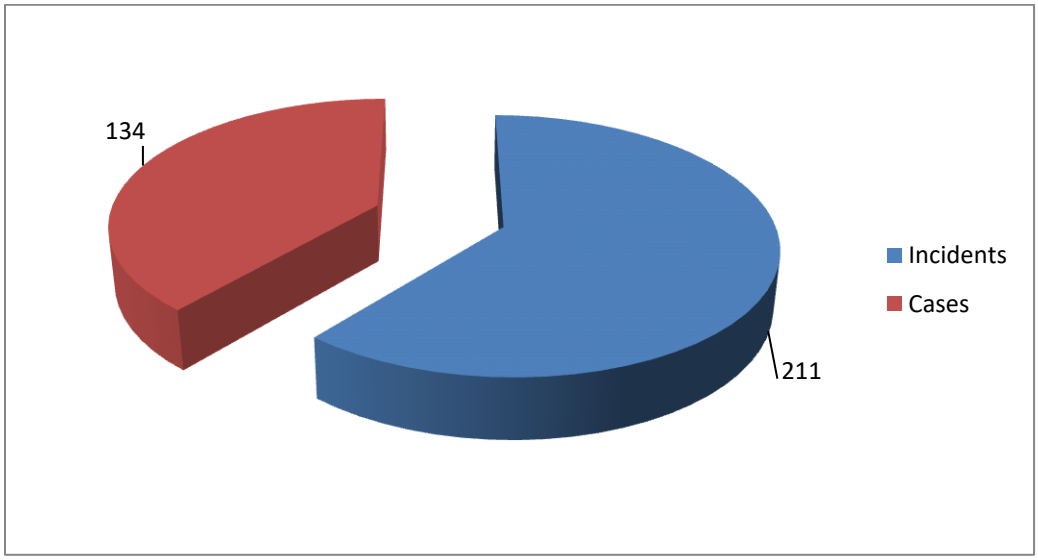
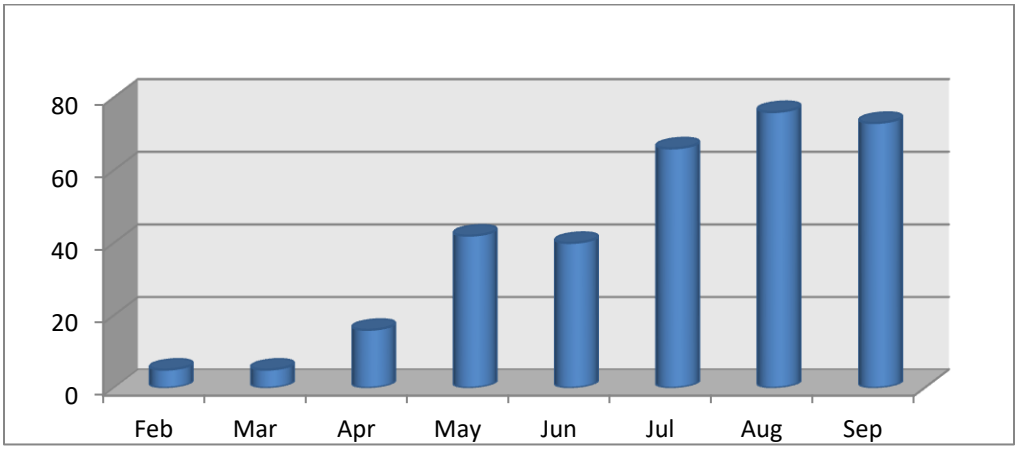


Figure 3. OCA Complaints & Incidents Received by Month (Total is 345)



During the reporting period January 30 to September 30, 2018, the OCA opened 134 cases from citizen complaints and OCA-generated concerns. The OCA also received 211 reports of incidents involving children in DCYF care (see section on Incident Surveillance). The increase over time reflects office start-up. There was no physical office or equipment in the first 3 months.

MAJOR AREAS OF CONCERN

Major areas of concern and findings were derived from a combination of complaints received, field work, and incidence surveillance. These areas of concerns and findings should not be presumed to be the extent of opportunities for learning. Once fully staffed in mid-May, three OCA staff responded to citizens, conducted field work, and monitored incidents within the confines of available resources and time. These represent the major concerns and findings identified to date.

- **Intake and Assessment**
- **Persistent Psychological Maltreatment**
- **Residential Treatment**
- **Juvenile Justice**
  - **Child in Need of Services (CHINS)**
  - **Sununu Youth Services Center (SYSC)**
- **Incident Surveillance**
- **Child Deaths**
- **Children in Court**
- **System of Care**
- **Children's Best Interest**

Intake & Assessment: Responding to Children at Risk

The intake and assessment of allegations of abuse or neglect are arguably the most impactful roles of DCYF. Decisions made at these points can save lives or tear families apart needlessly. The 2016 CSF Report primarily focused on assessments.[7] Findings included high workloads, insufficient training, rigid statute language and interpretation, and limited array of services or family access to services.[8] The report found that DCYF inadequately assessed risk of harm to children, and underlying conditions that affect safety and risk.[9] In January 2018, a report by Eckerd Connects on administratively closed assessments advised DCYF to prioritize and target resources to the then 2,200 overdue assessments.[10] As a result, DCYF contracted with a private organization to assist with processing the assessment backlog. After processing several hundred cases, the contractor stopped receiving assessments to complete, without explanation. A rise in intakes has correspondingly increased the number of overdue assessments. In September 2018, a backlog remained of approximately 2000 cases.[11] The 2018 federal Child and Family Services Review (CFSR) later found none of seven outcomes in substantial conformity,

[7] CSF Report, December 19, 2016, at 3, available at https://www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf.
[8] *Ibid*.
[9] *Ibid*.
[10] Eckerd Connects, *Report on DCYF Administratively Closed Assessments*, at , available at https://www.dhhs.nh.gov/dcyf/documents/final-eckerd-report.pdf.
[11] Data Source: DCYF ROM, Results Oriented Management.

including safety outcomes.[12] A key recommendation of the CFSR was to improve initial and ongoing safety and risk assessments.

The legislature responded in 2018 with funding for 33 additional staff positions. DCYF revisited policies and revamped training for DCYF workers. At the height of workload crisis, DCYF assessment workers carried over 90 cases on their load. By September 2018, the workload had dropped to 44 cases on average. Although much improved, the DCYF workload does not meet the recommended standard for adequate, safe assessment work of 12 cases.

Intake and Assessment: Citizen Complaints Received

Complaints received by the OCA represent real experience citizens have interacting with DCYF. They confirm the findings of the above-referenced reports and reviews that communication is in need of improvement. There were two prevailing themes among complaints received by the OCA:

- DCYF did not accept the referral made for suspected abuse or neglect.
- Reporters never heard back from DCYF after reporting suspected abuse or neglect.

The OCA heard from complainants that their allegations of abuse and neglect were not accepted for assessment by DCYF. The OCA also heard from complainants wanting to know the outcome of their abuse and neglect report to DCYF. Overall, complainants who contacted the OCA were often not familiar with how DCYF processes abuse and neglect reports, or the confidentiality laws that preclude DCYF from sharing information. With access to the DCYF records, the OCA could review a case and confirm for the complainant whether DCYF had acted within its legal responsibilities while still maintaining confidentiality.

The OCA coached callers with complaints about unreturned calls to contact CPSW supervisors, district office field administrators, or the DHHS ombudsman in order to problem solve and establish channels of communication. In some cases, the OCA contacted DCYF to alert the district office about delays in communication and, as a result, those communication concerns were resolved. The OCA continues to monitor these calls as a measure of success in increasing DCYF staffing levels and lowering workloads, and increased levels of training.

Intake and Assessment: DCYF Intake Staff Concerns

The OCA met with staff at Central Intake and the statewide assessment team (SAT). One outstanding theme of concern arising out of those meetings was communication with schools. Staff emphasized the importance of detail and timeliness in reporting, noting the following specific concerns:

- Despite the fact that all school personnel are mandated reporters, some schools funnel reports through one person, often a guidance counselor. Information communicated second and third hand may be incomplete.
- Schools report educational neglect too late. A child who misses a quarter of the school year meets criteria for educational neglect. If engagement with parents is unsuccessful, reporting neglect should occur before the end of the school year so as to better the chances of success and assistance for the child.

[12] United States Department of Health and Human Services, Children's Bureau, Administration for Children and Families, July 2018 *Child and Family Services Review*. https://www.dhhs.nh.gov/dcyf/documents/nh-cfsr-2018-report.pdf.

Intake and Assessment: Trends in Post Assessment Incidents

Reporting on critical incidents to the OCA is too recent to determine definitive patterns. However, there are concerns in New Hampshire and the surrounding region of children involved in critical incidents (serious injury or death) following multiple unfounded referrals or the closure of what is referred to as an enhanced assessment, which is required for an infant who has been prenatally exposed to illicit substances. There were two child deaths in 2018 following an enhanced assessment. DCYF's *Enhanced Response Policy 1184* requires four face-to-face visits in a prescribed time period for any substance-exposed infant. The assessment must remain open for at least the full 60-day assessment period and requires a safety plan. In addition, the assessment must include discussion about referrals to community services and participation in substance use treatment. The OCA will monitor this risk group and is planning to conduct a Systems Learning Review on a case involving an enhanced assessment to identify learning points.

During the reporting period DCYF there were 384 children born drug-exposed that likely prompted an enhanced assessment. That equates to 1,536 face-to-face visits, a burden on front-line staff and indicative of the extent of the opioid epidemic's impact. Infants who have been exposed to drugs may have complex medical conditions. Historically, DCYF nurses assisted CPSWs with complicated assessments. Currently though, DCYF only employs two nurses to serve the entire state.

Intake & Assessment Recommendations

- **Legislative Action: Allocate funding for 104 positions as recommended in DCYF's prioritized budget needs to ensure DCYF has sufficient staff to meet the standard of safe assessments.**
- **Legislative Action: Allocate funding for 15 nurses within DCYF to serve as a health resource on assessments, targeting medically complex assessments such as drug exposed infants.**
- **DCYF: Provide all families with infants born substance-exposed with extended home visiting programs.**
- **DCYF: Monitor long term outcomes for substance-exposed infants.**
- **DCYF: Promote a culture of responsive communication with all citizens.** Encourage team casework in situations where CPSWs need assistance maintaining lines of communication.
- **DCYF, Department of Education, and Granite State Children's Alliance:[13] Ensure training for all school personnel on mandated reporting responsibilities.**

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[13] The Granite State Children's Alliance has launched an initiative for training mandated reporters. https://knowandtell.org/

Psychological Maltreatment

Child maltreatment, including exclusively psychological abuse, has enduring negative effects on brain development. Victims may develop lifelong chronic conditions. Directed inward, that may appear as depression, anxiety, suicidal tendencies, or all the symptoms associated with post-traumatic stress. Outwardly directed symptoms may manifest as aggression, impulsiveness, hyperactivity, delinquency or later criminality, and substance use.[14]

What psychological maltreatment looks like:

- Spurning- verbal/nonverbal – acts that reject and degrade
- Exploiting/corrupting – encouraging inappropriate behaviors/attitudes
- Terrorizing – threats to physically hurt, kill, abandon, place in danger
- Emotional unresponsiveness – ignore attempts and needs to interact
- Isolating – consistently and unreasonable deny opportunities for necessary communicating and interacting with others
- Mental or medical health and educational neglect – ignore, refuse to allow or fail to provide[15]

The OCA has observed two areas of concern regarding children's experience of psychological maltreatment:

1) The low incidence of allegations involving psychological maltreatment being brought forward and founded for abuse or neglect.
2) Children's continued exposure to psychological maltreatment while under DCYF care during visitation with parents as part of reunification efforts.

Competing Definitions

RSA 169-C:3 II(c) defines an "abused child" in part as "*psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect.*"

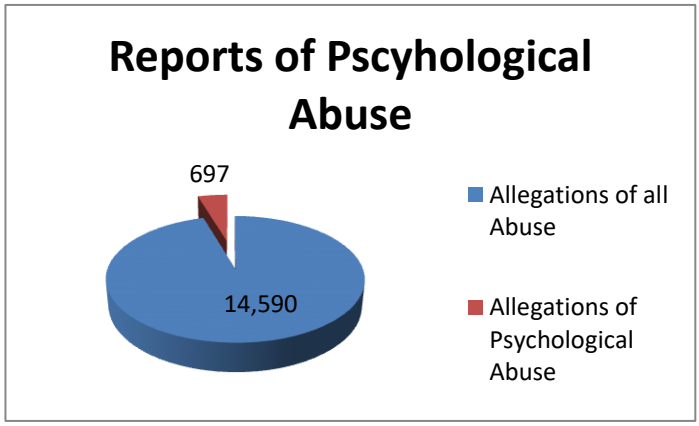
The American Professional Society on the Abuse of Children defines psychological maltreatment as "*a repeated pattern and/or extreme incident(s) of caretaker behavior that thwarts the child's basic psychological needs (e.g. safety, socialization, emotional support, cognitive stimulation, respect) and conveys to the child the he or she is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable."*

New Hampshire's statutory definitions of abuse and neglect, and the court's corresponding interpretations, limit the ability of DCYF to bring forward allegations of psychological maltreatment. [16] During the OCA reporting period, DCYF received 14,590 allegations of abuse or neglect. Of those only

[14] Teicher, MH, (2000). Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on Brain Science*, 2(4).
[15] Baker, A, Brassard, M, Hart, S, & Tom, K, (2018). Psychological Maltreatment Workshop. APSAC 2018 Colloquium, New Orleans.
[16] RSA 169-C:3, XIX.

697 were allegations of psychological abuse and only 25 were substantiated.[17] The statutory definitions describe outcomes, whereas the clinical definition put forth by the American Professional Society on the Abuse of Children describes actions taken by caretakers that have been proven to impact a child's sense of safety, self-worth, and basic health on into adulthood.[18]

Figure 4. DCYF Reports of Psychological Abuse



The majority of children in reunification process are supported by attentive CPSWs and clinicians. But there are situations in which psychological maltreatment that has characterized a parent-child relationship may persist during reunification work and beyond. The OCA has received complaints and read accounts in DCYF records of parents continuing to berate and bully their children, even under the watchful eyes of visit supervisors. In many ways, these instances of maltreatment are more profound with greater impact because having been removed from the abusive or neglectful parent, the professionals charged with their protection do not protect them, or may appear to reinforce the sentiment of the parent.

The lack of attention to psychological maltreatment is not unique to New Hampshire. It is well acknowledged as common, pernicious, and underreported.[19] The OCA has been told that DCYF attorneys hesitate to pursue petitions on psychological maltreatment because of their perception that the court will interpret the petition conservatively, and the "preponderance of evidence" standard required to prove an allegation is too difficult to meet. Nonetheless, in conversations with judges, the OCA has been told they cannot rule on petitions that are not brought before them. In fact, the OCA has been told by judges that the record reflects appropriate protective rulings when such cases are brought. Regardless of the reason, the data reflect few cases of psychological maltreatment. Yet, there is evidence of a high incidence.

When petitions are filed on allegations of psychological maltreatment and protective cases opened, there is still a problem of managing children's exposure, even while in protection. The federal Adoption and Safe Families Act (ASFA) requires DCYF to make reasonable efforts to reunify children with parents.

[17] Data Source: DCYF ROM, Results oriented Management.

[18] Spinazzola, H, Hodgdon, H, Liang, L, Ford, JD, Layne, CM, Pynoos, R, Briggs, EC, Stolback, B, & Kisiel, C, (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(S1): S18-S28. http://dx.doi.org/10.1037/a0037766.

[19] WHITE, CR, English, D, Thompson, R, Roberts, YH, (2016). Youth self-report of emotional maltreatment: Concordance with official reports and relations to outcomes. *Children and Youth Services Review*, 62: 111-121.

It also recognizes the importance of permanency for a child. The law thus requires a permanency hearing within 12 months. This is a good protection against living in lengthy states of instability, but legal milestones can be at odds with developmental milestones if children are continually exposed to psychological maltreatment during the visitation and reunification process.

> ***Case Narrative***
> **While on supervised visits with her children, the mother told them if they did not come home she would lose their social security money and therefor the house. She also told them she could not feed their pets. She accused one child of causing all the trouble and suggested that child not return home.**

Children in DCYF care are not the only ones who feel the impact of psychological maltreatment. The OCA received reports from foster parents about the anguish they experience when facilitating a visit or assisting in reunification efforts they know will distress a child. By the nature of the role, foster parents must bond with children in care. That bond is integral to child development and a child's ability to form attachments. Once bonded, it is counterintuitive to the foster parent to put a child in what they perceive to be a harmful situation. The OCA received reports of children acting out upon return from a visit, and losing gains in emotional stability or developmental milestones. When reunification is achieved, foster parents reported a continuing concern about the child's safety, and deep frustration and grief at not being able to continue to keep the child safe. The OCA repeatedly heard from foster parents that children are not protected from the psychological maltreatment of complicated reunification processes

The Foster and Adoptive Parent Association and other foster parent support groups provide a place for foster parents to process their concerns. However, many foster parents reported having had difficulty being heard by DCYF and the courts.

The OCA advocated for limiting reunification visits or providing better supervision in cases involving observed negative interactions with parents. Unfortunately, supervised visitation has become a problem in New Hampshire with the closure of specialized visitation centers. In December 2017, due to a loss of federal funds, two supervised visitation centers closed their doors to providing safe and secure exchanges and specialized supervision between children and a visiting parent. Trained supervisors can both protect children from improper interactions and direct parents toward recognizing the problem their behavior imposes. Careful observation and guidance improves therapeutic interventions for raising parenting skills. Successful and healthy reunification is unlikely if psychological maltreatment persists.

Psychological Maltreatment Recommendations

- **Legislative Action: Amend definitions of abuse and neglect in RSA 169-C:3 to better reflect psychological maltreatment as an action known to cause harm.**
- **Legislative Action and DHHS: Establish a supervised visitation program within DHHS.** DHHS mandate center participation in the New Hampshire Family Visitation and Access Cooperative.
- **DCYF: Enhance training for all persons who supervise visits to understand and be alert for psychological maltreating behaviors, protect children and provide guidance to parents.**
- **DCYF: Incorporate educational content regarding psychological maltreatment in parent education programs.**
- **DCYF: Support foster parents under stress.** Establish a policy of debriefing with foster parents during parent-child reunification.

Residential Treatment

As of September 2018, DCYF had 336 children placed in institutional, residential facilities rather than family-style placements like foster or relative-care homes. In an effort to understand residential care and New Hampshire's use of the service model the OCA visited 15 of the 26 in-state residential facilities, interviewed facility and DCYF staff and administrators, reviewed policy, practice, treatment plans, children's case records, and the scientific literature on residential care. The OCA did not find consensus on whether this model of care is helpful or possibly harmful for children.[20] One reason for lack of agreement on the benefits of the model is the inconsistency with which the concept of residential treatment is executed.

Residential Facilities: Regulation & cost

New Hampshire licenses and certifies several levels of congregate care, but all of them receive Medicaid reimbursement. Therefore all of them must provide some level of treatment and individualized treatment plans with identified goals to qualify under Medicaid regulations. The levels and range of cost for board and care (some with education) for residential treatment in New Hampshire include:

- Assessment Treatment Program $318.69 - 443.32 per day
- Intensive / Educational Facilities $201.93 - 788.59 per day
- Intermediate Group Home $130.02 - 194.06 per day
- Shelter Care Facilities $359.42 - 520.42 per day[21]

Residential Facilities: One of a continuum of services

Residential treatment is intended to be one of a continuum of services utilized to treat children with chronic conditions: most commonly the conditions associated with problematic behaviors resulting from adverse childhood experiences. The hallmark of residential treatment is a therapeutic milieu. The concept of therapeutic milieu is a holistic, round-the-clock environment in which every interaction with a resident child is intentionally responsive to the admitting condition and individual treatment plan. Milieu is the ecological expression of a specific model of care. It is designed purposefully to complement individual treatment and facilitate progress in a safe and supportive environment. Admissions, therefore, should be based upon careful assessment of a child's needs and the therapeutic capacity and milieu of the institution for an optimal match in placement. Most importantly, residential treatment is an intervention deemed necessary when home and community-based services are insufficient to meet a child's needs.

> ***"All they really did was put me in placements and I blew out of every one of them."***
>
> **Child**

[20] Hooper, S, Murphy, J, Devaney, A & Hultman, T (2000). Ecological outcomes of adolescents in a psychoeducational residential treatment facility. *American Journal of Orthopsychiatry*, 70(4): 491-500. Overcamp-Martini, MA & Nutton, JS, (2009). CAPTA and residential placement: A survey of state policy and practice. *Child and Youth Care Forum*, 38: 55-68.

[21] DHHS-DCYF Response to questions from 9/5/18 meeting of the *HB-1743 Committee to Study Alternatives to the Continued Use of the Sununu Youth Services Center Facility* (undated).

Beds: The meaning of residential treatment

The OCA observed the word "treatment" used without connection to specific models of clinical care. The limitations of home and community-based services, as well as limited residential options, have frequently pushed DCYF to seek any available bed, rather than specific clinically matching programs. Discussions with DCYF personnel confirm this. The OCA encountered children who appeared to be placed, not as a condition of a clinical program and needs match, but more out of the institution's willingness to accommodate DCYF's request to take the child. The OCA observed children's records with documentation of multiple requests for admission to a list of residential facilities whose only common factor was location in New Hampshire, not clinical offerings.

> ***"These are placement kids. It's a challenge to overcome that identity."***
>
> **Facility staff**

The licensing and certification process is not specific to any particular modality of treatment. Instead, the institutions are licensed based upon general public health and zoning standards.[22] DCYF does not contract for specific evidence-based treatment, or clinically driven outcomes with these facilities. Without specific therapeutic models, there is no anchor of a therapeutic milieu, rendering the facility without therapeutic meaning. Lacking a placement/clinical needs match and expectation, it is difficult to measure intended outcomes or effectiveness.

Prior to accepting a resident, and every 6 months thereafter, RSA 151:5-a requires facilities to complete a determination of whether the needs of a child continue to match capacity and offerings of the facility. The 2018 DCYF *Adequacy and Enhancement Assessment* (*Adequacy and Enhancement Assessment*) described limitations of reimbursement rates that were based upon 95 percent utilization.[23] That means facilities need to remain at full census in order to cover operational costs. There is inherent conflict in requiring facilities to determine whether children should remain in their care when they need the children's board and care in order to operate. In 2018 there was a slight rate increase, but the OCA heard consistently from providers that reimbursement was insufficient to cover necessary services. DHHS licenses and certifies services, while at the same time is a consumer of the residential service. Given the dearth of resources and pressure on DCYF to find places for children to stay, there is a risk of overlooking compliance

> ***"The residential treatment providers are adequate for what they are certified to do – provide certain beds."***
>
> **DCYF Administrator**

[22] RSA 170-E:30 Child Care Institution; Child-Placing Agency; Information Required. *In addition to the steps required in RSA 170-E:29, the department, upon receiving an application and authorization filed by a child care institution … shall, in cooperation with the operator, examine the facility or agency, and investigate the program and person or persons responsible for the care of children ... The institution or child-placing agency shall obtain and provide receipts of approval of state and local requirements pertaining to health, safety and zoning, as applicable. If the department is satisfied that the institution or child-placing agency conforms to the standards prescribed for the type of facility or agency to be operated, a license shall be issued. The commissioner or his designee may inspect the facility or agency at any time.*

[23] American Public Human Services Association and Alliance for Strong Families and Communities. (2018) New Hampshire Division for Children, Youth and Families: Adequacy and Enhancement Assessment Adequacy and Enhancehttps://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf.

concerns or appropriateness of admissions to solve an immediate problem of a child needing a "bed".

The OCA observed a drift in practice from seeking residential "treatment" to residential "placement" for children. This is noticeable in DCYF reports that consistently describe "bed capacity" rather than programmatic or service capacity to treat children for specific types of conditions such as post-traumatic stress disorder or attachment disorder. The OCA even encountered children who demonstrated the conceptual drift when they described where they had been, e.g. "*I went to placement*," meaning, a residential treatment facility.

Observations at in-state residential treatment facilities

The OCA visits to residential facilities were introductory in nature, not investigations or inspections. As such, this was not a systematic assessment process. Therefore, we do not have data or findings to make conclusions about the functioning or quality of care at individual facilities. General observations of the industry are summarized below.

The OCA observed no apparent licensing or regulatory irregularities among residential treatment facilities. Administrators and staff were consistently positive and enthusiastic about serving children. We observed creative resources, including a ropes course, adventure programs, Red Sox baseball games, animal husbandry, gardening, job opportunities and creative art projects. Some facilities have engaged surrounding communities as recipients for charitable activities and fundraising. Residents from one program attend local town meetings, assist at community dinners and have held bake sales to raise money for a cause. An emphasis on normative activities such as these contributes to social skills and community engagement.

The facilities' physical plants ranged from clean and freshly renovated to tired, cluttered, and in disrepair. The children's bedrooms ranged from cheerfully painted, developmentally individualized with decorations, to stark with no belongings evident or sufficient lighting. One facility had rooms with no windows. Many are situated beyond the reach of public transportation for ease of family visits.

There were characteristics of programs that confirmed the lack of clinical programming attributed to low reimbursement rates. Although DCYF reports having no policy requiring facilities to accept all admissions and keep them, facilities described a pressure to admit children without question. They referred to that pressure as a "no eject, no reject" expectation. This pressure, they intimated, caused them to have children in the mix with problematic behaviors including property damage, running from the facility, risk of criminal activity and general lack of success in their programs. The majority of children are placed in residential treatment due to manifesting problem behaviors, yet we did not encounter behavioral psychologists or programs implementing empirically designed individual behavior plans. The OCA was told there are limited mechanisms to reimburse behavioral psychologists. The lack of behavioral expertise was evident in bathrooms without toilet paper or paper towels. Children who repeatedly foul plumbing with paper products would be better prepared to return to community living with positive behavioral conditioning program that rewards positive, responsible behaviors in developmentally appropriate proper hygiene and infection control. The use of paper plates at all three meals is also an indicator of lack of behavioral programming and low expectation that children can learn to respect property and engage in the key social interaction of every family: taking meals civilly at table.

Keeping residential treatment facilities fully staffed is difficult for all providers. The low reimbursement rates limit wages and benefits. Creative solutions such as housing opportunities address the problem to

some degree. Most of the staff employed are low-wage direct care workers. Those facilities with schools also employ teachers and technicians. As indicated above, there is not an abundance of clinical staff. The majority of facilities do not employ nurses. Direct care staff are trained to administer medications in a DCYF-sponsored program. There is little apparent clinically appropriate supervision of medication administration by a registered nurse, the standard of care. DCYF formerly employed nurses in each district. They provided oversight of children with complex medical conditions or who were prescribed psychotropic medications. As stated earlier DCYF only has two nurses for the entire state. Thus, if residential treatment facilities do not have nurses monitoring the health and treatment of children in their care, there is no one with a trained eye for day to day assessment of complicated situations.

Out of state residential treatment

In 2018, DCYF placed 51 children in out-of-state residential treatment facilities. While there may be excellent or unique programs in other states that are helpful to New Hampshire children, they are not the best alternative. Distance interferes with relationships and oversight. Regulatory protections may differ from state to state. And the cost is significant. DHHS/DCYF reported that children are sent out of state for four reasons:

Children who are placed out of state are out of sight.

- Programs in state do not meet the children's specific treatment needs
- Programs in state have denied a child admission due to the child's behaviors
- Programs out of state are actually closer to the child's family along state borders
- There are no available beds in the state for the population

Daily cost range of Board, Care & Education in out of state facilities used by DCYF:

- Intensive/Educational Facilities $360.72 – 1,074.88 per day
- Intensive Residential Substance Abuse $489.61 per day
- Intermediate Group Home $286.17 - 290.02 per day[24]

The OCA has not completed visits to all 26 residential treatment facilities in New Hampshire, nor have we visited any out of state facility. This will be a priority for 2019 oversight activities. Children who are placed out of state are out of sight. Although policy still requires a monthly visit by caseworker, probation/parole office, children may not have family or CASA/GAL visits. They are completely removed from their communities and risk losing critical social ties.

Quality assurance in residential treatment

In order to ensure the quality of treatment delivered to children in residential facilities, every other year DCYF must conduct reviews to monitor program compliance with Medicaid regulations and DHHS rules, effectiveness, outcomes, and overall quality of service. The site visits are described in policy as intensive reviews that include consumer surveys, record reviews, HR file reviews, and interviews with all

[24] DHHS-DCYF Response to questions from 9/5/18 meeting of the HB-1743 Committee to Study Alternatives to the Continued Use of the Sununu Youth Services Center Facility.

stakeholders. On alternate years, each certified facility should receive technical assistance. DCYF has one person assigned to the role of Community Programs Specialist. In addition to annual reviews, this individual is responsible for certifying all residential treatment facilities that serve DCYF-placed children, including those out of state. The position assists with all placement identification and admissions, acts as liaison to all residential providers. The position is also responsible for receiving and monitoring RSA 126-U restraint and seclusion incidents and other critical incidents described below in the section on incident surveillance. There is limited oversight of medical care with only two nurses employed by DCYF. And there is no centralized repository for monitoring critical incidents or the use of restraint and seclusion in these facilities.

Preparing Residential Facilities for the Family First Prevention Services Act

The OCA has only minimally reviewed residential treatment services to date. Attention to residential treatment will take on an urgency as the state readies for a fundamental shift in service paradigm from abuse/neglect and removal to prevention and family preservation under the Family First Prevention Services Act. The Act will include minimizing use of residential treatment placements and ensuring when they are used, that they are appropriately matched to a child's identified needs with evidence-based treatment modalities.

In preparation for implementation of the Family First Prevention Services Act, providers must make substantial changes to become a qualified residential treatment program (QRTP), including:

- Be licensed and accredited (no facility in New Hampshire is currently accredited)
- Establish a trauma-informed treatment model with relevant clinical services (some NH facilities employ a trauma-informed model, while others endeavor to, but do not meet the standard)
- Must be staffed by registered or licensed nursing staff (few NH facilities employ nurses)
- Engage family in treatment plan (many of NH facilities do work with families)
- Provide discharge planning and family-based aftercare supports for minimum 6 months (some NH facilities offer community-based services)

DCYF will have to make significant changes for the law to take effect:

- Any child recommended for residential placement will require assessment of needs using a standardized assessment instrument, such as the Child and Adolescent Needs and Strengths (CANS)
- The child's needs assessment will be conducted by an independent entity – not DCYF or a provider who could benefit from admitting the child
- The child's assessed needs must be matched by the independent entity to the residential treatment facilities' specific treatment model (moving placement responsibility to an independent entity will resolve the conflict of DHHS being both oversight and consumer of services)
- The child's response to the treatment and progress towards outcome goals must be continually reassessed by the independent assessment entity and confirmed for continued match. (moving responsibility for review of progress to an independent entity will resolve the conflict of the facility assessing appropriateness of placement when placement is a source of revenue)

Residential Treatment Recommendations:

- **Legislative Action and DCYF: Increase DCYF staffing to three persons responsible for residential certification, oversight, incident surveillance and technical assistance.** Assign two staff persons to monitor the care, safety, and progress of children placed in residential treatment facilities.
- **Legislative Action and DCYF: Allocate funding for 15 nurses to be distributed throughout DCYF district offices by population ratio.** Assign nurses to monitor the health of children in residential treatment.
- **DCYF: Invest in supporting accreditation processes and training on evidence-based treatment models for residential treatment facilities.**
- **DCYF: Shift to contracting with residential treatment facilities for specific services with specific expectations.**
- **Legislative action and DHHS: Expand RSA chapter 135-F System of Care for Children's Mental Health to include an independent care coordinating entity that would conduct standardized, evidence-based child needs assessments, match children for placement, and evaluate progress as required.**
- **DCYF and DHHS: Move the Community Programs Specialist, along with at least 3 more staff persons, to the Bureau of Children's Behavioral Health to shift the focus from placement to treatment.[25]**
- **DCYF and DHHS: Create a reimbursement mechanism to reimburse for services of behavioral psychologist.**

Juvenile Justice Services: What Children Need

The Division for Children Youth and Families includes Juvenile Justice Services (JJS). They are responsible for providing services to children who are adjudicated as delinquent or as children in need of services (CHINS). Each child engaged with DCYF through JJS is assigned a Juvenile Probation and Parole Officer (JPPO) who supervises compliance with probation and parole and coordinates access to community-based and residential services. DCYF also operates the SYSC, the only architecturally secure facility for children in the state who are detained or committed for delinquency.

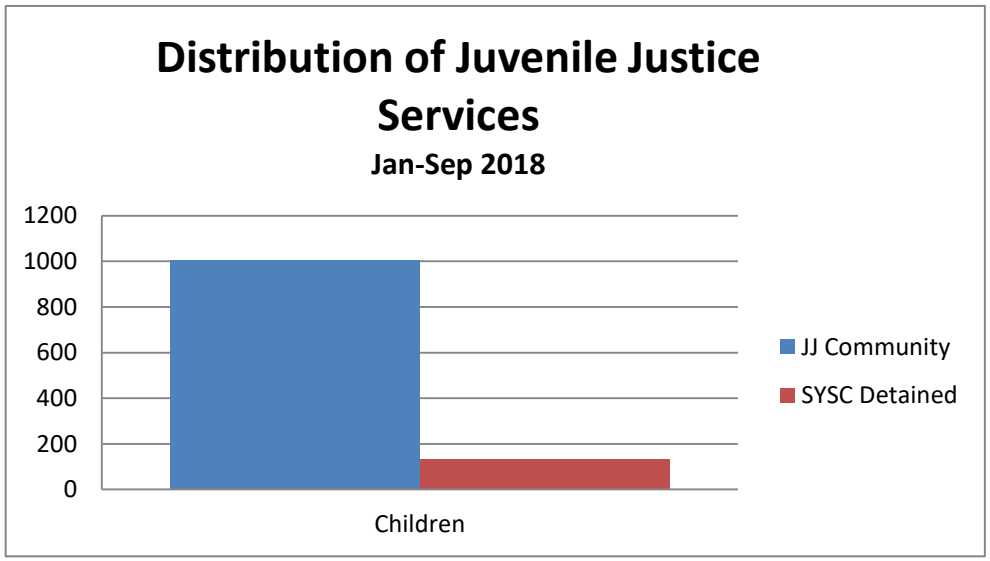
Juvenile justice data is fluid as children may have repeated offenses, admissions to SYSC, or parole, probation and some come and go around reporting periods. There were approximately 1,241 children served by JJS in the OCA reporting period of January 1 to September 30, 2018. Of those children, only 134 spent time at the SYSC, either committed, detained or both. The majority, 1,007, received community-based services and supervision from a JPPO.[26] That number includes CHINS and children on parole or probation. Although only one tenth of the children were at the SYSC, the cost of their care was $2.5 million. That appeared to be more than the entire budget expense for 1,007 children served in the

[25] In December 2018, DHHS moved the Community Programs Specialist to the Bureau of Children's Behavioral Health within the Division of Behavioral Health.

[26] Data source: SYSC Courtstream and DCYF ROM extracted 12/10/18.

community (SYSC expenditure was $13 million, community services $10.56 million). However, the OCA was unable to determine the true variation of costs between community-based services and SYSC. The OCA learned that DCYF and DHHS are not only an integrated agency programmatically, the agency also integrates its budget and expenditures. Expenditures on residential treatment for adjudicated youth, for example, are not easily attained as they are mixed with child protection treatment and other programs. The lack of transparency in the budget process will make it very difficult to determine savings in specific areas of system reform – a key concern of most legislators.

Figure 5. Children in Juvenile Justice System Served by Community Services and SYSC



In the first nine months of office operations, the OCA began an assessment of the children who enter the juvenile justice system and an examination of the system itself. The OCA received four complaints about children needing CHINS petitions and the majority of juvenile justice cases involved children at SYSC.

Children in need of services (CHINS)

The OCA received four requests for assistance on behalf of children who needed access to mental health or substance use treatment. As far back as 2003 it has been well documented nationally that families resort to the use of the juvenile justice system to access mental health services for their children.[27, 28] In all four CHINS cases referred to the OCA, the children were known to DCYF for having either child welfare or juvenile justice cases. Each case had been closed but the child was unable to maintain gains achieved during the course of the case. When seeking assistance anew, each family was told by DCYF or by law enforcement, that they could not file a CHINS petition. In two cases, the OCA brought the child's circumstances to DCYF's attention and advocated for assistance, prompting petitions to be filed

[27] United States Congress (2004). *Incarceration of youth who are waiting for community mental health services in the United States*. Washington, DC: House of Representatives Committee on Governmental Reform, available at https://www.hsgac.senate.gov/imo/media/doc/040707juvenilereport.pdf.

[28] Government Accountability Office (2003). *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*. Washington, DC: Government Accountability Office.

successfully. A third case was complicated by the child reaching age 18 and missing from his parents' home.

The fourth case brought to the OCA's attention involved concerns about a child who was not attending school and had failed to attend counseling services set up in a recent prior CHINS case. The child also had medical and mental health needs that were not being met. The school district offered the child a number of options, but he did not participate. Although out-of-home placement might have been helpful, the child was deemed ineligible due to his truancy status.[29] The OCA reviewed the case and discovered a protective referral had been made. As of the end of the reporting period, the OCA continued monitoring to ensure DCYF intervened and assisted in providing necessary supports to meet the child's needs.

The OCA also conducted in an initial review of the death of a child with an open CHINS petition. The OCA learned that there were multiple prior CHINS petitions for the child. In the most recent, DCYF never made contact with the child. The child was in communication with one parent. The complexity of the case identifies it as an opportunity for learning in an OCA Systems Learning Review in early 2019.

Case Narrative

One child was approaching the age of majority and would soon age out of eligibility for DCYF services. The child had previously been adjudicated delinquent. During the course of that case, the child's JPPO guided the child to substance use treatment and supervised the child's school attendance. With progress, the child's case closed.

Since then the child had increasing difficulties with substance use and truancy. The child was often missing from home. The child's parents were without hope. They were told they could not file a CHINS petition and the police told them they were unable to do so either. Unfortunately, the child turned 18 before the OCA could help.

Why families are unable to file CHINS petitions

The recent history of access to services as a CHINS[30] is one of confusion and change. In the early 2000s, anyone with a concern about a child could file a CHINS petition in court on three grounds: 1) truancy, 2) runaway/disregarding parental commands, and 3) repeated violation-level offenses. A range of dispositional options were available, including non-secure placement for treatment. In 2011, in order to cut expenses, the legislature made substantial changes to the CHINS statute, eliminating the 3 grounds above, and creating a new CHINS definition that included only children with severe emotional, cognitive or other severe conditions, including aggressive, sexualized or fire setting behaviors that are dangerous to self or others. The last category cannot otherwise be eligible for services through RSA chapter 169-C (child protection) or RSA chapter 169-B (delinquency). The number of CHINS cases dropped significantly. This dramatic drop in the number of children eligible for CHINS assistance is believed to have contributed to the closure of many treatment facilities, exacerbating the lack of access to treatment services.

As the impact was felt, the original CHINS grounds were resurrected in 2013. The statute now includes the older three grounds for filing with the added provision that allows for the filing of a CHINS petition for a child who "has exhibited willful repeated or habitual conduct constituting offenses which would be

[29] *See* RSA 169-D:17, I(b)(2)(B) (providing that "where the petition alleges that the child is a habitual truant under RSA 169-D:2, II(a) … the court shall not order the out-of-home placement of the child").

[30] Honorable Judge Susan Ashley, Rochester District Court. 2018 personal communication regarding recent history of CHINS law.

violations under the criminal code of this state if committed by an adult or, if committed by a person 16 years of age or older, would be violations under the motor vehicle code of this state."[31] However, the 2013 amendments included additional significant changes to the law. One amendment provided that residential placement is only an option for children who have been petitioned as runaways under RSA 169:2, II(b), or children qualifying due to severe mental health issues as alleged under RSA 169-D:2, II(d).[32]

Another amendment, and most relevant to the families who contacted the OCA, requires proof of having exhausted all other less restrictive means for obtaining services prior to obtaining a court order.[33] In implementing this amendment, DHHS developed *DCYF FORM 1326 Statement of CHINS Voluntary Services* that must be completed, signed, and submitted with the petition.

The OCA reviewed the content of the DHHS/DCYF website for evidence of instruction about CHINS and filing a CHINS petition. There was no information included about the *DCYF FORM 1326* or the expectation DCYF must sign off on it to be properly filed. This lack of clarity and accessibility of information has made it difficult for families to successfully file CHINS petitions.

CHINS Recommendations

- **Legislative Action, DHHS and DCYF: Allocate funds and fully implement the 10-year mental health plan, including expansion of the RSA chapter 135-F System of Care for Children's Mental Health so as to meet the mental and behavioral health needs of children and relieve parents of the burden of filing petitions in court to access necessary services.** Place priority on mobile crisis response and coordination of ongoing services.
- **DCYF and Courts: Provide education to all persons likely to encounter families seeking CHINS assistance (*i.e.*, DCYF staff, court staff, schools, law enforcement).** Develop a web-based training program on CHINS to ease reach and cost of training.
- **DHHS and DCYF:** Update the DCYF website to include explicit directions for filing a CHINS petition and insert a link to *DCYF FORM 1326*.

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[31] RSA 169-D:2,II(c); *see also* RSA 169-D:2 II (a), (b), and (d).

[32] RSA 169-D:17, I(b)(2)(A).

[33] RSA 169-D:5, II-a. "Any petition filed shall include language demonstrating whether appropriate voluntary services have been attempted, the nature of voluntary services attempted, and the reason court compulsion is necessary. The petition also shall include information regarding the department's determination as to whether voluntary services are appropriate for the child or family under RSA 169-D:5-c. Refusal of the child to participate in the development of a voluntary services plan may constitute sufficient information that voluntary service and support options have been unsuccessful."

Sununu Youth Services Center (SYSC)

The SYSC was built in 2006 at 1056 North River Road in Manchester. It is a locked correctional style facility designed to house 144 children in four separate wings. Since the facility opened, demand for placing children there has consistently declined.[34] This decline reflects general population and juvenile crime changes in New Hampshire that are expected to continue dropping for the next 20 years.[35] The now underutilized facility has received much attention for its cost as well as controversial use of restraints.

In the OCA's first year of oversight, the SYSC facility has been in a state of transition. Budget constraints, employee reduction and resulting insecurity, limited training and resources, significant external scrutiny, and political pressures have created a high stress work environment.

On May 8, 2018 the Disability Rights Center – New Hampshire (DRC) issued an investigative report finding that there was an unlawful use of restraint of a child at SYSC and that, as a result of the unlawful restraint, the child sustained a fractured scapula.[36] The DRC is New Hampshire's federally designated Protection and Advocacy agency empowered by federal statute to take certain actions on behalf of individuals with disabilities. The DRC report identified a child with a documented disability being the victim of an abusive and illegal restraint at SYSC. Although the report focused on the 14-year-old boy with disabilities who sustained a broken scapula, it also noted other incidents involving the use of restraint on residents at SYSC. The DRC's report drew media coverage and strong disagreement in a response from the DHHS Commissioner (Commissioner) and the Attorney General (AG),[37] who disputed that the restraint was unlawful.[38] In explaining the role and function of SYSC, they wrote that "SYSC staff must consider a youth's criminal and behavioral history"[39] and reiterated that "SYSC houses and treats a significant population of youth with serious and dangerous behaviors."[40] They suggested that the DRC had a "mindset" to under-represent the behavioral and criminal histories of the children at SYSC and, instead, to focus on their mental illness and/or disabilities.[41]

Two months later, DCYF issued the *Adequacy and Enhancement Assessment* containing descriptive data of 15 children at SYSC.[42] While the assessment described offense data, it also noted that sixty-two

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[34] Committee to Study Alternatives to the Continued Use of the Sununu Youth Services Center Facility, (2018). Final Report. New Hampshire General Court.

[35] New Hampshire Office of Energy & Planning, (2016). State of New Hampshire State and County Population Projections, https://www.nh.gov/osi/data-center/documents/2016-state-county-projections-final-report.pdf

[36] Disability Rights Center, (2018). *Unlawful Use of Physical Restraint at Sununu Youth Services Center,* Manchester, NH. www.drcnh.org

[37] DCYF's Response to the Disabilities Rights Center's May 8, 20118 Report Regarding Unlawful Use of Physical Restraint at The Sununu Youth Services Center (May 15, 2018). https://www.dhhs.nh.gov/documents/ag-reoport-sysc.pdf

[38] Ibid.

[39] *Ibid.*

[40] *Ibid.*

[41] *Ibid.*

[42] New Hampshire Division for Children, Youth and Families (2018). *Adequacy and Enhancement Assessment.* Prepared by American Public Human Services Association and Alliance for Strong Families and Communities. https://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf.

percent of the 15 children at SYSC had individual education plans for learning disabilities.[43] It further noted that sixty-seven percent of them had prior placements in residential settings,[44] and that all of the 15 children had history of exposure to substance abuse, family violence, and absconding behavior.[45] The assessment also outlined considerable limitations in resources at SYSC for children in need of mental and behavioral health services.

Who are the children of SYSC and what do they need?

The picture that began to surface of the children at SYSC was not one of violent criminals but of children with significant mental and behavioral health needs. Yet, despite all of the recent attention on SYSC, little attention had been given to the children themselves and their actual needs. The OCA identified this as a key concern.

> **People need to know this about me:** ***I am not just my record. When you see me in the community, I'm more than that. I like helping people.***
>
> **Child committed to SYSC**

The OCA acknowledges children confined at SYSC have broken laws and exhibited antisocial, sometimes violent behavior. It is well known that violent and antisocial behavior in children is often a manifestation of underlying conditions or responses to stress and trauma. Understanding the root cause does not dismiss the problem, but rather identifies opportunities to treat it and prevent recurrence – the essence of a separate juvenile justice system.

According to the *Adequacy and Enhancement Assessment*, SYSC relies upon the Structured Assessment of Violence Risk in Youth (SAVRY) instrument to assess for a child's propensity to engage in violence or delinquency. Children at SYSC are not assessed for underlying cause of behaviors and treatment needs. Absent an understanding of *why* children behave violently and antisocially, the behavior cannot be treated and will therefor persist.

Methods to Describe Children at SYSC

As the advocate for children's best interest, the OCA undertook to examine and better describe who the children at SYSC are and what they need. Methods of the OCA review included:

- Tour of the SYSC facility
- Interviews and conversations with director, acting director, supervisors, direct care staff, nurse, psychiatrist, program specialist assigned from the Bureau of Organizational Learning & Quality Improvement, and children
- Record review
- Monitoring of facility incidents
- Review of scientific literature on juvenile justice

Lacking resources for a rigorous record review with a standardized instrument, the OCA developed a record review data collection instrument loosely based on the Child and Adolescent Needs and Strength

[43] *Ibid.*
[44] *Ibid.*
[45] *Ibid.*

assessment (CANS). The CANS is a universal strengths-based assessment tool. It is used limitedly in New Hampshire under RSA chapter 135-F, System of Care for Children's Mental Health. A tool of this nature is required to bring the State of New Hampshire into compliance with the Family First Prevention Services Act in order to receive federal IV-E funding for residential placements. Factors from Adverse Childhood Experiences (ACES) and Resiliency surveys were also included in the OCA instrument. The instrument was not validated empirically, but was deemed adequate to facilitate an estimate of children's experiences and needs.[46] Using the instrument, the OCA collected data on experience of trauma, child risk behaviors, emotional needs, caregiver strengths, life domain functioning, strengths, and transition readiness.

What we learned about children at SYSC

The children were fairly homogenous in the three categories considered negative behavior causing indicators: behavioral/emotional needs, child risk behaviors, and trauma. The lowest scores across the group were in the transition readiness category. This is a category where high scores would have indicated skills necessary for a successful transition out of juvenile justice, including avoiding adult detention and navigating major life events.

The strength category had the highest average score possible. This shows that most of the children already had a foundation of positive strength skills. That is a strong indicator for resilience potential if given the right supports.

Identified Treatment and Program Opportunities for SYSC

Overall the data demonstrates potential for positive growth. The greatest need for resources is in two areas: treatment and programming.

Treatment. The data revealed that treatment is needed to address the numerous behavioral and emotional needs and child risk behaviors. Each child requires an individualized treatment plan. However, the similarities identified by the OCA's review suggest the children's treatment would be enhanced by reinforcement with a common, evidence-based, trauma-sensitive therapeutic milieu.

The OCA's observations of treatment and programming at the SYSC did not reflect capacity to meet the identified children's needs. The OCA discovered little reinforcement of the clinical assessments and treatment plans completed by the facility psychiatrist and clinicians, and unit milieu. Clinical recommendations might be prepared with links to electronic resources and E-mailed to unit staff, but the OCA was told staffing cuts limited time for reading. Safety plans developed with children were not routinely available or consulted in crisis. There was no empirically-derived, integrated trauma-sensitive therapeutic milieu. Instead, the SYSC program consists of "levels" that demand child responsibility for earning privileges through the demonstration of compliant behavior.[47] Privileges include, among others, off-unit activities or home furloughs. Punishments included, among others, unit isolation, 500-word

[46] The OCA strengths and needs instrument is structured in 8 broad categories with multiple attributes for a total of 86 behaviors or exposures. The 8 categories represent strengths, needs, adverse childhood experiences and resilience factors. Two reviewers collected data and checked responses for inter-rater reliability. Records may have been incomplete and extraction of personal experience data is not reliable in record review. The findings are estimates only as a first step in determining need for empirical assessment.

[47] Triangle Program (undated). SYSC Treatment Program: School/Residential/Clinical.

essays about the child's future, or loss of personal belongings. A child reported that to obtain the highest level of privilege, it would take earning 450 points. After having been at SYSC for several months, the child had only been able to earn 60 points.

The unit milieu presents as passive to reactive rather than purposeful and supportive. For example, confined children are at high risk for self-harm and suicide.[48] The OCA received reports of suicide attempts and learned that response to suicide attempts consisted of placing the child on continuous 1:1 watch for safety. Although a child may be given the opportunity to meet with clinical staff following a suicide attempt, there is no empirically-based clinical response to the crisis of a child attempting to end his or her life. Safety appears to be defined as not having access to the means to harm oneself. SYSC staff who are assigned to 1:1 watch of a suicidal child are placed in a difficult position with limited clinical training on how to support a youth in potentially fatal distress.

To their credit, the OCA observed strength in the SYSC staff preventing suicide. However, a robust therapeutic milieu and suicide protocol would include training for those staff working directly with children in crisis, intensive clinical response, and debriefing for all involved such life-threatening incidents.

The facility psychiatrist recommended a new suicide protocol, noting youth in detention and commitment have a different pattern of risk than youth in the general population. Response and

Table 1. Status of SYSC opportunities

Job Readiness		**Physical Activity & Fun**	
Wood Shop	Not Available Teacher died several years ago and was not replaced	Basketball	Most common physical activity. Not available consistently to all units Girls play very little
Auto Mechanics	Not Available Reports of either budget cuts and/or illegal activities	Fresh Air	Limited Use Some children report never going outside
Café/Commercial Kitchen	Limited use Budget cuts	Swimming Pool	Not Available. Closed several years ago due to disrepair
Computers/Internet	Not Available Reports of hacking and and/or budget cuts	Weight Room	Not Available Reportedly in disrepair
Art	Not available Budget cuts	Equine Therapy	Limited Availability Earned privilege
Library	Limited use Budget cuts		

[48] Bhatta MP, Jefferis E, Kavadas A, Alemagno SA, Shaffer-King P (2014) Suicidal Behaviors among Adolescents in Juvenile Detention: Role of Adverse Life Experiences. PLoS ONE 9(2): e89408. doi:10.1371/journal.pone.0089408

debriefing should be sensitive to the special circumstances. To date, the OCA is not aware that this protocol or any suicide protocol beyond 1:1 watch has been adopted.

Programing. The data also demonstrated that programming is needed to build transition skills. Transition skills, when paired with the appropriate treatment of the underlying issue, will position children for a better chance of success upon release.

The OCA assessment identified low scores in the area of transition readiness. Healthy child development requires physical activity, play, job readiness, and a sense of purpose. SYSC has the infrastructure to offer and support healthy activities, but much of the facility is not in active use or in need of repair. Staff report this is due to budget cuts. Some things, like the swimming pool, have reportedly been in disrepair for many years. Other things, like weights for exercising, have recently been discontinued. The auto repair shop is closed. Opportunities for job readiness are extremely limited.

The disconnect between the clinical programs and facility milieu impacts how the children are viewed and described, and ultimately their success at SYSC and upon release. In order to embrace an empirically-based, trauma sensitive therapeutic culture, the facility has to humanize the children and see them beyond their offenses and propensity for violence. A child with persistent problem behavior is most likely not receiving the necessary interventions to resolve that behavior. In some cases, the very institution may be a trigger for problematic behaviors. Placement at SYSC is in itself an adverse childhood experience with all the subsequent negative health and behavioral impacts. Capitalizing on the children's foundational strength and potential resiliency by facilitating the acquisition of life skills and job readiness, would produce better outcomes for the children and greater, safer job satisfaction for staff.

SYSC Recommendations

- **DCYF/SYSC: Administer the CANS assessment to every child admitted to SYSC.** Match treatment goals and discharge planning services to identified needs and strengths. Re-administer the CANS periodically to measure outcomes and discharge planning.
- **DCYF/SYSC: Develop evidence-based suicide prevention protocols and appropriate training.**
- **DCYF/SYSC: Commit to an evidence-based, trauma-informed therapeutic milieu with complete integration across all domains of children's' routines in the facility.** Provide intensive facility-wide training for all-staff integration.[49]

[49] In May 2018, DHHS reported in its response to the DRC's May 2018 report that training had begun for Trust-Based Relational Intervention (TBRI), a trauma-informed intervention technique, and that all SYSC staff would be trained in the model. TBRI is a thereaputic relationship-based model for training staff to care for children who have experienced complex trauma. In May, DHHS reported that SYSC leaders had been recently trained as trainers in TBRI and would begin training staff in June 2018 with a goal of implementing the practice by the end of 2018. As of September 30, only two staff had yet been trained. Prior to the date this report went to publication in January 2019, the OCA learned that all SYSC youth counselors had completed training. A DCYF administrator pointed out, however, that the model would not have full effect without building in facility-wide behavioral programming. A behavioral psychologist has been identified as a need to create and guide an appropriate program.

- **DCYF/SYSC: Update and reinstitute infrastructure for children to participate daily in physical activities and recreation, and for regular job readiness programming.** Revise SYSC policy so that necessary skills- building activities are therapeutic goals not contingent upon earned privilege.

OCA Accomplishments at SYSC

- Punitive writing assignments are no longer employed. The OCA conducted a literature review on the use of writing assignments as punishment. While there was little in the juvenile justice literature, the OCA did find pedagogical studies that concluded punitive writing assignments impact students' attitudes towards writing. There is a high risk of developing disdain for writing. This is reported as negatively impacting communication skills and employability. While monitoring incidents at the SYSC, the OCA noted repeated use of punitive writing assignments. We engaged leadership and have seen significantly less use of this consequence.

- At the OCA's request, safety plans are now available in Courtstream, the SYSC case management system and the OCA was also informed that they are posted on children's doors or walls. Feedback from children is that the safety plans are not used by staff in managing crisis situations.

- In the case of one child who made repeated suicide attempts, the OCA advocated he be moved to an acute-care setting and undergo a comprehensive behavioral functional assessment by a behavioral psychologist. A thorough behavior plan was designed. Initially, the child returned to SYSC without staff preparation to implement the plan. The child made another potentially lethal attempt and again the OCA advocated for acute hospital admission with a more appropriate plan thereafter. The child returned to an acute-care setting where he is awaiting an appropriate transfer.

NOTE: At the end of the OCA reporting year, the Committee to Study Alternatives to the Continued Use of the Sununu Youth Service Center Facility, per 2017 HB 1743, recommended that the OCA convene a working group to review the current system and develop a 10-year plan for juvenile justice. Through this work, the OCA will have the opportunity for a deeper system assessment to support broad system reform for children in JJS. The work group is scheduled to convene in January 2019 and will continue its work throughout the year.

Incident Surveillance

RSA 170-G:18, IV(a) requires DHHS to provide the OCA with "a copy of all incident or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department not later than 48 hours after the occurrence." The legislature did not define the term "incident" in requiring DHHS provide OCA a copy of all incidents. The lack of a definition has proven difficult to discern what incidents DCYF is mandated to report. Recognizing the broad impact of this application, the OCA recommended that DCYF meet the RSA 170-G:18, IV(a) reporting requirements by reporting any event

for which DHHS already generates a report. The OCA began receiving reports on a regular basis in late April 2018. Since that time, the OCA continues to meet with DCYF to clarify our mutual understanding of the reporting requirements.

The OCA has received the following types of incident reports from DCYF and/or DHHS:

- Missing Child Reports
- Recovery of Missing Children Reports
- Critical Incident Reports, excluding incidents occurring in residential facilities
- Use of Force Reports
- SYSC Major Incident Reports
- SYSC Moderate Incident Reports
- SYSC Minor Incident Reports
- SYSC RSA chapter 126-U reports regarding restraints and seclusions

As of September 30, 2018, the OCA had not received any incident reports involving children placed at in-state or out-of-state residential facilities. The OCA has learned DCYF does not have a centralized reporting system for incidents that occur in residential facilities or a formalized policy regarding tracking those incidents. When an incident occurs involving a child in the custody of the state, the facility notifies the respective child's caseworker or juvenile probation or parole officer. Because there is no centralized reporting or monitoring system for these incidents, DCYF has no way to monitor trends or recognize when there may be concerns with a particular facility or with a particular facility's treatment of a child.

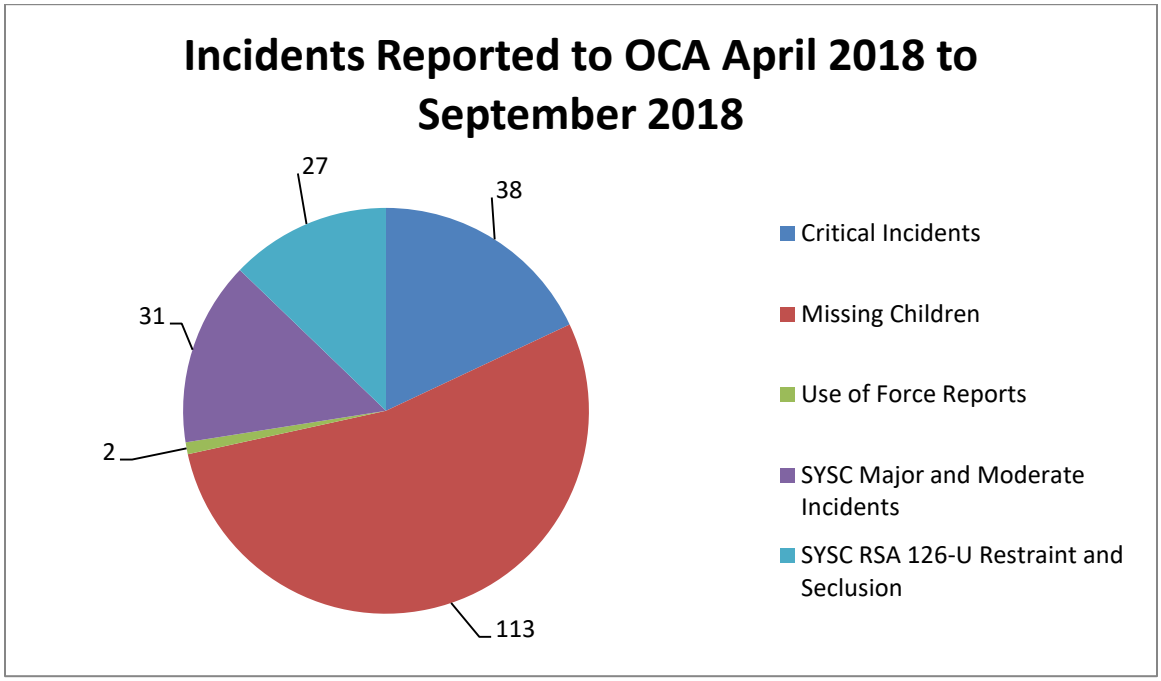
A Credible and Useful Incident Review Process

All incident reports received by the OCA are entered, and tracked, in the OCA case management system, with the exception of SYSC Minor Incident Reports. Each report is reviewed and analyzed for trends in practice, reporting, response, and follow-up services available to children. Cases that warrant deeper review for systemic implications will be presented in SLRs, the process and review discussed herein for which training and technical assistance were sponsored by Casey Family Programs. Based in safety science, the SLRs will contribute to identifying opportunities for learning and practice improvement. With approval and participation by DCYF staff in SLRs, the OCA will be able to undertake far more effective and productive review of incidents.

Incident Reports

Since April 2018, the OCA had received 211 statutorily mandated incident reports. When the OCA opens an investigatory case based upon a critical incident report, the OCA may review the child's case file, correspond with agency staff, and, if needed, meet with a child, CASA, GAL or facility staff. The OCA will also consult with relevant experts, as needed.

Figure 6. Incidents Reported to the OCA



Trends and Themes in Incident Reporting Procedures:

- Lack of clarity in critical incident definition leading to questions regarding what type of incidents require a formal incident report
- Inconsistencies in reporting, especially between district offices and JPPOS
- Omitting necessary information or errors in reported information (*e.g.*, dates, times)
- Information sometimes reported in fragments
- Lack of thoroughness and clarity in reports leading to questions about the incident itself
- Child's name is not easily found on the Critical Incident form
- Name of reporter not identified on Missing Child Report Worksheet

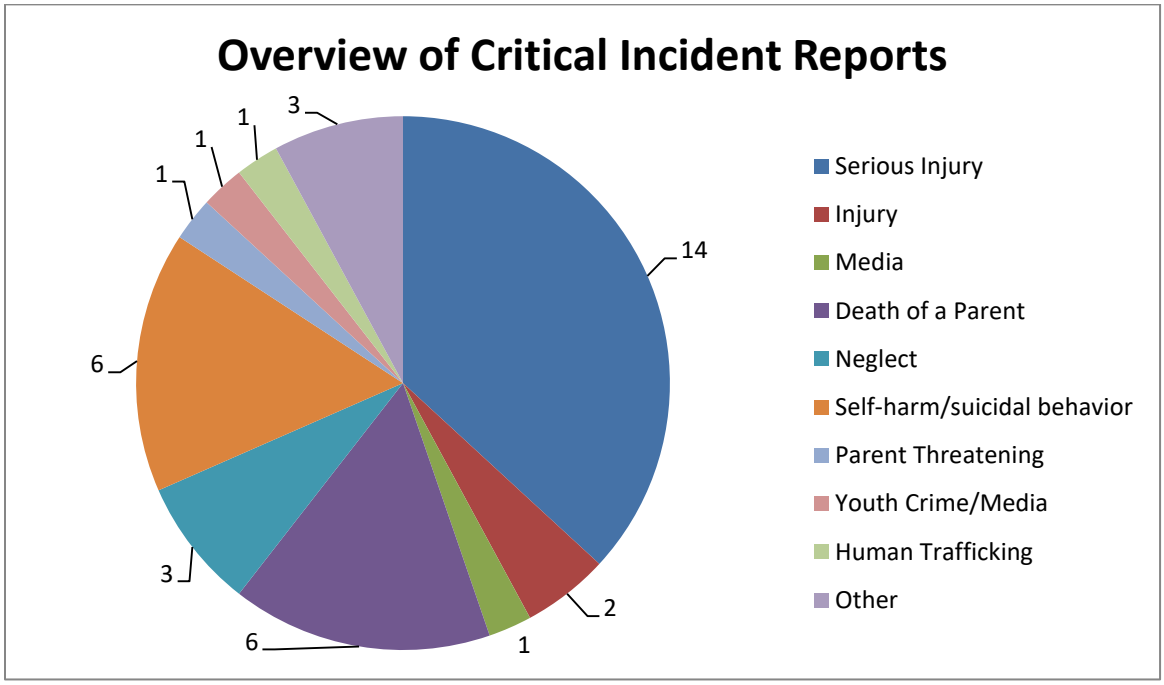
The OCA has raised these concerns with DCYF leadership, and, as a result, DCYF is now reviewing its critical incident policy, including its definition of critical incident. At the suggestion of the OCA, DCYF has communicated with Massachusetts to learn about the Massachusetts' incident reporting process.

Critical Incidents

The OCA conducts an internal preliminary review of each critical incident. The OCA monitors trends and tracks concerns regarding critical incident reports. Trends the OCA is currently watching are critical incident reports involving children or families with multiple prior unfounded assessments and critical incident reports involving children who were exposed to drugs at birth.

In 2019, the OCA will begin conducting SLRs on certain critical incidents to identify areas of system reform and improvement. These SLRs will provide information into incident occurrence and response by DCYF so as to better the safety of children and improve future outcomes.

Figure 7. Overview of Critical Incidents by Incident Type



Missing Children

New Hampshire had 182[50] missing children during the reporting period. The OCA began receiving and analyzing missing child reports on April 26, 2018. Between that time and the end of our reporting year in September, the OCA received notice of 130 of the 182 incidents of missing children. OCA data analysis only includes those 130 children.

Children are reported missing from home, residential placements, school, SYSC, and courthouses. The majority of children went missing from out of home placements, and among them, most from institutional settings. This aligns with research findings on children who "run away" with higher risk to do so from institutional or congregate care.[51]

> ***"They come to us as runners. They run"***
> **Facility administrator**

[50] 2018 DCYF Absconding Children & Youth Statistical Information.

[51] Clark, H, Crossland, K, Geller, D, Cripe, M, Kenney, T, Neff, B, & Dunlap, G, (2008). A functional approach to reducing runaway behavior and stabilizing placements for adolescents in foster care. *Research on Social Work Practices* 18: 429-441.

Courtney, M and Zinn, A, (2009). Predictors of running away from out-of-home care. *Children and Youth Services Review* 31: 1298-1306.

Characteristics of Missing Children

- 80% had been missing before
- 73% went missing alone
- 64% had a mental health diagnosis
- 40% admitted to using substances
    - 76% of substance users used marijuana
    - 35% of substance users used alcohol

Identified Concerns for Missing Children

Although DCYF's Missing Child Report Worksheet has a data field for concerns about risk of sex trafficking or other endangerment with a "yes" or "no" response option, only 4.5% of the missing child report forms received by the OCA have this section completed. Advocates working to prevent human trafficking make clear that it is crucial to screen all children who go missing to obtain accurate information and ensure that screening is not biased. However, it is not clear to the OCA that all children are properly screened for trafficking when they return home or to care. Notes in DCYF records sometimes reflect questioning by caseworkers or JPPOs, but the nature or thoroughness of this questioning or reporting of the questioning is not standardized.

Missing children are often referred to as "runaway" or "on the run." In discussion with operators of institutional placements and DCYF staff, the OCA observed a theme of blaming children for running rather than exploring the reasons that children may run. One executive of an institutional facility with a high incidence of children going missing told us, "*They come to us as runners. They run*." Another shared with us that a child who is admitted to the facility as a known "runner" may have his or her shoes taken so as to discourage the child from running. Unfortunately, the OCA reviewed a missing child report of a child who went missing without shoes. This demonstrates the ineffectiveness of the practice. This practice also puts a child at further risk of harm from injury, infection, and extreme temperatures.

Research on missing children suggests they run for a variety of reasons. Often it is to seek out and maintain relationships with family members or friends; or to escape being victimized or feeling unsafe. It may also be an attempt to gain control over their lives.[52] Facility operators expressed sensitivity to the potential risks and distress of the children, but, beyond watching children closely, an evidence-based treatment and intervention for prevention of running or clinically-guided debriefing upon return has not been evident in the facilities the OCA visited thus far.

The approach to missing children that imparts accountability on the child may distract from identifying and understanding the root cause of the behavior. Untreated mental or physical health conditions may manifest as behaviors that are difficult to manage. Response to trauma can cause a continuum of behaviors that range from complete withdrawal and failure to connect to explosive violence. While the incidence of substance use disorder as a primary diagnosis is low among children, adverse childhood experience and exposure to trauma increase the likelihood of substance misuse, increasing the risk of a child going missing. These concerns were recognized by DCYF staff member monitoring missing children who stated that almost all children who go missing use some sort of illicit substance.

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[52] Dworsky, A, Wulczyn, F, & Huang, L, (2018). Predictors of running away from out-of-home care: Does county context matter? *Cityscape: A Journal of Policy Development and Research*, 20(3): 101-115.

As noted in the *Adequacy and Enhancement Assessment,*[53] DCYF has developed a process for managing and tracking missing children. However, as one DCYF staff member noted, New Hampshire currently has inadequate stabilization and treatment options for children who run and, thus, until the state is able to address the needs of these children, they will continue to run.

Restraints and Seclusion

New Hampshire law, RSA chapter 126-U, prescribes limits as to how and when restraint and seclusion can be used and mandates careful monitoring and diligent, thorough reporting.[54] The use of restraints, in particular, restraints in prone position, has been found to be so lethal that the practice is prohibited in most states. To date, the OCA only receives regular RSA 126-U restraint and/or seclusion reports from SYSC. Residential facilities and foster homes annually report to DCYF the aggregate monthly number of restraints or seclusions. Those involving injury or death must additionally be reported per the requirements of RSA 126-U:10. Beyond this reporting, however, DCYF does not track or monitor restraints and seclusions.

In its review of restraints and seclusions at SYSC, the OCA observed that many such incidents occur following an event that triggers an emotional episode for the child. As discussed above, these events could likely be avoided were the children provided with adequate treatment and care in a fully integrated therapeutic milieu environment. For example, one report of an incident involving restraint of a child followed disclosure by the child to staff that the child was feeling depressed and was thinking of a friend who had hung himself. The staff member reported being called away during this conversation and telling the child that they could continue the conversation the next day. Shortly thereafter, staff reported that the child became upset and physically aggressive at being directed to go to the child's room. Staff further reported that, for the safety and security of all residents, the child was restrained and then escorted to the child's room.

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[53] New Hampshire Division for Children, Youth and Families (2018). *Adequacy and Enhancement Assessment.* Prepared by American Public Human Services Association and Alliance for Strong Families and Communities, at 13, available at https://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf.

[54] RSA 126-U:5, I provides that "[r]estraint shall only be used in a school or facility to ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or others. The determination of whether the use of restraint is justified under this section may be made with consideration of all relevant circumstances, including whether continued acts of violence by a child to inflict damage to property will create a substantial risk of serious bodily harm to the child or others. Restraint shall be used only by trained personnel using extreme caution when all other interventions have failed or have been deemed inappropriate." RSA 126-U:5, II further provides that "[r]estraint shall never be used explicitly or implicitly as punishment for the behavior of a child." RSA 126-U:5-a, I mandates that "[s]eclusion may not be used as a form of punishment or discipline" and "may only be used when a child's behavior poses a substantial and imminent risk of physical harm to the child or to others, and may only continue until that danger has dissipated." In addition, seclusion shall only be used "after other approaches to the control of behavior have been attempted and been unsuccessful, or are reasonably concluded to be unlikely to succeed based on the history of actual attempts to control the behavior of a particular child." RSA 126-U:5-a, II. Further, "[s]eclusion shall not be used in a manner that unnecessarily subjects the child to the risk of ridicule, humiliation, or emotional or physical harm." RSA 126-U:5-a, III.

Additionally, many restraint and seclusion events appear to relate to or follow from the lack of activity for the children at the facility – both physical and intellectual.

> ***"Why not? Something to do."***
>
> **Child at SYSC explaining self-tattooing incident.**

The OCA has observed a significant lack of measures and resources to address emotional needs of the child during and following an incident. For example, the OCA reviewed a video recording of one incident in which a child, who was already on suicide watch, threatened harm to self and staff with a small blade. Staff conversed with the child in an attempt to obtain the blade. When the child threatened self-harm by using the blade, staff physically struggled with the child to obtain the blade. Staff restrained the child on the floor for nearly twelve minutes until they were able to obtain the blade and apply handcuffs.

Following the incident, staff soothed the child still sitting slumped on the floor, and the nurse treated self-inflicted wounds. After approximately 10 minutes, staff assisted the child to sit on the bed. The child sat handcuffed on the bed in a cell with two to three staff members present at different times. Although staff occasionally conversed with the child, staff members also conversed amongst themselves. Several times the child attempted to join the conversation or appeared to laugh with staff at their conversation. The child remained sitting in handcuffs for nearly forty minutes until agreeing to "contract for safety" at which time staff removed the handcuffs.

At no time during this incident was a clinician present to process the incident with the child or what led to the child's self-harming behavior. OCA has heard from children and staff that these types of incidents occur because there is a lack of appropriately matched treatment and care for children. The OCA has also heard from staff about the trauma suffered not only by the children, but the staff who feel ill-equipped to deal with these crises. Without a full therapeutic treatment milieu that supports children in crisis, children will continue to have their needs unmet increasing the risk of harm to children and staff.

Incident Surveillance Recommendations

- **DCYF: Develop and implement a system for tracking and monitoring incidents in in-state and out-of-state facilities.**
- **DCYF: Establish an internal review system for regular review of critical incidents and RSA chapter 126-U restraints and seclusions.**
- **DCYF: Allow for regional, quarterly participation of 8-10 staff members in the OCA's System Learning Reviews.**
- **DCYF and DHHS: Incorporate an expanded statewide system of care targeting psycho-social and physical health assessment and treatment for children identified at risk for going missing.**
- **DCYF: Clarify and refine the critical incident reporting processes and *DCYF's Critical Case Incident Report Form 1099* to develop a consistent, informative reporting system.**
- **DCYF: Provide training to SYSC staff on evidence-based alternative behavior management techniques with the goal of eliminating the use of physical restraint and seclusion.** Until restraints are eliminated as a behavior management technique, establish a clinical support program to provide for the immediate care and treatment of children necessitating the use of restraint. Develop evidence-based protocols for review of all incidents and debriefing with involved staff.
- **DHHS: Adopt administrative rules for review of restraints as mandated by RSA 126-U:9.**

Child Deaths

The purpose of child death review is to identify and address trends in patterns of risk to children, to improve services to children and families, and to facilitate prevention strategies. The law explicitly mandates the OCA receive immediate reports of child death known to DCYF.[55] That includes children known to DCYF through an open or recent case as well as children who had no DCYF involvement but their death was suspicious for abuse or neglect.[56]

In 2018, DCYF reported the deaths of 10 children to the OCA. Five of the children had no history of DCYF involvement. One of those five was visiting New Hampshire and known to the Connecticut Department of Children & Families. The Connecticut Office of the Child Advocate will review that case. The OCA found no cause to review the deaths of the other four children as systems learning opportunities for DCYF practices specifically. However, each does offer an opportunity for learning and reinforcing public health prevention for child safety and fatality prevention. Suicide, safe sleep practices, and prenatal care in mothers with substance use stood out as critical learning points in those tragic deaths.

Suicide. Suicide is now one of the leading causes of death among children and adolescents.[57] It is highly associated with treatable mental health disorders such as depression.[58] Recognizing and assessing for the signs of pre-suicidality may be life-saving interventions. The New Hampshire Child Fatality Review Committee's (CFRC) last report (October 2017) noted suicide as a leading cause of intentional injury deaths for children and adolescents (65 suicides, ages 0-18, 2005-2015). Circumstantial issues that signal opportunities for prevention include isolation, change in behavior, family stress, and gender identity conflict.

Safe Sleeping. Bed sharing, couches and armchair sleeping, all substantially increase the risk of sudden infant death syndrome or accidental death. The American Academy of Pediatrics issued safe sleeping recommendations:

- Supine (back to sleep) positioning
- Firm sleep surface
- Separate sleep surface designed for infants (crib, bassinette, or play yard that conforms to safety standards)
- Remove all bumpers, pillows, and other objects from baby's sleep area

Prenatal Care in Mothers with Substance Use. The incidence of unintended pregnancies among women using illicit substances is rapidly rising with the opiate epidemic.[59] One of the most effective factors in healthy birth outcomes is participation in prenatal care. Concerns about access to health care, and fear

[55] RSA 170-G:18, IV(a).
[56] Ribsam, JE, Jr., (2018). Letter to Agency and Community Providers in re Central Intake screening process. This represented a change in policy. Historically DCYF has not screened in fatalities with allegations of abuse or neglect if there were no other children in the home for whom safety might be a concern. This change establishes a disposition relative to child abuse/neglect and central registry listing as appropriate.
[57] Heron, M, (2018). Deaths: leading causes for 2016. *National Vital Statistics Reports*, 67(6). USDHHS Centers for Disease Control and Prevention.
[58] American Academy of Child & Adolescent Psychiatry, (2017). Suicide in Children and Teens. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx.
[59] Planned Parenthood of Northern New England, (2018).

of detection by law enforcement impedes a substance-using women's access to prenatal care.[60] Ensuring access to health care can have positive influence on both birth outcomes and substance use rehabilitation.

Deaths with Active or Recent DCYF Cases

There were 5 deaths reported to the OCA that had open or recent DCYF cases. Cause and manner of death are determined by the Office of the Chief Medical Examiner (OCME). The OCA sought access to the cause and manner of deaths from the OCME. The AG prohibited the OCME from sharing information with the OCA about two of the deaths, impeding ability to determine whether a review would yield learning points for DCYF. One of those deaths involved a child the OCA had already preliminarily reviewed and made public comment about in March 2018. A summary review is provided below. Of the five deaths, two were known to DCYF as having been born exposed to drugs.

6-year-old, homicide

The OCA found a history of eight referrals of suspected abuse or neglect made to DCYF about the child's parents. Only one allegation was founded but resolved, therefore the case was never technically opened. The others were all unfounded. In each investigation, the OCA noted the child's father was documented as asking for assistance and demonstrating high stress from family relational issues and child care concerns. DCYF had no mechanism to assist a family at risk. The agency could only open a case and offer services if abuse or neglect were founded.

The OCA was able to share with legislators the DCYF history and obstacles to assist the family as an example of the need to re-establish and fund voluntary services – prevention services for families who are at risk of abuse or neglect without court involvement or substantiated offenses. There is no way of knowing if voluntary services would have saved the child's life. But the legislature responded with $1.5 million allocated for voluntary services and a limited number of families are now receiving assistance that is designed to decrease risk by guiding families in complex child rearing and relationship conflicts. Outcome from voluntary programs should inform decisions to broaden those voluntary options for preserving families and preventing tragedy.

16-year-old, accidental overdose

The OCA found a history of 14 referrals to DCYF for abuse and neglect, 5 of which were opened for assessment, all either unfounded or incomplete. There was a delinquency case opened at age 14 and 2 subsequent CHINS cases. The most recent open assessment and CHINS petitions were never completed due to the child being missing. The OCA has scheduled a Systems Learning Review on this case in early 2019.

Infant and 1.5 year-old, drug exposed infants

Prenatal exposure to alcohol, tobacco and illicit drugs is associated with physical and developmental complications. Unaddressed substance use disorders by parents can further place an infant at risk for abuse or neglect. The federal Child Abuse and Treatment Act (CAPTA) (P.L. 93-237) requires a "plan of safe care" for infants born exposed to illicit substances known as the enhanced assessment discussed

[60] Stone, R., (2015). Pregnant women and substance use: Fear, stigma and barriers to care. *Health & Justice*, 3:2. https://doi.org/10.1186/s40352-015-0015-5.

earlier.[61] Of the children seen by DCYF for enhanced assessment, one died from SIDS, one from natural causes.

18-year-old victim of motor vehicle accident

One child died in a motor vehicle accident. There were no indicated learning points specific to DCYF in this case. However, in general, motor vehicle accidents are the leading cause of death among teens, especially males. All children and teens should be aware of the risks associated with motor vehicle accidents. In addition to hazardous road conditions during New Hampshire's unpredictable weather, not using seat belts, distracted driving, impaired driving and driving with other teens or inexperienced drivers, are all risk factors that, when heeded, may save lives.

The Urgency of Child Death Review

The outrage of Brielle G. and Sadie W. deaths was fueled by a lack of information about what DCYF did and did not do for them. It was a major impetus for establishing the OCA. When testifying in support of SB 239, Senator Carson explained her reason for creating the OCA, "… *we were promised that we would find out what happened to two little girls that died, there is no mention of those little girls in that report whatsoever. None. The office of the childhood ombudsman would get us those answers. We can't fix something if we don't know what's wrong with it*."[62] Shortly after Brielle and Sadie's deaths, the United States Commission to Eliminate Child Abuse and Neglect Fatalities issued a report and national strategy to eliminate such deaths. Key among their recommendations included systematic child death and near-death reviews, sharing of data, a multidisciplinary approach to family support, application of safety science for system improvements and leadership with accountability.[63]

Over the past 8 months, the OCA has sought to form a relationship with the Child Fatality Review Committee (CFRC) – the entity responsible for reviewing child deaths.[64] The CFRC has not conducted any reviews of child deaths in the past year. The DCYF stopped conducting internal reviews when the OCA requested to observe the process as part of oversight responsibilities. The policy governing the reviews needed to be revised to include the OCA. That was not completed until after this reporting period. When Casey Family Programs presented the idea of a system learning review process based in safety science, the OCA saw an immediate opportunity. As described earlier, the SLR provides the OCA with a collaborative, evidence-based instrument and process of examining critical incidents like child deaths. In early 2019, the OCA will commence with the first SLR on a child's death and then conduct them monthly thereafter on deaths and incidents as resources allow. Timeliness and access to information will be essential to an optimal learning process. Determining whether to conduct a death review relies upon cause of death. If cause of death is natural and unavoidable, review would be deemed unnecessary. The OCA has proposed and will advocate for an adjustment and clarification of the statute in order to facilitate the prompt review of child deaths to determine any necessary system improvements and prevention of further loss of life.

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[61] DCYF's *Enhanced Response Policy 1184*.

[62] *Hearing, Senate Finance Committee*, February 14, 2017.

[63] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office.

[64] *See* New Hampshire Executive Order 95-1.

Ch**ild Death Recommendations**

- **Legislative Action: Codify the Child Fatality Review Committee.**
- **Child Fatality Review Committee: Review preventable deaths that represent opportunities for strengthening public health initiatives to reduce child death, including suicide and motor vehicle accidents.** Develop and promote initiatives educating parents on safe sleep and prenatal care.
- **DCYF: Conduct internal death reviews.**
- **DCYF: Allow for regional, quarterly participation of 8-10 staff members in the OCA's System Learning Reviews.**
- **DHHS and Division of Public Health Services: Review incidence of unintended pregnancies associated with illicit drug use and rates of participation in prenatal care among substance using women to develop public health education and screening for the prevention of unintended pregnancies and to improve birth outcomes.**
- **DCYF: Review compliance and outcomes of enhanced assessments.** Monitor all enhanced assessment-involved infants for long term outcomes.
- **DCYF: Expand voluntary services to reach more families at risk of abuse and neglect.**
- **Legislative Action: Allocate requested prioritized needs funding to expand community based voluntary services.**

Children in Court

The bedrock of both child welfare and juvenile justice is the understanding that childhood is a process of development and requires special protections. Children cannot protect themselves against neglectful or abusive parents. Likewise, the undeveloped brain in delinquent behavior can be rehabilitated and socialized to healthy maturity. As benevolent as the state's intentions may be in trying to protect children from harm, children's best interests have not historically always been considered or protected. This is especially true when systems have struggled to maintain the standard of care and community trust has faltered. Statutory interpretation that leans towards parental rights, as it has in New Hampshire, may also interfere with a child's best interests in abuse and neglect cases. Similarly in juvenile justice, a history of over-institutionalizing and failing to treat and provide for children's underlying needs threaten healthy development.

Decisions to confirm the state's involvement in a child's life often take place in the court. In New Hampshire, DCYF may bring an abuse and neglect petition to the court. In those cases, CPSW-informed DCYF attorneys, who are supervised by the Attorney General, then present DCYF's case to the court for ruling. In addition, most juvenile delinquency and CHINS petitions are also processed through the court, and the court will make a decision as to the proper course of action to meet the needs of the child. JPPOs may recommend plans for remedy or services for treatment needs. Given the significance of having state-involvement in families' lives, and accepting that the state may at times falter in representing a child's best interests, states have established mechanisms for another layer of protection that assures a child's interests are heard before the court. Federal law and supreme court decisions, codified in New Hampshire law, require that in abuse and neglect proceedings under RSA chapter 169-C,

every child is appointed a volunteer court-appointed special advocate, (CASA/GAL)[65] or another GAL if a CASA/GAL is not available. Public defenders are often appointed to represent children in juvenile delinquency cases.

The roles of the CASA/GAL or GAL and the public defender offer a third voice that has historically been relied upon to represent the child's best interest, and in juvenile justice cases, the child's stated interest. The OCA has observed these roles to be crucial, particularly in the context of recent DCYF history. In its first few months of work, the OCA has encountered a perception that DCYF attorneys, CPSWs, and JPPOs are not consistently prepared for court or that their work does not thoroughly represent a child's circumstances. The OCA has also heard complaints that the court ignores reports or dismisses DCYF recommendations. System reforms under way in both DCYF and the courts are building collaborative relationships, and, to the extent workloads contribute to these concerns, workloads are slowly being addressed in DCYF and the courts. In the meantime, concerns remain about ensuring that a child's best interests are presented.

The OCA does not have jurisdiction or oversight over CASA/GALs, GALs, or attorneys who represent children in juvenile justice cases. However, the OCA is statutorily mandated to oversee DCYF to assure that the best interests of children are being protected, and how a child is represented in court determines whether, how, and for how long a child is involved with DCYF. The intricate and moving parts of the systems warrant comment and recommendations to ensure children are best served.

Four common themes have arisen in complaints received by the OCA and from the OCA's observations of representation of children in court by CASA/GALs, GALs, and public defenders.

- Time spent with, and availability for child clients
- Inadequate representation
- Understanding of child needs and basic child development or adverse childhood experiences
- Inadequate training specific to child development and adverse childhood experiences

CASA/GAL. CASA/GALs are required by the parent organization CASA/NH policy to see children at least monthly. They meet with and prepare children for court hearings. They remain involved with children for the life of the case, attending treatment team meetings, educational meetings and generally monitor children's wellbeing while in the care of DCYF.

The OCA has not received complaints about inadequate representation of children's interests by CASA/GAL. There have been complaints from parents and guardians who disagreed with a CASA/GAL, and at least one case of children not liking the CASA/GAL personally, but, to date, the OCA has yet to receive concerns about the adequacy of CASA/GAL representation.

GAL. GALs are obligated only, "on at least one occasion prior to making a final recommendation to the appointing court," to meet in person with the child.[66]

[65] The Federal Child Abuse Prevention Treatment Act of 1974 required children be appointed a guardian ad litem (GAL) for an added layer of protection. By the late 1970s, it became clear that the role required special training and support for complex children's cases. Court Appointed Special Advocates (CASA/GAL) were conceived as an organized, supervised role with standardized training specific to child development and needs of children. CASA New Hampshire (CASA NH) came into being in 1988, and its role was codified in RSA 169-C:10 in 1996.

The OCA has received complaints regarding the performance of GAL, although those complainants are generally referred to the GAL Board. In one case, the OCA received complaints about a child's child protection case that included concerns regarding the child's representation by a GAL. In that case, the GAL dismissed concerns voiced by a pre-adoptive foster parent who expressed concern that awarding the child to an unfamiliar biological relative could impact the child's development. The pre-adoptive mother had warned about the risk of various chronic conditions associated with adverse childhood experiences that can result from multiple placements, such as attachment disorder. In the GAL's report to the court, the GAL suggested the pre-adoptive mother's concerns were unfounded because the child was so young (under five years). Further, the GAL noted the child had only been in one previous foster placement and that most foster children have attachment issues. The GAL suggested that without a diagnosis, the child should not be labeled with such concerns. The GAL remarked that the child was young and resilient, stating that children can bond to more than one caregiver without negative consequences.

While the GAL's recommendation may turn out to be the best for the child, dismissing well-established science on adverse childhood experiences places children at risk. By treating those concerns so dismissively, the GAL inhibited opportunities for preparing the relative to be vigilant for signs and symptoms and also to practice prevention strategies to ensure optimal wellbeing. Additionally, the GAL's misinformation about the risks associated with any loss of relationships and placements suggests a knowledge deficit in a critical area of science for one who would represent the best interests of children. It is important to know that resiliency is not a naturally occurring phenomenon, but one that requires circumstances to thrive: consistent caring adults, stability in relationships, a sense of purpose, a sense of belonging and needs met. Although the continuing education obligations of GALs allow for education in child development, trauma, adverse childhood experiences and resiliency, they are not required.

Public Defenders. Juveniles are not provided with appointed counsel at every stage in the juvenile justice proceedings. Public defenders are typically not appointed until after the initial hearing (arraignment) leaving little time to gather discovery and prepare for the adjudication. Further, after appointment, public defenders are instructed to close their cases upon completion of the court hearing and only open the case again if reappointed for a new court event (i.e. review hearing). Public defenders are not provided caseloads or schedules to go to treatment team meetings at residential placements, Individual Education Plan meetings at schools or other non-court events where critical decisions are made about the child's case and service options. Although the New Hampshire Public Defender provides excellent specific juvenile training to its new lawyers, there is neither a specialized unit within the Public Defender's Office to provide juvenile defense nor any organization or juvenile clinic within New Hampshire to act as a clearinghouse for juvenile legal issues or to provide ongoing support and training for juvenile practitioners.

There are several barriers to the adequate representation of youth in New Hampshire including but not limited to: the fee requirement for appointment of a public defender for each court event (from adjudication to multiple review hearings); the practice of inexperienced lawyers representing juveniles at the New Hampshire Public Defender; the assigned credit value of juvenile cases within the New Hampshire Public Defender case assignment system and the corresponding payment schedule to

[66] New Hampshire Administrative Rules, Gal 503.12(a).

juvenile contract attorneys for each court event (i.e. $99 for a review hearing); the lack of ongoing support and training opportunities for juvenile practitioners particularly around adolescent development as it relates to juvenile defense. The American Bar Association and the National Juvenile Defender Center acknowledge the need for specialized, quality, accessible representation for all youth. An independent assessment of the representation of youth would provide an in-depth review of the current system, barriers to success and recommendations for improvements. National Juvenile Defender Center selects four states each year to review and assess the state of juvenile representation. New Hampshire would benefit from an assessment to fully understand the best way to address barriers to representation of youth. [67]

In reviewing children's records at SYSC, the OCA has observed infrequent or no visitation documented between a child and his or her attorney. This infrequency is confirmed by children who report that the only time they see their attorney is at court, and, even then, contact is limited to a brief visit before a hearing. Lack of legal representation at all phases of the proceeding, including after adjudication and disposition, is detrimental to children's rights, access to treatment, education, and meeting their overall needs.

Based upon these observations, the OCA is committed to ensuring children's best interests and voices are heard in court. To that end, given the OCA's unique role and access to all case records, there may be times when the OCA could provide a voice for those interests in court. The OCA has discussed this possibility with judges, who have agreed that an independent view could be helpful, and also that known missing information ought to be shared to assure a child's best interests are met.

The OCA has been advised by the AG that there is no authority for the office to intervene to be heard in court. The OCA's inability to share information gleaned in case review leaves the OCA in an ethical quandary. RSA 170-G:18 affords the OCA with the great privilege of access to information. Absent a mechanism to share that information when critical decisions are being made renders the access mere invasion of privacy without reason. For example, in the case referenced above regarding the GAL, had the OCA been allowed to report to the court, the OCA could have shared information regarding the science of adverse childhood experiences and the long lasting impact that multiple placements can have on a child's physical and mental health. The OCA could further have shared with the court that the child had known the pre-adoptive family prior to placement for adoption, and was well-bonded with the family. The GAL recommended that the child be placed with a relative. However, the OCA had information indicating the child had not seen the relative since infancy, and the child did not know the relative. Additionally, the OCA could have shared that the GAL never visited the child in the pre-adoptive home, and the DCYF record reflected the child demonstrated some symptoms of reactive attachment disorder, common with history of maltreatment. To be sure, DCYF communicated some of this information to the court, but it is not clear that it communicated all of it.

[67] A. Elbroch, New Hampshire Juvenile Defense Attorney (2018).

Children in Court Recommendations

- **DCYF: Initiate a systems learning dialogue with the Court about expectations and perceived areas of improvement.**
- **DCYF: Review legal training for DCYF attorneys for adequacy and enhancement.**
- **GAL Board: Mandate training on child development, trauma, adverse childhood experiences, and resiliency for GAL representing children.**
- **GAL Board: Raise the minimum one visit prior to final recommendation and mandate personal meetings with child clients in all potential permanency placements to observe relationships and bonding.**
- **Courts and DCYF: Allocate additional resources or expanded support of CASA NH to supplant recruitment, training, and supervision of more specialized CASA/GAL.**
- **Public Defender: Establish specialized juvenile defense unit and extend period of representation to allow attorneys to remain on a juvenile delinquency case even after the conclusion of the dispositional hearing.**
- **Courts and/or Legislative Action: Support a mechanism allowing the OCA to provide information, as necessary, in complicated abuse and neglect cases.**

System of Care

In July 2018, OCA Director O'Neill accompanied a group of DCYF and Children's Behavioral Health administrators, legislators and a member of the court on a 2-day site visit to New Jersey for a review of their Children's System of Care. It was an opportunity to see first-hand how New Hampshire could be more effective responding to children's behavioral health needs. To their benefit, New Jersey has created a system that already meets many requirements of the Family First Prevention Services Act. As explained earlier, that law will shift federal Title IV-E and IV-B funding, traditionally used for foster care, towards more preventive services for at-risk families, such as mental health and substance use treatment, and in home parenting training.

First initiated in 2000, the New Jersey system is fully operational. The system has an independent system administrator, single point of entry, and a wide network of services. To families, the system looks like: availability of help from mobile response and stabilization services 24 hours a day, 7 days a week, 365 days a year, anywhere in the state. When families need assistance, a team is assigned to assess child and family needs, and a case management organization applies a wrap-around model to coordinate a holistic range of services from home to hospital to address identified needs using the standardized Child and Adolescent Needs and Strengths (CANS) assessment tool. Return-on-investment studies are underway for financial outcomes. However return on investment for children's benefit was impressive:

- Fewer children in institutional care
- Fewer inpatient stays
- Closure of state-operated psychiatric hospital and residential treatment centers
- Reduction from 350+ children placed out of state to one
- Children in out-of-home care have more intense needs than pre-system of care
- Fewer children in detention, 11 detention centers closed
- All services are matched to children's identified needs[68]

[68] New Jersey Department of Children and Families, (2018). Children's System of Care: Beginnings and Sustainability.

In 2016, New Hampshire took the first steps toward building a comprehensive system of care for children's behavioral health. The intent was to increase service effectiveness, improve outcomes for children with behavioral health challenges, reduce out-of-home care, and coordinate care across systems.[69] A truly grassroots initiative driven by consumers and advocates, the system encompasses a centralized care management entity, care coordination, family and youth supports, coaching and training, and connection to a needs-based array of services. Most importantly, for purposes of planning, a system for capturing and applying outcomes-driven data to monitor effectiveness is integral to the design. By September 2018, the program was serving approximately 70 families and positioning for expansion.[70]

Components of the children's behavioral health system of care are addressed in the DHHS 10-Year Mental Health Plan, including mobile crisis response units and a single port of entry. Other opportunities for aligning services and sharing resources include the "hub-and-spoke" system of care for substance use treatment currently under development and the regional network of services supported by the Bureau of Developmental Services.

Not every child identified as needing psychological or behavioral health services has a mental illness. Developmental disabilities often require behavioral interventions. There are also times when a child's behaviors may be a manifestation of an underlying medical illness. Behavioral symptoms may distract caregivers from the true cause. The OCA has advocated for children who were exhibiting concerning behaviors and not receiving indicated medical assessment to receive comprehensive medical care.

A true, holistic system of care for children would align all aspects of health services. That includes a medical assessment by a provider trained in specialized assessment of child abuse. Providers trained in child abuse assessment are more likely to recognize abuse, know and meet clinical guidelines, and have success in children receiving necessary follow-up visits for comprehensive care.[71,72] New Hampshire does not have an established system to medically evaluate abused children. No aspect of a child's health should be left out of an assessment.

Every child's story the OCA has encountered is an exacerbated version of what it could have been. The SYSC and the residential programs are just a reminder of an unacceptable delay in responding to children's needs. Having an early, rapid-response system of care that addresses all children's medical, mental, behavioral and crisis needs is critical to ensuring children's safety and wellbeing.

[69] RSA ch. 135-F.
[70] Ungerelli, E. (October 2018). Building systems of care in New Hampshire: Scaling-up family-and youth-driven wraparound. NH DHHS Bureau of Children's Behavioral Health.
[71] White, et al (2008). Use of child advocacy consults in the pediatric emergency department improves adherence to clinical guidelines. *SCAN, The American Academy of Pediatrics Newsletter of the Section on Child Abuse and Neglect*, 122(3):611-619.
[72] Anderst, et al, (2009). Is the diagnosis of physical abuse changed when Child Protective Services consults a child abuse pediatrics subspecialty group as a second opinion? *Child Abuse and Neglect*, 33:481-489.

System of Care Recommendations:

- **Legislative Action and DHHS: Allocate funds for the Bureau of Children's Behavioral Health identified prioritized needs.**
- **Legislative Action and DHHS: Create and allocate funds for DHHS's 10-Year Mental Health Plan.** Place priority on mobile crisis response units to reach every family in need, community care standardized strengths based assessments, and establishing an independent single portal of entry and provider of quality assurance.
- **Legislative Action: Create a child abuse specialized medical evaluation program with on-call specialists.**

Children's Best Interest

In a system designed to protect children, the OCA has observed that the best interests of children are often lost or forgotten. Child welfare laws have been slow to evolve to fully protect the interests of children. New Hampshire's Child Protection Act, RSA chapter 169-C, is no different. A recent amendment to the purpose of the Act may help to change that. It was intended to elevate the safety of children above all other interests. However, it remains to be seen whether courts and the child welfare system will follow suit to make a child's safety and best interest paramount. To date, many cases reviewed by the OCA have yet to mirror that legislative intent.

The slow progress of public policy intended to protect children from harm reflects not only a reluctance to interfere with parental rights and acknowledgement of the importance of family to children, but a system lacking in necessary resources to support the children for which it is designed to protect. As a result, examination and protection of children's best interest is more often than not secondary to the rights and interests of the many individuals involved in a child's life and the system which purports to protect those interests.

Children's best interest encompasses more than the rights of their parents or protection from physical abuse. Yet, as noted by the 2016 CSF Report, the emphasis in statute interpretation in New Hampshire is on visible, physical injuries.[73] Citing the treatment of children in high risk situations as major concern, the authors wrote, *"The statute is a contributor, and the rigid interpretation of the statute … inhibits assessment staff from making appropriate determinations in assessments."*[74] A 2016 New Hampshire Supreme court decision suggests that, despite a recent change to the statute, deferment to parents' rights may continue to be held paramount.[75] Strong argument on behalf of an abused or neglected child's interests may move the court's interpretation closer to the legislature's intent. Alternatively, more distinct and clear language in the statute may be needed to protect children if protection of children is truly the intent of the *Child Protection Act*.

In its works thus far, the OCA has heard from DCYF caseworkers and attorneys who have confirmed the finding of the 2016 CSF report by expressing their reluctance to bring forth cases of neglect or abuse,

[73] Center for the Support of Families, (2016). *Quality Assurance Review of the Division of Children, Youth and Families*.
[74] *Ibid*.
[75] *See, e.g., In re J.H.; In re A.H.*, 188 A.3d 1030 (N.H. 2018).

expecting parents' rights to prevail. The OCA has also spoken with caseworkers who feel constrained by supervisory decisions, court orders or a lack of resources to help the children they serve.

One caseworker shared stories from eight cases in which she had concerns about a court's rulings. In each case, the caseworker described what appeared to be evidence that supported significant concerns about the safety and wellbeing of the children with court orders returning the child to the accused parents, dismissing the case, or declining to adopt DCYF's recommendations. In one case involving neglect petitions against both parents, the caseworker described a situation in which the child was initially removed from a relative foster home and sent home with mother mid-trial, despite substance abuse concerns because the father's attorney realized that he did not have the entire discovery. In another case, the caseworker shared that the court had declined to terminate the parents' rights despite a contrary recommendation by two psychologists who had conducted evaluations on the parents. According to the caseworker, the psychologists recommended that neither parent should have any unsupervised time with their four-year-old child due to concerns for the mother's inability to learn appropriate parenting and coping skills and the father's failure to address his prior history of sexual abuse with another child for whom his rights had been terminated. The caseworker explained that the court's decision not to terminate the parent's rights left DCYF, and by extension, the child, "in limbo" as to permanency, despite DCYF's recommendation that the child be adopted by the relative caregiver with whom the child had been living for two years.

In another case, the OCA received concerns about a case involving severe physical abuse of a child by the boyfriend of the child's mother. The mother was inconsistent with her story and failed to take the child to the doctor in spite of being told by the doctor at previous visit for earlier injuries that the child was in danger of more harmful injury. There was history of domestic violence and sexual assault between the mother and her boyfriend. There were also unexplained concerns about substance abuse by the mother. Although the caseworker wanted to file a petition with the court and to have the children removed from the home, DCYF worked with the mother out of court and a petition was not filed due, in part, to concerns that the petition would not be successful.

This theme of relegating the child's best interest secondary to other interests or concerns can be seen in the many case examples discussed throughout this report. These cases illustrate the need for greater emphasis to be placed on the best interests of the child. Mandated to assure that the best interests of children are being protected pursuant to RSA 170-G:18, III(a), the OCA seeks to clarify legislative intent and to further elevate the interests of children under the law, named after all, the *Child Protection Act*.

Children's Best Interest Recommendations:

- **Legislative Action: Amend RSA chapter 169-C to put the child's safety and best interest as the paramount purpose of the statute.**
- **DCYF: Support and establish policy that empowers caseworkers, supervisors, and attorneys to take the necessary actions in each case so as to interpret the statute as intended to protect the safety of children.**

HIGHLIGHTS OF OCA 2018 ACCOMPLISHMENTS

The preceding major concerns described represent themes the OCA has observed in citizen complaints, field work, investigations and incident surveillance. In addition to these broader findings, the OCA has seen case-specific accomplishments. A sampling of these accomplishments is listed below.

- Testified before the legislature in support of funds for voluntary services. Allocation of $1.5 million for DCYF to provide voluntary services.
- Successfully advocated for amendments to RSA 170-G to allow anyone to contact the Office of the Child Advocate with a concern about DCYF, to protect those complainants who contact the office, and to share information with the public in a child's or the public's interest.
- Successfully advocated for two children to obtain CHINS petitions to access needed services.
- Assisted in obtaining sibling visits between two siblings in a foster home and their sibling who lived with a parent.
- Assisted a child in foster care to obtain a birth certificate to access a driver's license and job.
- Assisted a foster mother to help her obtain visits with her former foster child.
- Successfully advocated for a child to obtain a functional behavioral assessment and appropriate treatment placement.
- Advocated for specialized medical care for a child with a complex medical condition.
- Brought together multidisciplinary team to assist a child aging out of DCYF care.
- Successfully advocated for a foster child to remain with the child's foster family for the birthday celebration the foster family had planned for the child.
- Advocated in numerous cases for DCYF to communicate with parents and foster parents regarding their questions and concerns.
- Collected individualized data on 19 children at SYSC to develop a preliminary assessment of their needs.
- Prompted DCYF to consider conducting further background checks on relative caregivers and requiring relative caregivers to be licensed as foster parents.
- Facilitated DHHS post the phone number for DCYF's abuse and neglect central intake on the front page of its website.