State of New Hampshire

Office of the Child Advocate

RSA 170-G:18

2019 ANNUAL REPORT

The Office of the Child Advocate

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

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All artwork featured in this report was contributed by children in the care or supervision of DCYF for the OCA Art Project.

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Office of the Child Advocate

Moira O'Neill

Director

February 14, 2020

The Honorable Sharon Carson
Oversight Commission on Children and Families
State House, Room 124
Concord, New Hampshire 03301

RE: Office of the Child Advocate Annual Report Pursuant to Chapter RSA 170-G:18, V

Dear Senator Carson,

It is my honor to present, pursuant to RSA 170-G:18, the 2019 Annual Report of the Office of the Child Advocate (OCA). This report is respectfully submitted to you as Chair of the Oversight Commission on Children's Services.

Looking back on the year of service to children, the OCA is optimistic for New Hampshire's children. Perhaps nothing speaks success for the past year like the passage of Senate Bills 6 and 14. Senate Bill 6 invested in the workforce at the Division for Children, Youth and Families (DCYF). Senate Bill 14 expanded community-based services and mental health supports for children and their families. An enhanced workforce and expanded array of services will better meet children's needs and prevent or minimize adverse childhood experiences (ACEs).

In the context of a larger government system with competing needs and limited resources, it is encouraging that children have remained on, and benefited well from, the state's agenda. This is reason for optimism. Nonetheless, there remain persistent obstacles to New Hampshire's intentions of ensuring children are developmentally healthy and successful.

The OCA was established to bring to light needed system improvement and to ensure that DCYF is consistently acting in the best interest of children. The science of evaluating human services informs us that poor child outcomes and even tragedies are the product of faulty systems, processes, and conditions contributing to environments in which mistakes happen or are not prevented. No matter the circumstances, there is much to be learned from these instances. While new fiscal investment is welcome – it will not help children if we have not identified and learned from weaknesses in order to improve the system. Transparency and accountability are predicated on learning.

Over the past year, the OCA has sought reliable, empirically based methods of credible review. Our System Learning Review (SLR) process, grounded in safety science, is a rigorous mechanism for examining

systemic influences over practices and decision making. The guidance we take from DCYF frontline staff and administrators in the SLR ensures authentic representation of the daily pressures encountered in child protection and juvenile justice services. In response to the SLR *Summary Report*, one child protection social worker (CPSW) wrote, "It is the first time I have ever seen my job described as I experience it." Getting at those descriptions, the real story of state services, is the only way we will get to remedies for system accountability and reliably positive outcomes for children.

In the 2019 reporting period, the OCA examined over 1000 events with potentially adverse effect on children, possibly due to actions or inactions of DCYF or other system response. Approximately one third constituted citizen concerns. The rest, 694, were reports of incidents involving children who were injured, restrained, secluded, suffered a parent death, or went missing. What we learned most from those reports was that reporting was incomplete. The OCA was not receiving reports of *all* incidents. DCYF was unable to report events from private residential facilities because they had no centralized database or tracking system from which to generate reports. The incidence of restraint and seclusion reported to the legislature annually indicated the OCA was not receiving hundreds of reports of incidents from which both the OCA and the DCYF could be learning.

The OCA identified prevailing themes in all of our work this past year, most notably, the importance of open communications and relationships across all domains of children's services. In other words, community-building is key to achieving the best outcomes for children in New Hampshire. The more each sector of children's services understands the roles and responsibilities of the other; the more we talk about what works and what does not work, the sooner we will arrive at remedies to system weaknesses and healthy, more successful children.

New Hampshire has never had a voice for children with quite the platform the OCA holds. As we tease out the most effective ways to educate and influence positive change, we urge stakeholders to acknowledge the OCA's mandate: to oversee DCYF and to promote the best interests of children. We are uniquely empowered to shine the light on system learning opportunities. But these opportunities must be recognized as such, in the context of children's interests. With that empowerment comes the responsibility for hard conversations often met by defensiveness. New Hampshire must make a strong commitment to stay focused on children and see in independent review a shared goal to honor children's interests. We do see progress and welcome investments in the workforce, the array of services, and a redesign of services that will now be contracted and therefore accountable to specific child outcomes. We also see much more work to be done. The children we talk to see it too.

We look to the coming year with priorities in elevating children's voices, incorporating their perspectives in the contemplation of policy that affects them, and above all, promoting understanding of the experience of childhood, especially the development of brains. Learning about children, how they develop, what they communicate through their behaviors, and what they need most is the best way forward for public programs serving them. Children are telling us they need most to be at home or in a home-like setting with a foster family. The science and outcomes of evidence-based practice confirms that the children are correct. The OCA has not encountered a single child who expressed preference to be incarcerated or in a residential facility. We did encounter a few who recognized the hard fact that home was not the best place for them. Parents and foster parents recognize children's desires and needs, but too often express a lack of skill, support, or resources to meet those needs. Decision makers should look

to those pleas and the science behind them and move forward without delay to implement community and home-based supports and services, including intensive supports for foster homes. Schools will be an important partner in these efforts. Schools are where children spend their waking hours; they are a key safety net for recognizing and responding when children are in trouble. Schools are also too often the gateway to juvenile justice when children's needs are not recognized or met. Senate Bill 295, *An Act Relative to the Office of the Child Advocate,* under consideration in the 2020 legislative session, aims to help expand OCA services to children in school, not yet under DCYF care, as a means to prevent that trajectory and strengthen resources for children.

In 2019, the Office of the Child Advocate demonstrated its work in the publication of several reports and issue briefings. We addressed, in depth, the issue of children whose parents are incarcerated, the response to infants born substance exposed, and the use and reporting of restraints and seclusion. We also reported summary findings of SLRs conducted on five child deaths and one parent death. Those reports are dense with research, learning, and systemic recommendations. Therefore, this 2019 Annual Report is an account of the activities of the Office of the Child Advocate rather than the state of child protection and juvenile justice services. It is an account of our work and DCYF's response to it.

The OCA's recommendations, gleaned from system-wide reviews, individual case advocacy, and even outreach and education, have been consistent. This report reiterates them as key to success for DCYF and the broader system-serving children: Improve knowledge of child development, promote interprofessional understanding, enhance communication, acknowledge the barriers of bias, and expand and stabilize the array of services for children and families.

We in the Office of the Child Advocate are grateful and honored for the opportunity to serve the children of New Hampshire. We thank you and the members of the Oversight Commission on Children's Services for your enduring support, feedback and, when needed, re-direction. We look forward to more hard, but meaningful work in 2020.

Thank you,

Moira K. O'Neill, PhD, RN, Director

SELECTED ACHIEVEMENTS IN 2019

2019 was a productive year for the Office of the Child Advocate, and therefore, for children in New Hampshire. Achievements ranged from affecting the care and comfort of individual children to broad system changes in transparency, collaboration and effective state systems. To understand the breadth of the OCA's work, below is a brief list of accomplishments by category of impact.

Child and Family Focused Achievements

- A child placed at the Sununu Youth Services Center (SYSC) expressed concern that children were issued used underwear. Although laundered, the children felt uncomfortable and disrespected. The OCA brought this concern to the attention of DCYF administrators and shortly after, the facility issued brand new underwear to all children. Now each child is issued a personal set of underwear upon arrival at SYSC. One DCYF administrator, visibly uncomfortable with the thought of children wearing used underwear noted, "In 35 years of this work, it never occurred to me to think about underwear. That is just not right." When the OCA shared this accomplishment with the child who brought the concern to our attention, he smiled and responded proudly, "I did that."
- Children being adjudicated may qualify for a public defender attorney to represent their expressed interests in court matters. Unlike children involved with child protection services, they are not assigned a guardian ad litem (GAL) to represent their best interest. When an adjudicated child was discovered to have incapacitated and inattentive parents, the OCA advocated successfully for the appointment of a GAL to ensure the child's best interests were served in development of future plans.
- A child was considered for placement by DCYF in a facility over 1,000 miles away. Despite resistance to the OCA informing the Court's decision, the OCA was able to ensure all parties were informed of the child's needs and the incomplete efforts of DCYF on the child's behalf. The child was able to remain at home with outpatient support. The child completed the school year successfully while remaining gainfully employed.
- The OCA successfully assisted a grandmother open lines of communication to negotiate for increased visits with her grandchildren. The OCA also provided the grandmother with information and assistance to advocate for training so she could meet requirements to apply as an adoptive home for another grandchild. She provided feedback to the OCA that the DCYF training and the assistance the OCA provided opened her eyes to understanding the trauma her grandchildren were going through and DCYF processes and procedures.
- In a case for which parents were uncooperative and threatening, DCYF would have closed an abuse/neglect assessment as incomplete without seeing or ensuring the safety of the infant of concern. The OCA successfully advocated the assessment remain open due to serious safety concerns: an older sibling was already in state care for neglect. DCYF subsequently filed a petition for neglect on both parents. Unfortunately, the parents left the state before the infant and family could be assisted. DCYF alerted the receiving state.
- The OCA successfully assisted a family to obtain sought after information about their child's medication regime at a residential facility.

Transparency in Government

- Through the OCA's advocacy, the Department of Health and Human Services (DHHS) created website links accessible to the public for direct access to all DCYF policies. Now all persons with involvement in DCYF services can be better informed on DCYF obligations and what to expect when working with the agency. These policies can be found at https://www.dhhs.nh.gov/dcyf/policies.htm.
- The OCA convened six System Learning Reviews (SLR), the first comprehensive review of DCYF-involved child deaths conducted in two years. The reviews employed a process based in safety science to promote full, open, honest engagement of staff and administration to identify learning opportunities for improving child protection, juvenile justice and all the intersecting systems. The OCA conducted specific reviews on five child deaths and one parent death.

Promotion of Community Education and Collaboration

- The OCA's Issue Briefing, *Parents Incarcerated in the New Hampshire State Prison System*, improved communication between DCYF and the Department of Corrections (DOC), prompted information and training sessions by the DOC's Family Connections Center for DCYF, improved visitation paperwork to facilitate child and parent visits when appropriate, and prompted community conversations throughout the state with the showing of documentary films.
- The OCA's System Review Briefing, *DCYF's Enhanced Response to Substance Exposed Infants*, alerted the public of a broad review underway. It examined the experience and needs of infants and families and the response of the state's many-layered system. Even before the release of a final report, the briefing increased awareness of the problem and drew many experts, champions and families into a productive dialogue aimed at solutions to a complex problem.
- The OCA participated in Dartmouth Hitchcock Health and the Children's Hospital at Dartmouth Hitchcock's 2019 Youth Summit elevating, understanding and empowering the voice of New Hampshire's children. As a follow-up to this event, the OCA participated along with youth, the Department of Education, and community stakeholders in the Youth Voices – Knowledge – Empowerment – Understanding program as part of the 99 Faces Project Series at Dartmouth Hitchcock Hospital. The program sought to educate on and explore the challenges young people face today.
- The OCA represents children's voices on the advisory board for *Know and Tell*, an educational initiative of the Granite State Children's Alliance. The program is aimed at protecting children through educating on recognizing and reporting child abuse or neglect.

Juvenile Justice Reform

- The OCA convened the Child Advocate's Working Group on Juvenile Justice to examine areas in need of reform and develop a 10-year plan. More than 40 advocates, DCYF staff, public defenders, mental health professionals, parents and legislators have participated in building a collaboration of reform for New Hampshire. Special events included well-attended public summits with the

members of the national Youth Corrections Leaders for Justice and one of the leading effective community-based intensive family support programs, Multi-Systemic Therapy.

- The OCA contributed successfully to DCYF's application for an Annie E. Casey Foundation Grant and now actively participates on New Hampshire's interdisciplinary team in the Transforming Juvenile Probation Certificate Program through the Georgetown University Center for Juvenile Justice Reform and the Council on State Governments Justice Center.

Legislative Action

- The OCA consulted on the development of, and testified in support of raised legislation before the New Hampshire legislature. Some of the bills addressed recommendations made in the OCA's 2018 Annual Report. Most notably they included Senate Bills 6 and 14 that grew the child protective services workforce and expanded the community-based system of care.

OCA Resource and Stability Enhancements

- The OCA convened the first regional meeting of Independent Child Advocates and Ombudsman to build alliances and supports to advocate for children in general and for New Hampshire children when moved across borders.
- The OCA's achievements and demonstrated value to the legislature and governor resulted in allocations for two additional positions for the Office and substantial budget increase for FY 2020 and 2021, 25 and 44 percent increases respectively.
- Senate Bill 295 *An Act Relative to the Office of the Child Advocate*, clarifies the independence of the OCA, expands services to children beyond DCYF, and enhances the membership of the Oversight Commission on Children's Services by including the voice of family and individuals who experienced DCYF services as a child. The bill is sponsored by a bipartisan group of legislators committed to the interest of children.

Children, advocates, legislators, providers and others gathered to discuss New Hampshire's juvenile justice system on June 21, 2019

RESPONSE TO 2019 RECOMMENDATIONS

As measures of progress for the State, responsiveness of the department and other parties, and achievement of the OCA on behalf of children, we reviewed recommendations made in the *2018 Annual Report of the Office of the Child Advocate.* There were nine categories of recommendations based upon major areas of concern identified by children, families, other constituents and as a result of OCA-generated reviews. Subsequent responses to the recommendations, by category, appear in the list below.

2018 OCA RECOMMENDATIONS & RESPONSE

DCYF INTAKE AND ASSESSMENT

***Recommendation**: Referral to home visiting for infants born exposed to substances for extended period and monitoring of their long term outcomes*

Response: The department is receiving technical assistance from the Government Performance Lab (GPL) at Harvard University's Kennedy School. One GPL Government Innovation Fellow is focusing on improving connections for a community collaborative model to promote in all districts, with linkage between Maternal Child Health, DCYF, and the community. Monitoring the children for the long term is sensitive to issues of privacy, and not fully the role of DCYF. However, DCYF is considering a means to flag involved children born exposed to substances in their electronic case management system. This way, if a child returns to the agency's attention, their needs may be anticipated. Surveillance of this sort represent mechanisms for measuring risk, needs, and effectiveness of DCYF services over time.

***Recommendation**: Promote a culture of responsive communication, including using team casework to maintain responsiveness*

Response: The department reported they are assigning responsibility for constituent relations to receive and respond to inquiries. Fourteen case aids were included in the budget. Once filled, those positions may assist with supporting and maintaining communication. A team casework model has yet to be embraced**.**

***Recommendation**: Train all school personnel on mandated reporting*

Response: DCYF staff have been active in the design and implementation of mandated reporter training, *Know and Tell*, an initiative of the Granite State Children's Alliance (GSCA). Local school districts have independently engaged with *Know and Tell*. In 2019 the program estimated they would train over 4,000 participants, including three full school districts. The OCA later made a recommendation that all state employees complete the on-line mandated training *Know and Tell* offers as a model of responsibility to the universal mandate of RSA 169-C:29. GSCA is working with officials to review state employee training requirements. The Department of Natural and Cultural resources is examining *Know and Tell* training opportunities.

PSYCHOLOGICAL MALTREATMENT OF CHILDREN

***Recommendation**: Enhance training to recognize psychological maltreatment and provide guidance to parents*

Response: The Child Welfare Educational Partnership (CWEP), the DCYF training partnership with Granite State College, are considering re-development of programing. There is training available for providers and staff but it is not mandated.

***Recommendation**: Incorporate psychological maltreatment in parent education*

Response: This is another area under consideration for redevelopment. The Family Resource Centers around the state have traditionally been the resource for parent education. New contracts are being developed with potential for attention to educational content.

***Recommendation**: Establish debriefing for foster parents during reunification*

Response: DCYF sees this as a role for the resource workers, newly supported positions with the influx of new staff. This will be an area to watch as staffing is addressed.

RESIDENTIAL TREATMENT

***Recommendation**: Invest in supporting accreditation process and staff training*; *Shift to contracting for specific services*

Response: This is underway. FY20-21 budget includes funds for "system redesign" up to $30,000 for qualifying residential programs to assist in accreditation process. The department is planning to "re-procure" the entire system. One program was awarded a contract for specific services, prescribed conditions, and expected outcomes. The OCA is monitoring for DCYF's contract compliance oversight that should ensure safety and effectiveness of outcomes.

***Recommendation**: Move Community Program Specialist to the Bureau of Children's Behavioral Health*

Response: Two positions were moved to Bureau of Children's Behavioral Health with an aim for shifting emphasis of residential admissions to treatment vs. placement.

***Recommendation**: Create reimbursement mechanism for behavioral psychology*

Response: Behavioral psychology is not utilized as a resource for children with developmental, trauma-induced or communication disorders expressed as behavior. DCYF continues to struggle with understanding and meeting of behavioral health needs of children. Instead actions emphasize treatment for mental health and substance use disorders and overlooks conditioning and communication disorders that manifest as behavior. DCYF acknowledges that this is a struggle and that there is a need to break down siloes with developmental disability services, develop resources, and include behavioral psychology as part of the service array for children.

JUVENILE JUSTICE

***Recommendation**: Enhance information and guidance for filing a CHINS petition*

Response: This recommendation does not appear implemented to make it easier for a parent to locate and navigate the process for obtaining a CHINs petition. In fact, the DCYF website appears to have less information about CHINS petitions since the OCA recommended enhancing it. The OCA could not find any links to the Court's information pages. The only references to CHINS, found after much searching on the DCYF web page, include:

(1) DCYF home page – CHINS is mentioned in a sentence under Juvenile Justice, but without explanation

(2) DCYF home page link to a 2015 outdated CHINS webinar

(3) DCYF Juvenile Justice page – there is one sentence mentioning CHINS in the introductory paragraph

(4) DCYF Probation & Parole page – there is a link to Children in Need of Services (CHINS) with a description of the child, but no information types of CHINS or how to access the service

(4) DCYF policy page – there is a link to DCYF Policy *1325 Chins Intake*. There is no information or link to the forms referenced in the OCA 2018 Annual Report that are required for a CHINS petition.

***Recommendation**: Assess children at SYSC with the Child & Adolescent Needs & Strengths instrument (CANS) and match to services*

Response: A DCYF administrator explained that child assessments using the CANS will be part of broader system of care expansion, and include discharge planning. An SYSC administrator stated that children at SYSC will be prioritized as the system of care expansion rolls out in spring 2020, but explained that currently there is no funding to pay for certain assessments.

INCIDENCE SURVEILLANCE

***Recommendation**: Develop evidence-based suicide protocols at SYSC*
Response: DCYF Policy *2054 Suicide Prevention* addresses suicide and prevention procedures at SYSC, but there is no clearly articulated clinical protocol for prevention or response to suicidal behavior. A DCYF administrator stated this will be a task for a psychologist in the process of being hired in December 2019.

***Recommendation**: Institute evidence-based, trauma-informed, therapeutic milieu at SYSC*
Response: DCYF reported development of a therapeutic milieu and all related training/support will be tasked to a new staff psychologist. In 2019 the majority of SYSC staff were trained in Trust-based Relational Intervention (TBRI), a trust-based, trauma-informed modality of program culture emphasizing safety, healing relationships, and nurturing of internalized coping skills. There has yet to be an assessment of outcomes since training was implemented. SYSC also instituted post-incident debriefing but specific debriefing training resources for the facilitator are necessary to ensure a consistent, systematic, meaningful process.

***Recommendation**: Implement consistent surveillance of incidents in all facilities*
Response: DCYF reported a system for receiving incidents occurring in private residential facilities would be instituted in Mid-December 2019.

***Recommendation**: Establish internal review system for critical incidents, restraints and seclusion*
Response: A DCYF administrator acknowledged lack of reporting consistency with the *Critical Incident Report Form 1099*. Review and redesign is part of larger reform of incident surveillance in a regional partnership with the University of Kentucky's Center for Innovation in Population Heath. DCYF reports that it is taking a thoughtful approach and is reviewing its processes across systems within the department to ensure a consistent review process for staff. This, along with changes in the outside partnership translates to a slow progression. Training is scheduled in February 2020 for DCYF and department staff on the Safe Systems Improvement Tool that is designed to provide a reliable, consistent means of critical incident analysis.

CHILD DEATH

***Recommendation**: DCYF participation in OCA System Learning Reviews (SLR)*
Response: The OCA convened six SLR in 2019 with over 40 DCYF staff participants, including field staff and administrators. Feedback has been positive. The OCA's October 30, 2019 *System Learning Reviews: Summary Report* released after the OCA's 2019 reporting period details findings and recommendations from all events plus a comprehensive review of all child deaths with DCYF involvement since the OCA has been operating. This report can be found at https://childadvocate.nh.gov/reports.aspx.

CHILDREN IN COURT

***Recommendation**: Initiate learning dialogue with courts about expectations and areas for improvement*
Response: No specific outcomes have been identified for this recommendation. A DCYF administrator pointed to the Court Improvement Project (CIP) and the issuance of new permanency protocols. The OCA has not yet reviewed DCYF involvement in the CIP.

***Recommendation**: Review adequacy of legal training for DCYF attorneys*
Response: DCYF reports a new attorney educator. The Attorney General's Office, which oversees DCYF attorneys, has stated that all negative DCYF court decisions are reviewed and DCYF attorneys are trained based upon those reviews. It has also been reported that there are now monthly meetings for attorneys and regular training for attorneys designed to improve consistency in practice. DCYF administrators report work underway on increased practical training for attorneys.

***Recommendation**: 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*

Response: The New Hampshire Public Defender has not established a juvenile defense unit, but reports that in certain areas of the state there is "virtually specialized juvenile work" being done. In addition, in some cases public defenders are remaining on a juvenile's case regardless of the child's path in the system. There is also now one attorney from the Public Defender's Office available to regularly represent children at parole hearings. This has been described as both helpful and confusing for children, when two attorneys are associated with an ongoing case. The National Juvenile Defense Center undertook a system-wide review of legal defense for children in New Hampshire. Their report is expected in Summer 2020.

SYSTEM OF CARE

***Recommendation**: Expand statewide system of care targeting psycho-social and physical health assessment and treatment*

Response: SB 14 passed into law in June 2019. Services are expected to be under contract in spring 2020, including mobile crisis response, expansion of in-home wrap-around services, and evidence-based strengths-based needs assessments that will be applied to match services.

***Recommendation**: Expand Voluntary Services (VS)*

Response: From July 2018 to July 2019 there were 84 new VS cases serving 417 clients. There are some issues identified in tracking services offered during an assessment that may not be tracked as VS.

CHILDREN'S BEST INTEREST

***Recommendation**: Empower DCYF staff to take necessary actions as statute intended in protection of children*

Response: There have been several legislative initiatives addressing the best interests of children, some overlapping and not in a comprehensive strategic way. The department has sought several legislative initiatives to support DCYF's work. For example, because there is an imminent sunset of RSA 169-C:12-e establishing a rebuttable presumption of harm in cases where there is evidence of a custodial parent's opioid drug abuse or opioid drug dependence, a bill has been proposed to add a provision to RSA chapter 169-C creating a rebuttable presumption of harm in certain enumerated circumstances, including when there is evidence of a parent, guardian or custodian's substance misuse that is adversely affecting a child's care or supervision, when that parent is not engaged in treatment, when there is evidence of a parent, guardian, or custodian's impaired driving or operating a motor vehicle in violation of the law while a minor is in the vehicle, and when there is evidence of a perpetrator parent, guardian, or custodian's exposure of a child to physical violence directed at a household member or pervasive emotionally abusive behavior directed at the child or another household member. There is also a proposed bill allowing a court to order a parent, guardian or other caregiver to produce a child for an interview or evaluation required as part of an investigation of suspected abuse or neglect.

NEW HAMPSHIRE'S CHILDREN

The total estimated population of New Hampshire is 1,356,458 people.[1] An estimated 298,626 or 19 percent of the total population are children under the age of 19.[2] Table 1. depicts a breakdown of the estimated population of children by age.

Table 1. Estimated 2020 Population of Children by Age

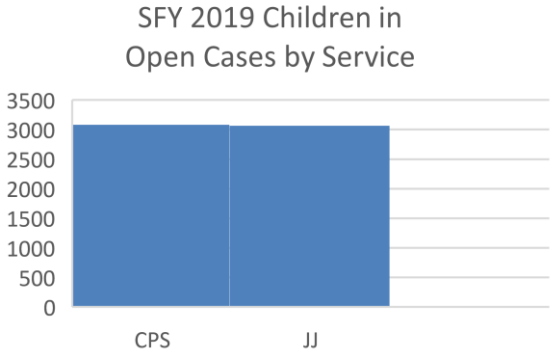
AGE	EST. POPULATION
<5	68,435
5-9	70,091
10-14	75.003
15-19	85,097
Total < 19	298,626

Births 12,105 (2017)
Deaths 12,504 (2017)[3]

The most recent live birth data (2017) available from the Department of Health and Human Services website indicates births are not replacing deaths in New Hampshire. With so few children and a considerably aging population in general, every child is precious. The population of children involved in child protection or juvenile justice services is correspondingly small compared to many other states. It is a potentially manageable population that is not without remedy.

In state fiscal year (SFY) 2019, DCYF child protection services (CPS) received 30, 993 calls of suspected abuse or neglect of children. Of those, 12,361 assessments for abuse or neglect were conducted with 30,091 children involved. When assessments determined abuse or neglect had occurred, child protection social workers (CPSWs) served 3,086 children in opened family services cases. In open family cases 1,779 children were in placement outside of the homes at any time during the year.[3] Under juvenile justice services (JJ), DCYF served 3,071 children, the majority of which were supervised in their homes but 499 were placed in institutions, including the Sununu Youth Services Center (SYSC) where 101 children entered the facility in 2019.[4] See Figure 1. for comparison of children served by child protective and juvenile justice services.

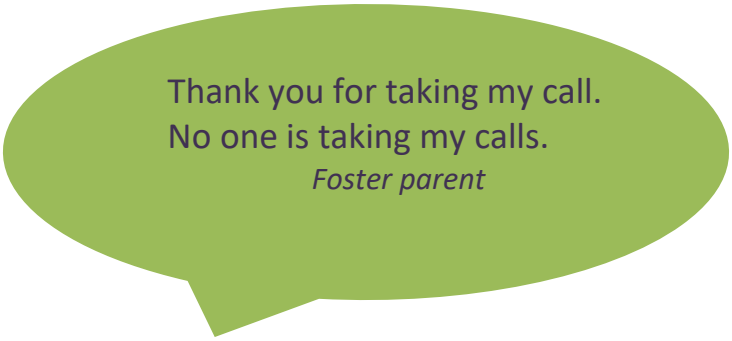
Figure 1. Children served in open DCYF cases by child protective and juvenile justice services



[1] New Hampshire Office of Strategic Initiatives, (2019). 2018 Population Estimates of New Hampshire Cities and Towns. https://www.nh.gov/osi/data-center/documents/population-estimates-2018.pdf
[2] New Hampshire Office of Strategic Initiatives (2016). Population by Age. Prepared by Economic & Labor Information Bureau, NHES. https://www.nhes.nh.gov/elmi/products/chartroom/documents/chart21.pdf
[3]Division for Children, Youth and Families, (2019). Annual Data Book 2019. State of New Hampshire Department of Health and Human Services CYF Annual Data Book 2019, available at https://www.dhhs.nh.gov/dcyf/documents/data-book-2019.pdf.
[4] *Ibid.*

CITIZEN CONCERNS

Under **RSA 170-G:18, III**(i), the OCA shall," 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."

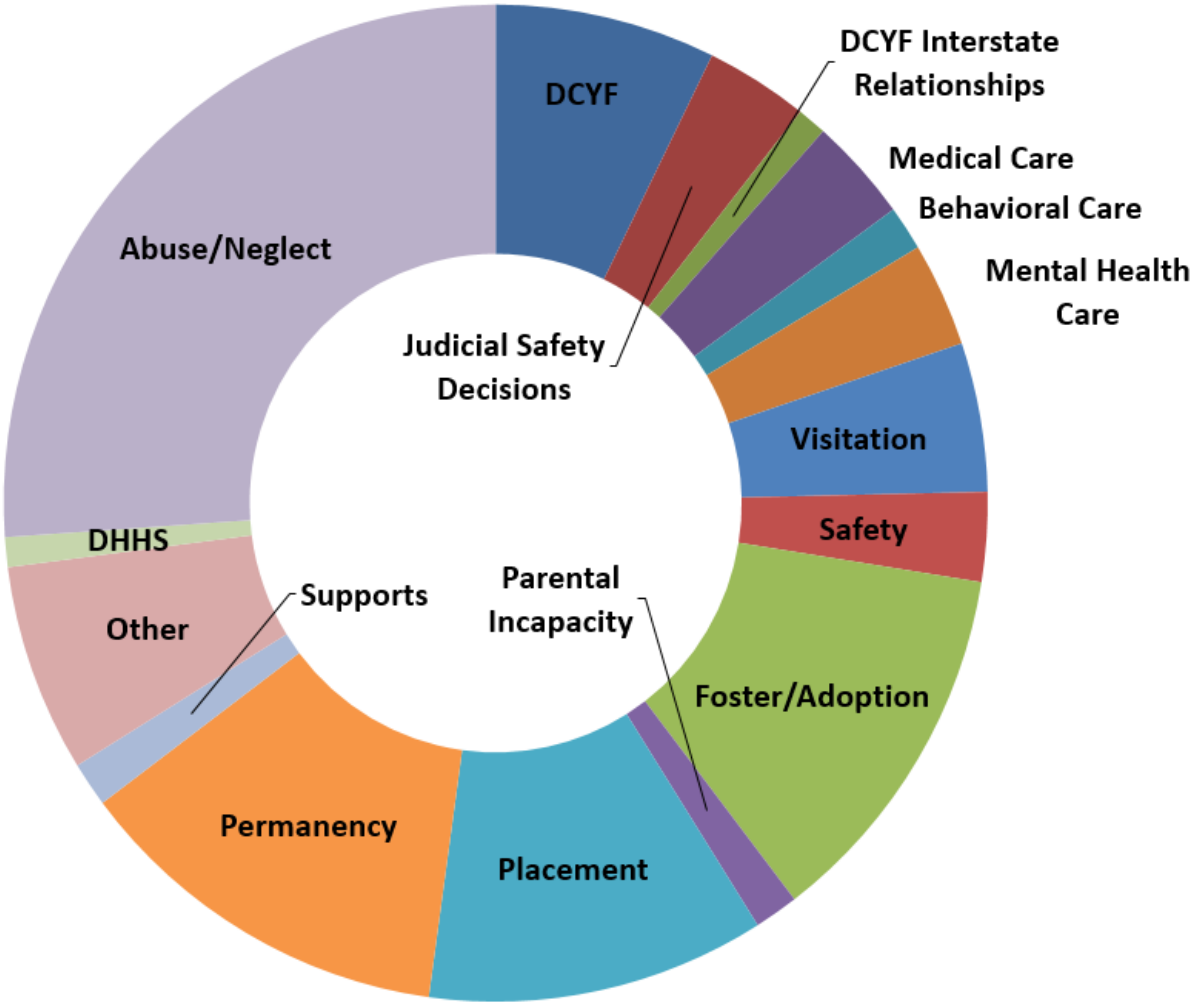


In the 2019 reporting period, the OCA received 331 calls, E-mails, visits, and office-initiated complaints from citizens concerned about the care and protection of children. The concerns came from parents, grandparents, and foster parents; children themselves, their caseworkers and court appointed special advocates; legislators, teachers, doctors, nurses and judges. The areas of child welfare concerns expressed by callers are depicted in Figure 2.

Themes that emerged among those concerns include the complexities involved in time for processes, the importance of contact, the impact of response, and the fairness of decisions. Citizens saw the essential need for children to have permanent homes as soon as possible. Lost time in delays, especially for the very young, are detrimental to child development. Oftentimes these delays are needed to allow parents to recover and gain necessary parenting skills, but this does not diminish the impact that delay in reunification or permanency has on children. Important relational bonds and sense of belonging are essential to the sense of permanency that equips a child with intellect, social skills, and engagement. And yet time away from family diminishes memory and may encourage new family just as hard to leave when or if reunification happens. Older children, approaching adulthood, without permanency face the complexities of jobs, college, and independent living without the benefit of a safety net in family.

Contact, meaning connection and presence in a child's life, was a key concern of grandparents and extended family. Whether seeking to guard children in their parents' absence or just visit regularly, many family members felt frustration from family separation due to circumstances beyond their control or that they just did not understand. Parents, while struggling with substance use or mental health, expressed the tragic loss of parental rights with little opportunity to maintain some place in a child's life because of persistent instabilities or inconsistencies in the capacity to be there for children. The best interests of children is to be with family, unless it is not. The great weight of these decisions effects everyone: children, parents, family members, foster parents and families, guardians, educators and caseworkers.

Figure 2. Child Welfare Concerns



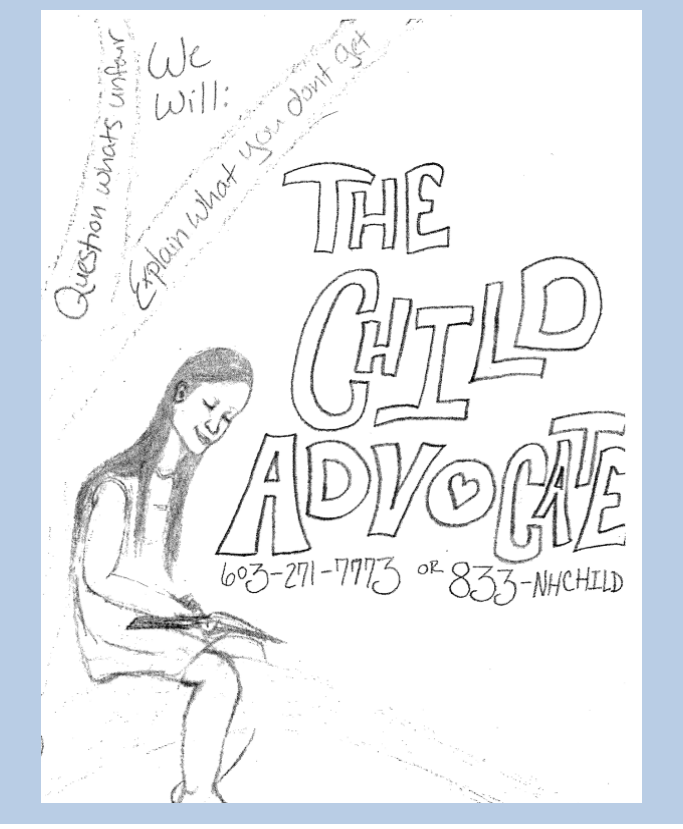
> MY CASEWORKER SAID SHE HAD 40 KIDS AND DIDN'T HAVE ENOUGH TIME TO DEAL WITH ALL OF THEM.
>
> NH Youth placed in a facility

A child's perception that a caseworker never visits or returns calls is that child's reality. The OCA lived the experience of the frustrated parent or foster parent's experience awaiting call returns. The OCA also heard from constituents who expressed positive relationships with caseworkers, but who witnessed the overwhelming caseloads and reported concerns to promote systemic change. Senate Bill 6 signed into law, establishing 77 new positions for DCYF over the next two years – hopefully enough to allow caseworkers to get some breathing room and address the backlog. But delays in hiring, and time needed for training left many caseworkers with increased caseloads once again and many calls unreturned in 2019. The OCA received reports from caseworkers themselves expressing alarm at the lack of support for them to get the job done.

The OCA heard about and from the Courts in 2019. Fairness was reported absent in lengthy delays to permanency or too swift action to terminated parental rights. Judges expressed frustration and lack of trust after receiving incomplete court reports. On the other hand, caseworkers reported concerns because judges ignored their recommendations even in cases they believed to be substantiated and complete.

All of the concerns the OCA received told the story of a system that still awaits an infusion to the workforce and an empowerment of staff to make decisions their experience informs them are the best ones for the children in DCYF's case. The remedy will not be positions filled alone. The calls the OCA received from frantic parents seeking mental health or behavioral health care for their children confirmed the gaps in services and the importance of Senate Bill 14 that will expand the system of care, if implemented as intended. With caseworkers and families well-resourced, results should be measured in lower abuse and neglect rates or fewer adjudicated children.

The OCA heard concerns about dropped calls to central intake and frustrations with the call system for reporting abuse or neglect. Parents, community partners and other members of the public reach out to central intake not only with concerns for abuse or neglect, but also for information and referral assistance. The OCA learned that the central intake office recently upgraded the phone system to a call center. Calls are now sent to a queue for the next available Central Intake worker, reducing the call wait time and dropped calls that callers may have previously experienced. Central Intake is now also able to track the average length of wait time to make adjustments responsively.



CRITICAL INCIDENTS

Pursuant to RSA 170-G:18 IV,(a), DHHS must "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."

In the 2019 reporting period, the OCA received notice of 694 incidents. Of those 694, 185 were incidents of missing children, 16 were of child deaths, and 338 were incidents that occurred at the Sununu Youth Services Center (SYSC) – the only facility for which the OCA received regular incident reports. See Figure 3. depicting incident reports received by category.

Incident reports received by the OCA did not reflect actual occurrence. Other than the electronic data management system in the SYSC and an organized database for monitoring reports of missing children, DCYF did not have a surveillance mechanism for tracking and monitoring incidents system-wide. Therefore, the data the OCA received skewed to a false appearance of highest incidence at the SYSC.

Upon receipt of an incident report, OCA staff enter the information into the OCA case management system for monitoring trends. We review each incident and, if necessary, a child's case is checked for any concerns about care, protection, and planning, whether for permanency or transition out of services. The OCA also checks for transition planning, access to special education services, clinical care, legal representation, and impending milestones such as eighteenth birthdates with impending release to be sure a plan is in place for a child's success in the community.

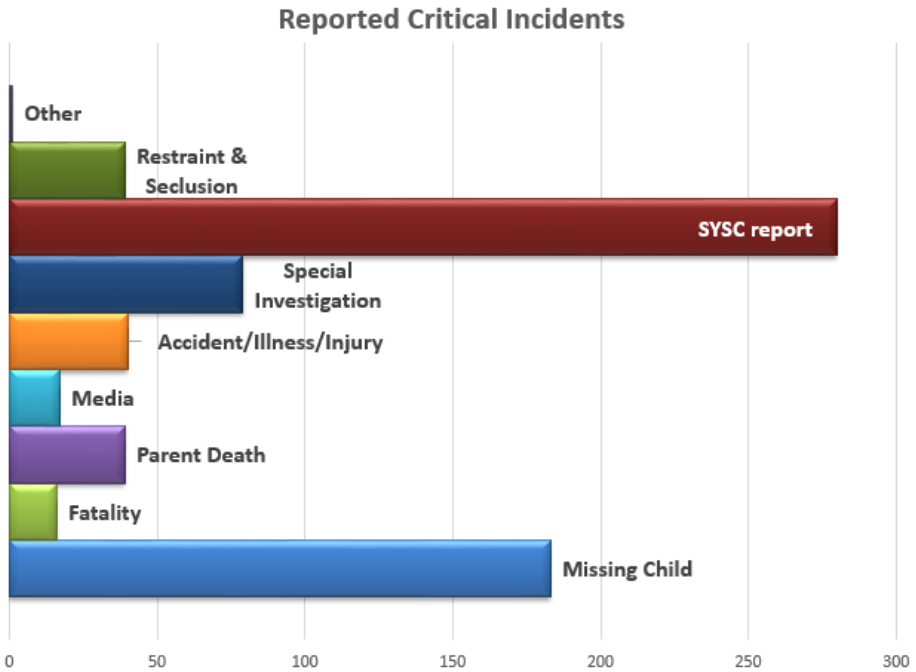
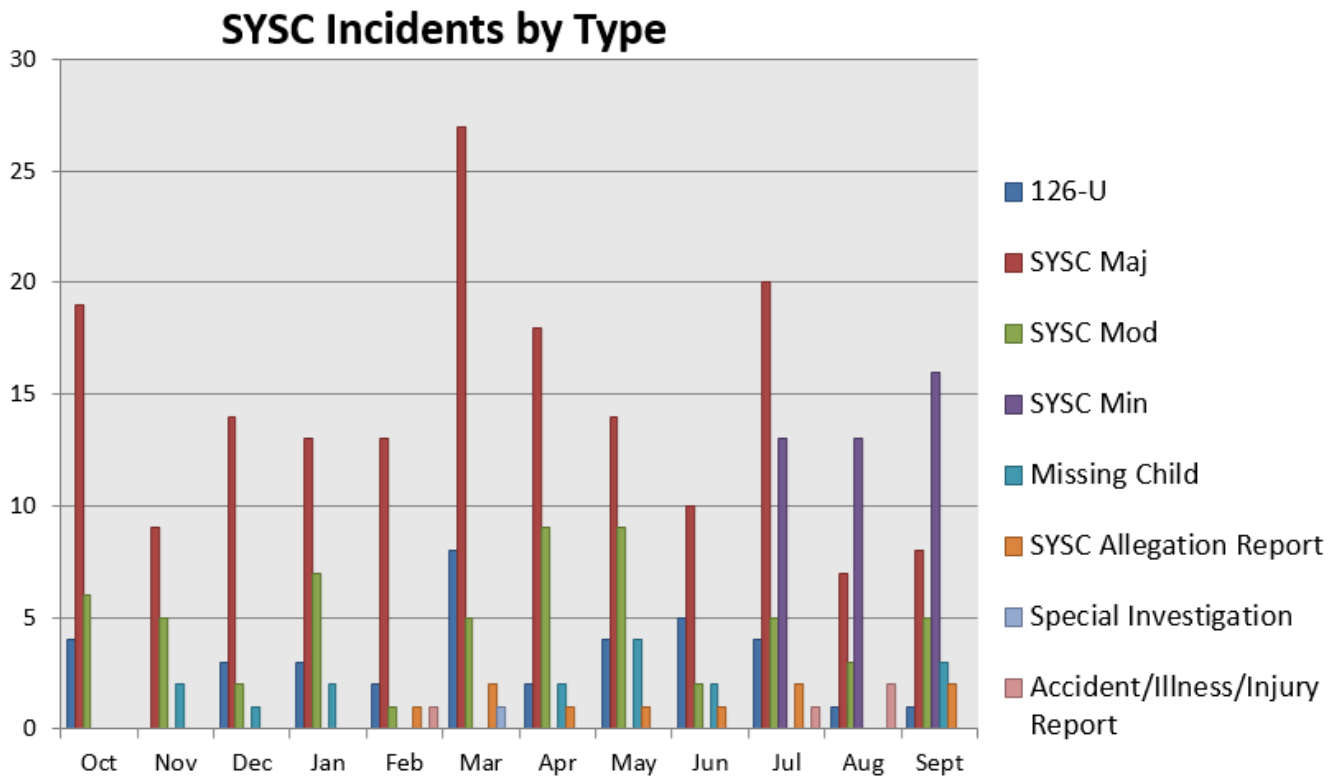


Figure 3. Incident reports received by category

Incidents at Sununu Youth Services Center

Figure 4. Incidents by type at SYSC



RSA 126-U - Restrictive intervention report determined to be seclusion or restraint

SYSC Maj - Major Incidents (Ex.: Assault, restraint, harassment, theft, gang drawings)

SYSC Mod - Moderate incidents (Ex.: horseplay, theft, threats, dishonesty, language)

SYSC Min - Minor Incidents (Ex.: damaging property, not following staff directives, disrespect to staff/peers, unauthorized movement, statements about absconding/going AWOL from the facility, inappropriate language)

SYSC Allegation Report - report for an allegation of sexual abuse or sexual harassment

Missing Child - reports of children/youth who left their legal place of residence without knowledge or permission of the parent, guardian or legal custodian or the juvenile justice system who escape or abscond

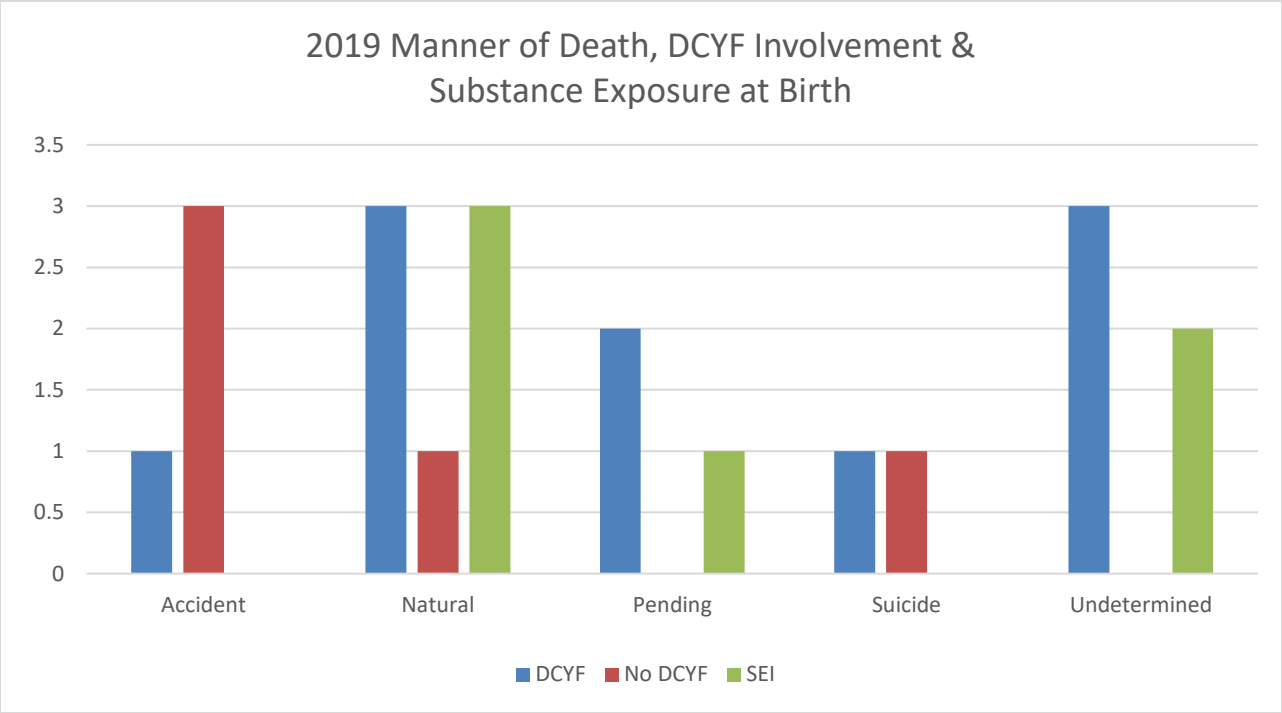
Special Investigation- DCYF Special Investigation Unit is assigned to respond to suspected abuse or neglect in residential treatment programs, foster family care and DCYF homes

Accident/Illness/Injury Report-report of accident/illness/ injury to youth in residential treatment programs, foster family care and DCYF homes

Incidents of Child Deaths

The OCA *2019 System Learning Review Summary Report* summarized incidents of child deaths since February 2018 when the OCA first began operations.[5] Sixteen child deaths occurred in this 2019 annual reporting period, ten with history of DCYF involvement, one with family history not involving the subject child, and five with no DCYF history other than a DCYF assessment of the child's death (Figure 5). Six of the children who died in the 2019 reporting period, ranging in age from 1 month to 2 years, were originally referred to DCYF due to being born exposed to substances.

Figure 5. Child deaths by manner and DCYF involvement



Incidents of Children Born Exposed to Substances

The incidence of children who were born substance-exposed and later involved in critical incidents, including death, suggested a pattern of risk in OCA monitoring. That trend prompted an OCA System Review (described below in the section on special reviews).[6] The System Review of DCYF's response to infants born substance exposed, just like the System Learning Reviews of child deaths that are also described below, demonstrate the OCA process of incident surveillance that informs oversight of DCYF. Observations of events involving individual children point to broader system issues that, when comprehensively examined, identify opportunities for system improvements.

[5]Office of the Child Advocate 2019 System Learning Review Summary Report (Oct. 30, 2019), available at https://childadvocate.nh.gov/documents/reports/2019-System-Learning-Review-Summary-Report.pdf

[6] Office of the Child Advocate System Review 2018-01 DCYF Enhanced Response to Substance Exposed Infants (Nov. 21, 2019), available at https://childadvocate.nh.gov/documents/reports/OCA-SR-Subs-Exp-Infants-11-22-19.pdf

SPECIAL REVIEWS: ISSUE BRIEFINGS AND SYSTEM REVIEWS

Issue Briefing: *Parents Incarcerated in the New Hampshire Prison System*[7]

The purpose of an Issue Briefing is to raise awareness of the issue and promote improvements to system response. Through a series of visits to New Hampshire State Prisons facilitated by the DOC Family Connections Center (FCC), the OCA learned of concerns regarding children whose parents are incarcerated. An estimated 15,000 New Hampshire children have experienced a parent's incarceration at some point.[8] On March 1, 2019 there were almost 1,500 New Hampshire children with parents in prison that authorities knew about.[9] Concerns expressed by parents who were incarcerated, combined with concerns received from other sources including foster parents, prompted the compilation of an Issue Briefing to bring to light the issue of children experiencing parental incarceration.

An incarcerated parent constitutes a significant loss to a child. It is an adverse childhood experience (ACE), impacting child development and, like other ACEs, leads to increased risk of long term physical and mental ailments.[10] Parents returning home after incarceration may be unprepared for the transition back to a caregiving role. Children also may require careful preparation for the reintegration of a parent into an evolved family routine with resumption of interrupted relationships. In cases involving DCYF, where families are further disrupted by out of home placements during a parent's absence or imposed supervision, communication between parents, children and DCYF is essential for maintaining relationships and/or achieving permanency. The DOC, as custodian of the parent, is a partner in facilitating those relationships or the process of children achieving permanency.

Children of parents who are incarcerated are at increased risk of being under care or supervision of DCYF. Child protection is guided by federal law. Most relevant to parents who are incarcerated is the federal Adoption and Safe Families Act,[11] that requires children have permanency in living arrangement within 12 months of being taken into care. During those 12 months, the state must make family reunification a priority. The most recent federal Child and Family Services Review assessed DCYF to be out of

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[7] Office of the Child Advocate Issue Briefing Case Number 2019-04-IS01 (Apr. 30, 2019), available at https://childadvocate.nh.gov/documents/reports/Issue-Briefing-Case-Number-2019-04-IS01.pdf

[8] The Annie E. Casey Foundation (2016) A Shared Sentence: The Devastating Toll of Parental Incarceration on Kids, Families and Communities. (Based on 2011-12 National Survey of Children's Health. Includes only children whose incarcerated parent ever lived with them).

[9] Viola, T, (2019). Negotiating the Prison System: To Have Better Outcomes for Children. Presentation at the DCYF Conference, Nashua.

[10] Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP, Marks, JS, (1998). Relationship of childhood abuse and household dysfunction to many of the leading cases of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4): 245-258. https://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract

[11] PL 105-89 https://www.govinfo.gov/content/pkg/PLAW-105publ89/pdf/PLAW-105publ89.pdf

conformance with the expectation of family engagement, especially with fathers.[12] Engagement is more complicated when parents are incarcerated. There is a disproportionate rate of terminated parental rights among those who are incarcerated. That is often due to length of sentencing that extends beyond the 12 months to permanency. In addition, obstacles to communicating about the DCYF and court process further interfere with maintenance of a child-parent relationship. Without consistent communication, parents may also not be informed of opportunities to maintain alternative relationships, such as voluntary mediated agreements with adoptions. In those arrangements, children achieve healthy permanency with a new family and, if agreed upon by adoptive parents, may have some form of contact with biological parents.

Through observations made during the prison visits, the OCA identified several themes of strengths and need for improvements in a brief assessment of the problems identified by parents who are incarcerated (Table 2.).

Table 2. DOC-DCYF System Strengths and Needs

STRENGTHS	**NEED FOR IMPROVEMENT**
• Parents' desire to maintain family relationships and connections with their children • Parent willingness to participate in parenting education • Access to parenting support and education, provided by the FCC • Facilitation by the FCC for family engagement • DOC supervision and assessment for safety • Supportive environment for parent-to-parent engagement • DOC new E-mail system with universal access • DOC system-wide telephone access • FCC staff and DOC case managers to facilitate communication • FCC staff presenting at DCYF leadership meeting and 2019 DCYF conference	• Federal Child & Family Review identified engagement of fathers as a key area for improvement • Insufficient funding for the FCC (limited staff, equipment, camp slots, other events) • Cost of E-mail/phone communication with DCYF, OCA • Obstacles to visitation for all parties due to transportation, paperwork, communication, and complex logistics of incarceration • Lack of transition preparation for parents and children at impending release to home • DCYF untimely communication regarding opening of cases, case status changes, caseworker changes, court dates • DOC case managers' untimely communication • DOC-DCYF familiarity with roles, contacts and procedures

Communication was identified as the key solution to maintaining relationships, complying with court orders and facilitating appropriate permanency plans for children when parents are incarcerated. The OCA identified needs in the process, obstacles encountered, and potential solutions that were summarized and provided to DCYF and DOC for system improvements. As a result, DCYF and DOC staff participated in meetings and staff trainings to clarify lines of communication and access to information. Paperwork for

[12] Children's Bureau, (2018). Child and Family Services Reviews: New Hampshire Final Report. U.S. Department of Health and Human Services, Administration for Children & Families, Administration on Children, Youth and Families.

visiting state prisons has been examined and refined. The OCA made recommendations for improving inmate access to communication through free phone calls and E-mails. The DOC assured the OCA that it would investigate the possibility of free calls to DCYF and the OCA. The OCA has not received an update as to whether that has been instituted. Access to tablets for video-visitation, currently limited to participants in the DOC FCC parenting educational programs, was also being considered.

Beyond DCYF and DOC prisons, publication of the OCA's Issue Briefing on children with parents who are incarcerated coincided with the availability of informative documentary films about children of incarcerated parents and their experience. The OCA facilitated collaborative relationships between the DOC FCC, New Futures Children's Behavioral Health Collaborative, Children's Hospital at Dartmouth and others in holding community forums for viewing the documentaries and engaging community conversations for further awareness raising.

System Review: *DCYF's Enhanced Response to Substance Exposed Infants*

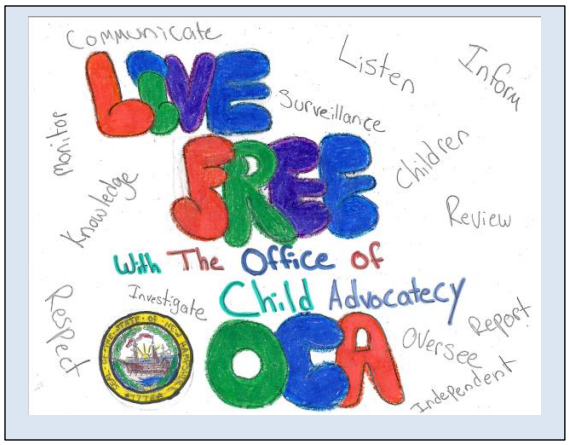
In December 2018, the OCA began a ten-month review and examination of DCYF's response to infants impacted at birth by virtue of being born exposed to substances in the context of the larger community system designed to preserve families and keep children safe. During the 2018-2019 reporting period, the OCA received alerts to 18 critical incidents involving children who were exposed to substances at birth. In addition to the children involved in critical incidents, the OCA encountered 14 children through citizen concerns brought to the OCA's attention or through case discovery in OCA case reviews.

Federal laws mandate two responses for states to address the high health and safety risk associated with exposure to substances at birth. Under the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction Recovery Act of 2016, to be eligible for a grant under the Act, governors are required to provide assurance that the state has a law or a statewide program relating to child abuse and neglect that includes policies and procedures "to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder."[13] This state law or program is to include a requirement that health care providers notify child protective services of the occurrence of such condition in infants.[14] Second, CAPTA requires assurance of the development of a plan of safe care for infants "born and identified as being affected by substance abuse or withdrawal symptoms" to ensure the safety and well-being of such infants following release from the care of health care providers.[15]

In New Hampshire, RSA 132-10-e requires health care providers to develop a plan of safe care for infants "born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder." Under, RSA 132:10-f, health care providers

[13] 42 U.S.C. §5106a(b)(2)(B)(ii)
[14] *Ibid*.
[15] 42 U.S.C. §5106a(b)(2)(B)(iii)

are mandated to report suspected abuse or neglect of an infant to DCYF, and, if the infant has a plan of safe care under RSA 132:10-e, such plan shall accompany the report.



DCYF's *1184 Enhanced Response* Assessment policy recognizes the importance of early intervention after birth. When there is a report of an infant born exposed to, and affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Syndrome, DCYF policy requires an "enhanced response assessment."[16] It is designed to ensure the health and well-being of the infant and to support parenting capacity to meet the infant's needs. During the course of the review, the OCA learned that DCYF is reviewing the *Enhanced Response Policy*.

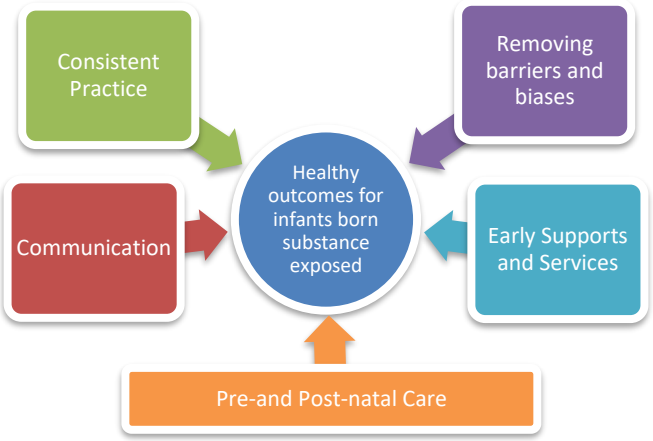
Of the thirty-two children born substance exposed and identified for the system review, the OCA conducted eighteen in-depth individual case reviews, and tracked recurring themes from the other fourteen cases. The OCA thoroughly reviewed relevant state and federal laws and DCYF policy and practice relating to infants exposed to substances, including *DCYF's Enhanced Response Policy 1184*.[17] Taking a collaborative approach, the OCA met with over eighteen DCYF staff members and numerous relevant community stakeholders, including hospital staff, treatment providers, pediatricians, obstetricians, and mothers with lived experience.

Early findings in the review demonstrated that the essential components underlying healthy outcomes for infants and their families is consistent interprofessional communication and relationships, and supportive, trauma-informed pre-and post-natal care. Figure 6. shows the interplay of necessary components to achieving healthy outcomes for infants born substance exposed and their families.

[16] *See* DCYF's *Enhanced Response Policy 1184*, available at https://www.dhhs.nh.gov/dcyf/documents/dcyfpolicy1184.pdf

[17] Note: The federally mandated plan of safe care is a separate and distinct plan than any plan required under the DCYF enhanced response policy. A plan of safe care is developed for every infant born exposed to substances whereas DCYF's *Enhanced Response Policy* applies only in cases involving suspected abuse and neglect.

Figure 6. Interplay of Necessary Components for Healthy Outcomes of Infants Born Substance Exposed



The System Review report was completed and published subsequent to the reporting period of this annual report.[18]

System Review Briefing: *Use and Reporting of Restraints and Seclusion of Children*

In May, 2019, the OCA opened a System Review of practices surrounding the use and reporting of restraint and seclusion on children placed in residential treatment facilities by DCYF, and the SYSC. This inquiry was prompted by concerns about the high reported number of restraint and seclusion incidents in New Hampshire. Despite the high numbers, the OCA was not regularly receiving reports of incidents of restraint and seclusion pursuant to the department's responsibility to report incidents under RSA 170-G:18 IV, (a). Over time, the OCA learned that this was due to the fact that DCYF did not have a centralized reporting system for incidents.

RSA chapter 126-U, the New Hampshire statute governing restraint and seclusion, limits use to only when there is a "substantial and imminent risk of serious bodily harm to the child or others."[19] Even though providers are legally limited to using restraints in emergencies only[20] and seclusion when behavior poses imminent risk of harm,[21] the department reported over 20,000 incidents of restraint and seclusion at DCYF-certified facilities since 2014.[22] To be clear, this number included incidents involving children at those facilities who were not involved with DCYF. However, because the numbers were in aggregate, and because the OCA was not receiving individual reports, there was no way of determining whether they

[18] Office of the Child Advocate System Review 2018-01DCYF's Response to Substance Exposed Infants (Nov. 21, 2019), available at https://childadvocate.nh.gov/reports.aspx.
[19] RSA 126-U:5, I, RSA 126-U:5-a, I
[20] RSA 126-U:5
[21] RSA 126-U:5 a, I
[22] RSA 126-U:9, II requires the commissioner provide an annual report to legislative committees of cognizance. The sum 20,000 plus was arrived at by adding *all* reported incidences of restraint and seclusion from the commissioners reports between 2014 and 2018.

represented an extraordinary number of emergencies, or widespread inability to meet children's behavioral needs.

There is no therapeutic benefit to the use of restraint or seclusion. The United States Department of Education states that "[t]here is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques."[23] Experiencing restraint or seclusion is physically and emotionally harmful to children, many of whom already have a history with abuse and other trauma. Application of restraint also affects staff members, including physical injuries and psychological harm.[24]

In addition to restricting use of restraint and seclusion and prone restraints, RSA chapter 126-U, mandates specific notification requirements when a restraint is used.[25] It further requires the Department of Health and Human Services (the Department) to periodically review practices and data collection and report annually on the number and location of reported restraints and the status of any outstanding investigations.[26] The law also mandates the commissioner to adopt rules for regular review of records maintained by facilities regarding the use of seclusion and restraint.[27]

Proper review of restraints and seclusion is necessary, not just to fulfill a statutory responsibility, but to ensure the health and safety of children under the care of DCYF and the staff who care for them. Insights and helpful recommendations can only be made from comprehensive analysis of detailed incident reports.

The restraint and seclusion System Review pertained only to DCYF policies and practices. The OCA received complaints about children placed residentially by educational services. However, the OCA has no jurisdiction over the education services and therefore is unable to review those cases or advocate for those children.

The System Review report was completed and published subsequent to the reporting period of this annual report.

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[23] U.S. Department of Education (2012). Restraint and Seclusion: Resource Document. Washington, D.C. Accessed at https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf.
[24] U.S. Department of Health and Human Services (2010). Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services. Accessed at https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf.
[25] RSA 126-U:7, 126-U:7-a
[26] RSA 126-U:9, II
[27] RSA 126-U:9, I(a)

System Learning Reviews

In February 2019, the OCA launched its System Learning Review process (SLR) of incidents and deaths of children involved with DCYF. The OCA is the first independent oversight agency that Casey Family Programs[28] 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 to create a review instrument and process specific to the OCA's oversight needs in conducting incident reviews. Collaborative Safety, LLC is a consulting agency that works with numerous public and private human services organizations throughout the country to develop systemic child fatality review processes and align organizational culture change to that process.

Collaborative Safety, LLC developed the SLR and accompanying instrument for the OCA to review deaths and incidents. The process accounts for the complexity of multi-system influences on child welfare decision making. It is a collaborative evidence-based review process grounded in safety science. Safety Science is an integrated science of evaluation that cultivates a safe environment for honest, open problem solving. By employing safety science, the OCA seeks to contribute to a "safety culture" conducive to active reflection, problem solving and learning, all necessary for improving practice and better outcomes for children.[29,30] In October 2018, Collaborative Safety consultants held a two-day training on the SLR process for OCA staff, DCYF staff, department staff, and legislators.

The purpose of the SLR is to understand how systems function and the influences of the systems on decision-making. This model has three approaches to system improvement:

1. Shift from a culture of blame to a culture of accountability
2. Focus on systemic methods of learning and investigation
3. Address underlying systemic issues with sustainable solutions rather than superficial issues with quick fixes.

SLR participants examine the case-specific and underlying systemic issues that, when addressed, will improve practice and service delivery to prevent injury or death. Throughout the process, information is strategically and thoughtfully connected to understanding the whole situation of a case and its outcome. DCYF frontline child protective workers, juvenile probation and parole officers, supervisors, field administrators, and other administrators participate in SLRs to provide local expertise in an examination of the system and context of events.

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[28] Casey Family Programs is a national charitable organization with the mission to provide, improve and ultimately prevent the need for foster care. https://www.casey.org/.

[29] 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.

[30] 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.

The OCA conducted six SLRs in the 2018-2019 OCA reporting period: five incidents of child deaths and one incident of a parent death.[31] All of the six SLRs involved cases for which at least one DCYF safety assessment was currently underway or had recently been completed.[32] The OCA's 2019 System Learning Review Summary Report was completed and published subsequent to the reporting period of this annual report.[33]

Safety Science training with DCYF staff, the OCA and others. October 25-26, 2018

SLR Participant Feedback

The OCA surveyed 35 DCYF staff who participated in the 2019 SLRs. 16 staff responded to the survey. Figure 7. shows the results of four of the nine survey questions.[34] All 16 respondents indicated that they would participate in another SLR. Some of the written responses to the survey questions included feedback regarding the process. The OCA has incorporated this feedback into the SLR process.

[31] On October 30, 2019, the OCA released its first System Learning Review Summary Report. The report can be found at https://childadvocate.nh.gov/reports.aspx .

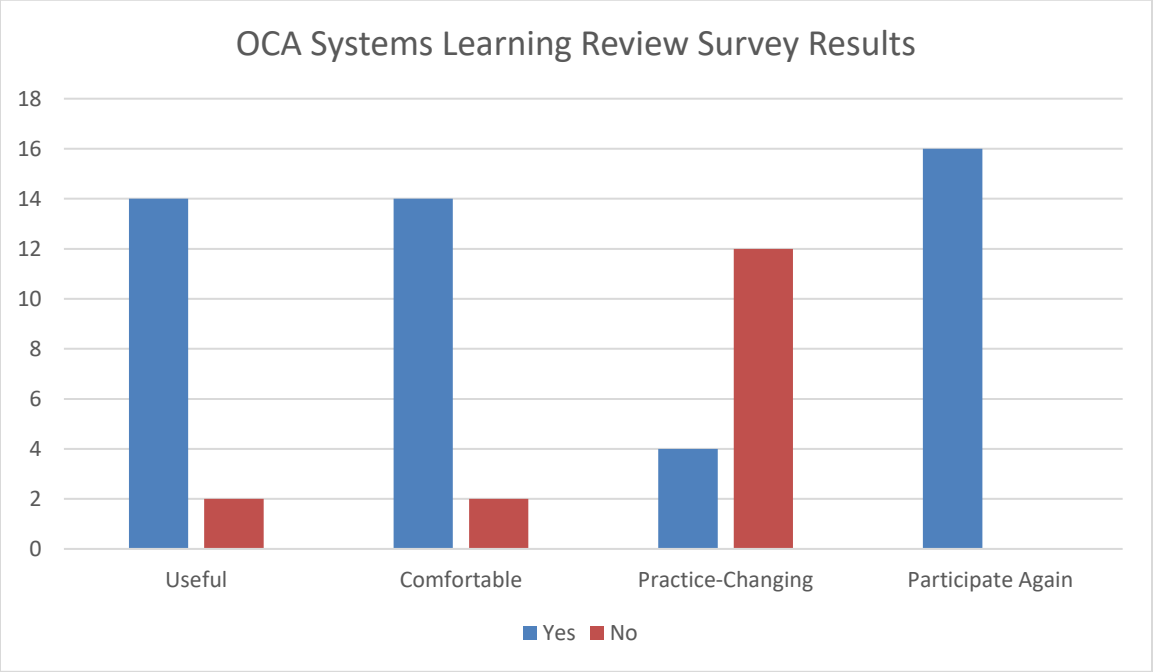
[32] Pursuant to DCYF Policy *1172 Planning the Assessment* "[t]he primary goal of the Assessment process is to ensure the safety of the child(ren)."

[33] Office of the Child Advocate 2019 Systems Learning Review Summary Report (Oct. 30, 2019), available at https://childadvocate.nh.gov/reports.aspx

[34] The remaining five questions were as follows:

1.) Did you feel that the materials provided adequately prepared you for the System Learning Review? (Responses: 16 yes, 0 no)
2.) Do you have any recommendations for changing the System Learning Review process? (Responses: 4 yes, 12 no)
3.) Would you feel comfortable recommending a case for the Office of the Child Advocate to review in a System Learning Review? (Responses: 13 yes, 2 no, 1 skipped)
4.) What is your role with DCYF? (5 CPSWs, 1 program specialist, 2 administrators, 5 supervisors, 2 field administrators, 1 skipped)
5.) Please provide any additional feedback or comments you have about the System Learning Reviews? (Individual responses)

Figure 7. Survey results of SLR DCYF staff participants



Useful	Did you find the Office of the Child Advocate System Learning Review useful for identifying system improvement and areas to strengthen case practice?
Comfortable	Did you feel comfortable participating in the System Learning Review?
Practice	Did you learn anything that has changed your practice or have you seen any changes to practice in your office since a System Learning Review?
Participate	Would you participate in a System Learning Review with the Office of the Advocate again?

Implementation of practice changes resulting from learnings at the SLRs has taken time, however, the OCA has heard feedback from DCYF administration that staff are appreciative of learnings from the SLRs and that some of the specific practice-enhancing learnings have been raised at meetings as a means for change. The OCA has also heard additional feedback directly from DCYF participants. One DCYF staff member described the SLR process as "a great learning experience" and reported that the staff member felt the "review process was positive and helpful." One supervisor shared that the SLR was "a very positive process" and that one of the supervisor's staff left "the review with many ideas about how [they could] use [the] information to inform practice in the future. It was very interesting to look at the assessments from a Systems perspective and to break down all the different areas that affect the work that we do." One field administrator wrote that she had spoken with some of her "staff who really liked the process. They felt that it was nonjudgmental and that it was quite helpful."

The OCA plans to conduct six SLRs in 2020. These reviews will continue to focus on incidents and child deaths, and will also include complex case review.

THE CHILD ADVOCATE'S WORKING GROUP ON JUVENILE JUSTICE

At the end of the OCA reporting year 2018, the Committee to Study Alternatives to the Continued Use of the Sununu Youth Services Center Facility, HB 1743, Chapter 355:7, Laws of 2018, recommended the Child Advocate convene a special working group on juvenile justice. Its purpose would be to review the future direction and needs of the state in terms of youth services including housing of troubled youth as well as treatment. The Committee recommended the working group be composed of experts in the "treatment and handling of troubled juveniles" as well as including both elected and appointed officials and members of the public. The working group was charged with developing a 10-year program model to modernize the state's youth incarceration program and facilities by studying the latest work of other states. The Committee emphasized a special emphasis on the provision of treatment of all levels of care in addition to ensuring adequate resources.

SYSC Word Art

The Child Advocate's Working Group on Juvenile Justice first convened in January 2018. The group includes: DCYF staff and administrators, including SYSC staff; public defenders, residential and clinical providers, advocates, legislators, juvenile diversion, the Disability Rights Center, Court personnel, a parent, advocates and the Department of Education. Early meetings were dedicated to examining the current system of juvenile justice from first point of contact, diversion, court processing, probation, detention, confinement and after care. Issues addressed included access to prevention services, parental reimbursement for services, and assessment of children's needs. Invited speakers included a young adult who experienced 7 years of juvenile justice involvement. The OCA also cast a wide net for resources in accordance with the Committee's call for developing a 10-year plan by studying the developments in other states. Table 3. contains a select list of persons and organizations who have assisted the Working Group to craft a framework for the project.

Table 3. Networking results: Resources and supports to the Child Advocate's Working Group

RESOURCE	SUPPORT
Nancy Weiss, MSW Director, Disability Initiatives, University of Delaware; National Leadership Consortium on Developmental Disability	Provided guidance and resources for promoting understanding needs of children with developmental disabilities and positive behavioral interventions
Tim Curry, Esq. Legal Director, National Juvenile Defender Center	Provided guidance and expertise in examining systems of public defense for children. In parallel to the OCA's efforts, the NJDC began a statewide assessment of legal defense of children; the report is due in summer 2020.
Abby Anderson, Executive Director, Connecticut Juvenile Justice Alliance	Reviewed CT's experience with reform. Emphasized importance of planning and establishment of array of services. Described missteps in planning for closing CT's juvenile correctional facility. Encouraged engagement of children and families. Provided other resources.
Liz Ryan, President and CEO, Youth First Initiative Jill Ward, Youth First Initiative Maine Carmen Daugherty, Youth First Initiative WDC	Provided guidance in engaging children and elevating children's voice. Reviewed policy and federal grant obligations
Vincent Schiraldi, Senior Research Scientist Columbia University, Co-Director Justice Lab Vidhya Ananthakrishnan, Director Youth Justice Portfolio Lab, The Justice Lab	Provided guidance in research, consensus building, educating, and reform. Connected the OCA with Youth Correctional Leaders for Justice, a partner of the Justice Lab
Jane Tewksbury, Past Executive Director of MA Dept. of Youth Services, Past Director of the Brazelton Center at Boston Children's Hospital, member Youth Correctional Leaders for Justice	Provided guidance in state juvenile justice needs assessment, consensus building and planning for juvenile reform. Featured speaker at the Working Group's Juvenile Justice Forum
Patrick McCarthy, Past Executive Director and CEO of Annie E. Casey Foundation, Past Commissioner of Delaware Youth Corrections , member Youth Correctional Leaders for Justice	Provided guidance, conducted a system review/assessment of current conditions and needs. Featured guest at the Working Group's Juvenile Justice Forum
Mara Sanchez, Juvenile Justice Program, Cutler Institute, University of Southern Maine	Shared Asset Mapping Project alignment with community-based continuum of care, including workforce resources, results based accountability, municipal responsibilities, academic partners and data.
Keller Strother, Director, MST Services	Featured guest for forum on multi-systemic therapy, a 24/7, evidence-based intensive child and family driven treatment

In June 2019 the Working Group hosted a forum featuring representatives of the national organization Youth Correctional Leaders for Justice, a partner of the Columbia University Justice Lab.[35] Two former youth correctional leaders, Jane Tewksbury of Massachusetts, and Patrick McCarthy of Delaware, lead a community conversation and met with key legislators. They provided guidance for development of the Working Group's strategic plan.

The results of the community conversation and Patrick McCarthy's statewide assessment were synthesized into major themes of action:

- New Hampshire leads the nation in the general wellbeing of its children. It has a small number of children in out of home placements. NH could be a national model for juvenile justice.

- There is a consensus vision in NH for juvenile justice but the details need to be developed. Many of the children placed in SYSC have experienced multiple failed placements in other programs, but after a brief period at SYSC, they are released to return home.

- Public safety is the ultimate concern but research shows the best investment in long-term public safety, is to address underlying causes of entry into the juvenile justice system. Misaligning services to a child's individual needs is harmful. In the trajectory of a child to SYSC, we need to find out what was missed that would have helped to keep the child at home or in the community.

- Research has shown that a probation model focused on "accountability as punishment" and emphasizing compliance and sanctions, rather than incentives and success, does not support positive outcomes. New initiatives focused on positive outcomes for children, family and the community will provide opportunities for staff leadership, professional development and growth.

- The child and family system as a whole lacks a smooth streamlined process. Child Welfare, Juvenile Justice, Behavioral Health, and the School System should be viewed as a single continuous system where a child's individual service plan is carried out across agencies with coordinated case management. The result of disconnected system siloes has been a high rate of residential placement.

- A narrative of worsening juvenile crime rates and violence is widely accepted as fact but is contradicted by data from law enforcement, the courts, and juvenile justice. The children's actual narratives are poorly understood. A better understanding of a child's treatment needs combined with knowledge of brain science and child development, can inform effective interventions for both public safety and child well-being.

- Individualized, intensive wrap-around services for children and their families grounded in quality strengths-based needs assessments have been proven to lead to successful outcomes. With that assessment information, it is likely that the majority of children at SYSC and in other institutional settings could be transitioned home successfully and efficiently, with a full continuum of care in the community. There is no need to wait for a new "system" to be in place. Piloting intensive,

[35] The Columbia Justice Lab is using research, policy development, and community engagement to examine and move forward justice reform. One of the initiatives of the Justice Lab is a Youth Justice Initiative promoting a more community-centered approach to juvenile justice. See https://justicelab.columbia.edu/.

individualized wrap around supports and services with a small group of children will instruct the development of a broader system of care.

- One critical need is to hear more from the children themselves, 30-40 spokespersons, as a means of building community understanding and empowering self-care and advocacy.

- An expressed area of concern was a recent change to detention screening. It will be important to ensure that all screening/assessments are used consistently and comprehensively measure each child's needs/strengths, in addition to risk.

- A key component to success will be good descriptive data to answer key questions about how to improve outcomes for children, families and communities.

- Provider support in the form of guidance, training, re-designs and adequate reimbursement will enhance innovation in juvenile justice care.

> "For both Child Welfare and Juvenile Justice, there is a total of almost 400 kids in residential treatment/congregate care, including 70 placed out of state; 200 of these are juvenile justice-involved youth. So while the rate of incarceration may be low, the rate of residential placement is quite high."
>
> *Patrick McCarthy, Youth Correctional Leaders for Justice*

To acknowledge and address each of the identified themes, the Working Group has established seven subcommittees aimed at drilling down the best design and practices to meet the needs of New Hampshire children. The subcommittees include:

Safety Subcommittee: Examining quality and effectiveness of risk assessment and conditions of confinement as they effect children; and surveying children, communities and stakeholders on perceptions of safety

Staff Innovation and Leadership Opportunities Subcommittee: Examining need and opportunity for training, leadership in innovation, and staff-generated re-design of roles and responsibilities

Finance Subcommittee: Evaluating use of funds in the juvenile justice system as related to desired outcomes and potential cost savings in community-based intensive wrap-around services

Status of Children Subcommittee: Identifying resources for children's needs assessment capacity, including during system reform; identifying enhanced transition from institutional care to community; examining methods to integrate in-depth child development and brain science in current staff training; identifying family needs and potential for engagement during system innovation

Community-Based Services: Considering asset mapping; reviewing quality assessment component of federal and state licensing requirements for community-based programs and ratings history for each programs; creating a population-level needs assessment; examining benefits of models of care and availability: Multi-Systemic Therapy (MST), Family Functional Therapy (FFT)

Process & Procedure Subcommittee: Reviewing training of lawyers, judges, and juvenile probation and parole offices (JPPO); assessing the scope of representation by defense attorneys and their access to dispositional expertise within the scope of the attorney-client privilege; assessing supervision, support and guidance for JPPO

Data Subcommittee: Promoting access to and use of reliable data; conducting an assessment of available data and match to data needs; formulating clear questions to determine if there is a need to collect additional data not currently collected; matching outcomes with financial expenditure data; making recommendations for Bridges system redesign; exploring options for looking at data across systems (juvenile justice, child welfare, health care, education)

A preliminary report of the Child Advocate's Working Group on Juvenile Justice is due in Spring 2020.

Transforming Juvenile Probation Certificate Program

The collaboration of the Child Advocate's Working Group on Juvenile Justice situated the OCA to be in a position to support an exciting opportunity for New Hampshire that puts planning into action. The *Transforming Juvenile Probation Certificate Program* is an offering of the Georgetown University Center for Juvenile Justice Reform and the Council on State Governments Justice Center. The Annie E. Casey Foundation awards grant funding to state teams to participate in this intensive training and mentored capstone project.

NH Probation Reform Team at Georgetown University

DCYF recruited a team and successfully submitted a proposal with input from the OCA. The New Hampshire team includes the DCYF director, a juvenile justice administrator and supervisor, a public defender, a prosecutor, a District Court judge, a coordinator of a diversion program, and the director of the OCA.

The focus of the program is to improve outcomes for children who encounter the juvenile justice system. Probation, as we see in New Hampshire, is generally the default disposition for children. Approximately 95 percent of children involved in juvenile justice receive supervision at home on probation rather than confinement at the SYSC. Yet there have been no adjustments to the rules of probation for 20 years. The rules and orders associated with probation are

often disconnected from a child's offense and the goal of recidivism reduction. Furthermore, the system response to violations are counterproductive, despite minimal danger to society.

The team will endeavor to expand diversion opportunities and redesign the rules of probation. Having learned that just contact with the system sets a child on course for poor outcomes, the team will focus on diversion from the system and promoting positive youth development opportunities that assist children in achieving the developmental milestones of adolescence that lead to success. The team will submit a capstone project proposal. In addition to a weeklong intensive training at Georgetown University, the team will be supported by the national experts as the project is researched, designed and implemented in the coming year.

OFFICE OF THE CHILD ADVOCATE ACTIVITIES

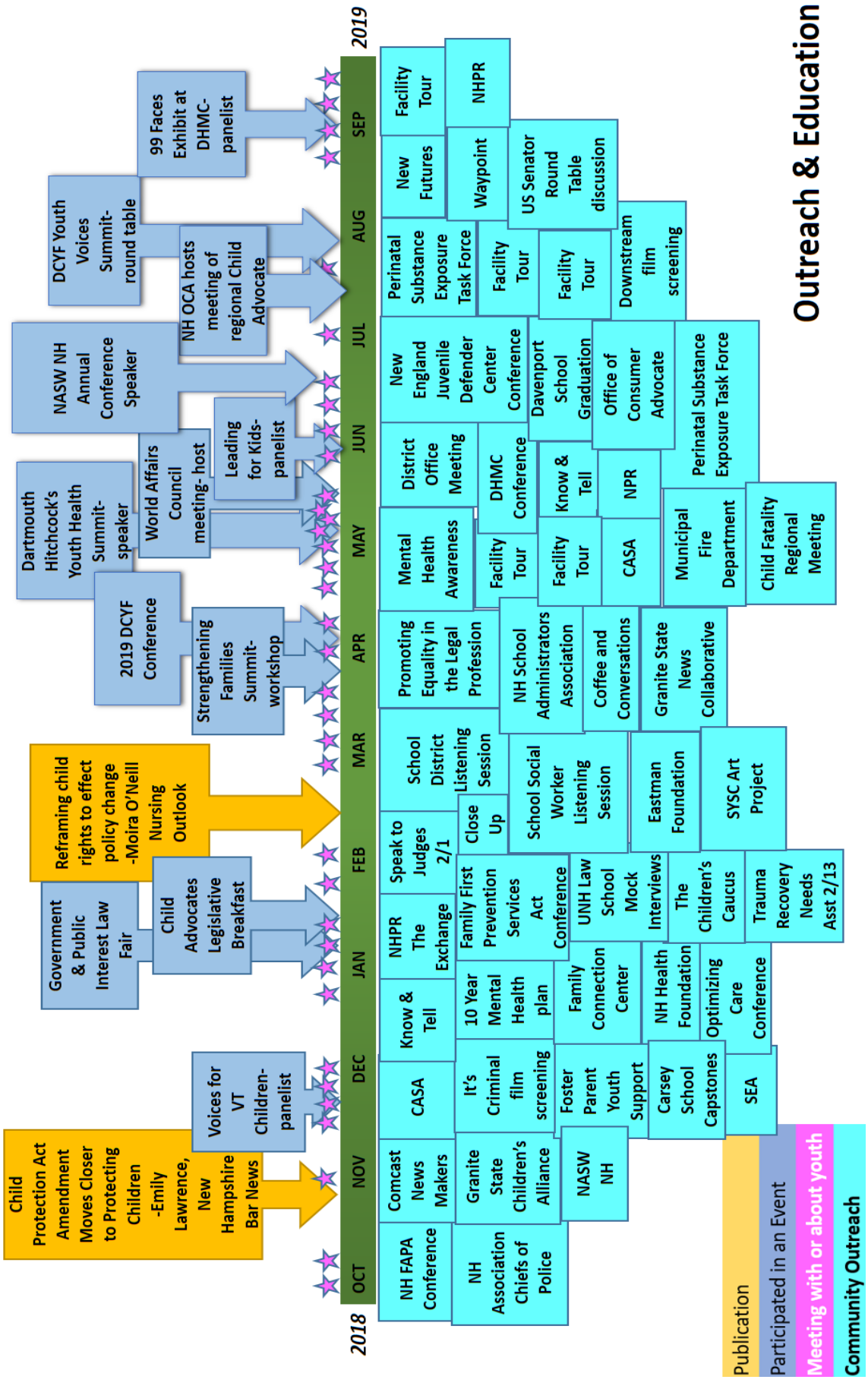
Pursuant to RSA 170-G:18, III,(h), the OCA shall "perform educational outreach and advocacy activities in furtherance of the mission and responsibilities of the office." Most of the 331 cases the OCA opened from citizen concerns involved provision of information and coaching for navigating DCYF and other state systems. As the mission and mandate of the OCA includes promoting children's interests, the OCA serves as a platform for contributing to the dialogue about children in New Hampshire. That includes participating in conversations and events about child development, children's physical, mental, and behavioral health; best practices and standards of care in children's services, and state and federal policy affecting children.

In the 2019 reporting period, the OCA participated on the continuum from local to national, and international conversations about children. The OCA was at the table with child advocates from across the country to talk about the language of child advocacy at a meeting convened by Leading for Kids. Leading for Kids is a new advocacy organization committed to improving the health and well-being of children by creating a movement to change how we talk about children, how we can invest wisely and productively in their futures, and how our decision makers can better protect their rights and reflect their voices.[36]

Regionally, the OCA convened a meeting of our neighboring New England child advocates and ombudsman from Maine, Massachusetts, Connecticut and Rhode Island. It was the first meeting of its kind. It allowed for establishing helpful relationships for our practice and for shared responsibility when children cross borders as New Hampshire's children often do.

In between those bigger conversations, the OCA routinely met with the governor, legislators and legislative committees, DCYF and other state agency administrators, advocacy organizations, public defenders, judges, medical providers, and perhaps most importantly, children, parents, foster parents, and extended family. A visual review of select activities and events follows on the next two pages.

[36] https://www.leadingforkids.org/


Outreach & Education
2018
2019
OCT
NOV
DEC
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MAR
APR
MAY
JUN
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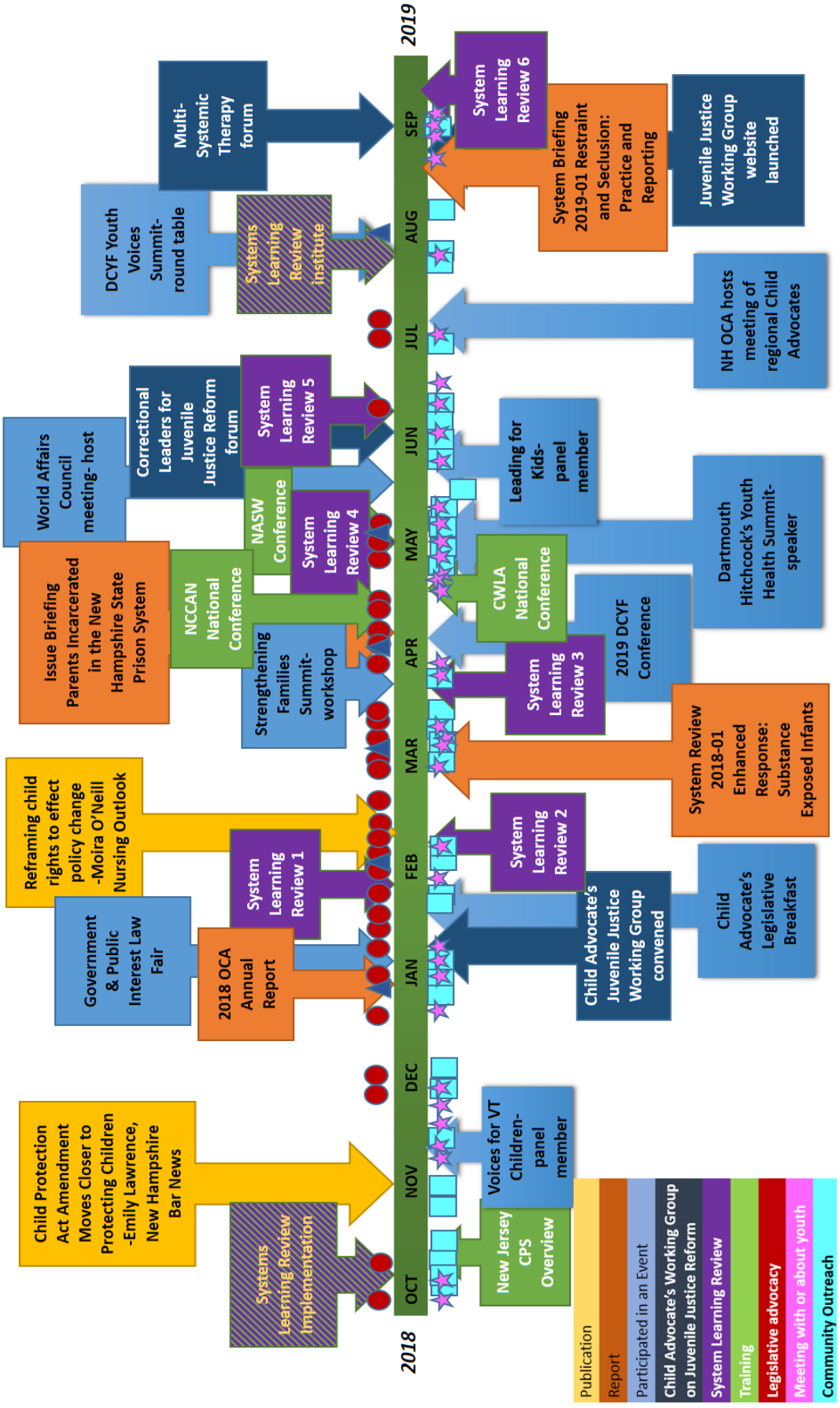
AUG
SEP
NH FAPA Conference
NH Association Chiefs of Police
Comcast News Makers
Granite State Children's Alliance
NASW NH
CASA
It's Criminal film screening
Foster Parent Youth Support
Carsey School Capstones
Know & Tell
10 Year Mental Health plan
Family Connection Center
NH Health Foundation
Optimizing Care Conference
SEA
NHPR The Exchange
Family First Prevention Services Act Conference
UNH Law School Mock Interviews
The Children's Caucus
Trauma Recovery Needs Asst 2/13
Speak to Judges 2/1
Close Up
School District Listening Session
School Social Worker Listening Session
Eastman Foundation
SYSC Art Project
Promoting Equality in the Legal Profession
NH School Administrators Association
Coffee and Conversations
Granite State News Collaborative
Mental Health Awareness
Facility Tour
Facility Tour
CASA
Municipal Fire Department
Child Fatality Regional Meeting
District Office Meeting
DHMC Conference
Know & Tell
NPR
Perinatal Substance Exposure Task Force
New England Juvenile Defender Center Conference
Davenport School Graduation
Office of Consumer Advocate
Perinatal Substance Exposure Task Force
Facility Tour
Facility Tour
Downstream film screening
New Futures
Waypoint
US Senator Round Table discussion
Facility Tour
NHPR
Child Protection Act Amendment Moves Closer to Protecting Children -Emily Lawrence, New Hampshire Bar News
Voices for VT Children-panelist
Government & Public Interest Law Fair
Child Advocates Legislative Breakfast
Reframing child rights to effect policy change -Moira O'Neill Nursing Outlook
Strengthening Families Summit-workshop
2019 DCYF Conference
Dartmouth Hitchcock's Youth Health Summit-speaker
World Affairs Council meeting- host
Leading for Kids-panelist
NASW NH Annual Conference Speaker
NH OCA hosts meeting of regional Child Advocate
DCYF Youth Voices Summit-round table
99 Faces Exhibit at DHMC-panelist
Publication
Participated in an Event
Meeting with or about youth
Community Outreach

2019 OCA REVIEWS AND ACTIVITIES



LEGISLATIVE CONSULTATION

OCA Staff at the State House

The 2019 legislative session was an active one for the OCA. The OCA monitored and reviewed a number of proposed bills, and met regularly with legislators and advocates regarding legislation. In addition, the OCA was a member of a multidisciplinary group examining children's rights in New Hampshire.

Senate Bill 6, *An act relative to child protection staff and making an appropriation therefor*
SB 6 appropriates funding to DHHS to hire 27 CPSWs in fiscal year 2020 and an additional 30 CPSWs in 2021. The bill further appropriates funding to DHHS to hire 9 child protective service worker supervisors in fiscal year 2020 and an additional 11 supervisors in 2021.

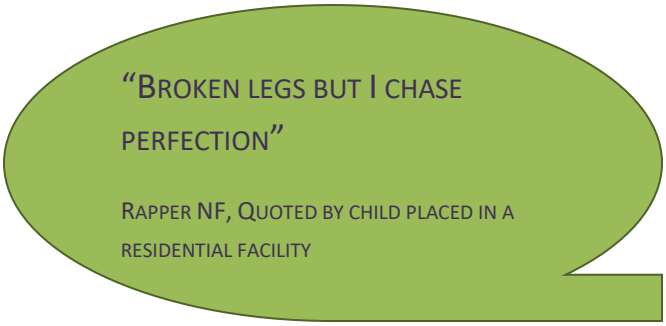
The OCA provided testimony in support of the bill on January 22, and April 9, 2019. The OCA advocated that these positions are critical to ensuring child safety by addressing the insufficient workforce. The OCA cited high caseloads and staff turnover as affecting CPSWs ability to effectively perform their job and protect children. In addition, the OCA noted that the bill did not address the equally important need for district office nurses, program specialists, administrative support, Bridges support or a research analyst.

The bill passed and the Governor signed it into law on June 3, 2019.

Senate Bill 14, *An act relative to child welfare*
SB 14 established an improved system of care for children's mental health services including mobile crisis response and stabilization services. The bill requires DHHS to establish case management entities as part of a system of care for children and to establish contracts with behavioral health service providers to comply with evidence-based practices. It further requires DHHS to establish a family support clearinghouse and system of care advisory committee. Additionally, the bill mandates utilizing assessments and treatment planning for all children in court-ordered placements and requiring medical assistance screenings of children in the juvenile court system.

On February 12, and April 9, 2019, the OCA provided testimony in support of SB 14. The OCA advocated that the bill is necessary to prevent or further prevent adverse childhood experiences. SB 14 addresses the growing unmet mental and behavioral health needs of children in New Hampshire by creating an evidence-based infrastructure to address those needs. SB 14 is also necessary to align New Hampshire with the requirements of the Federal Family First Prevention Services Act of 2018 and situate New Hampshire to maximize child welfare while capitalizing on federal funds and cost savings in the long run.

The OCA recommended a few minor changes to the bill. Senate Bill 14 phases in coverage of children receiving coordinated care by small percentages over two years. The OCA recommend that *all* children should receive coordinated, individualized care from the start. The OCA also suggested that membership of the System of Care Advisory Committee include families and children who have aged out of the DCYF system with first-hand experience of the state's care. The legislature adopted this recommendation. In addition, the OCA recommend all services have some track record for empirically proven success to bring the state into alignment with the federal law for optimizing federal funds, rather than phasing in a small percentage of evidence-based programs.



The bill passed and the Governor signed it into law on June 3, 2019.

Senate Bill 30, *An act relative to the advisory board on services for children, youth, and families*
SB 30 broadened the membership criteria for members of the advisory board on services for children, youth, and families and establishes a quorum.

The OCA testified in support of the bill in concept on April 16, 2019. The OCA suggested amending the bill to include representation of families impacted by the DCYF as the voice of families and family experience is crucial to guiding DCYF in serving them. The legislature accepted this recommendation and included members of the public whose family has been affected by DCYF as required members of the advisory board.

The bill passed and the Governor signed it into law on July 29, 2019.

Senate Bill 107, *An act relative to extended foster care under the child protection act*
SB 107 provided that voluntary services under the child protection act may include the extension of foster care to individuals under 21 years of age who meet criteria regarding education and/or employment, or who are incapable of meeting the requirements due to a medical condition.

The OCA testified in support of this bill on January 29, 2019, but advocated for clarity in the bill's eligibility requirements. The OCA recommended that the requirement include persons who, under RSA chapter 169-B, were in custody due to delinquency.

Stability in foster care or other supports will change a life's trajectory from tragedy to productivity and wellbeing. A recurring theme in accounts of children involved with DCYF is that they decline to extend services with DCYF and months later realized they just cannot make it on their own. The OCA advocated that SB 107 is critical to providing individuals with services any time prior to the 21st birthday. The OCA further believes this option will benefit young people with substance use disorders. The OCA explained that, with increasing access to substance use treatment through the Governor's hub and spokes project, young people may recognize the opportunity DCYF has to offer once progressing with recovery.

The bill was laid on the table in the Senate Finance Committee.

Senate Bill 118, *An act establishing a child fatality review committee* SB 118 established a child fatality review committee to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire. The committee would use the reviews to identify factors associated with the deaths and make recommendations for system changes to improve services for infants, children and youth.

The OCA testified in support of SB 118 in concept on February 12, and April 30, 2019. The OCA explained that SB 118 is necessary to fulfill the critical public health function of child fatality review in identifying system learning points in state and local systems that may prevent child injury and death. The OCA successfully recommended striking the language in the bill describing one of the objectives of the committee as enabling state agencies, law enforcement, health care providers and community-based organizations to potentially prosecute child fatalities. The OCA explained that the purpose of child fatality review has historically been system improvement, not prosecution. The OCA also noted that the bill is vague on how the committee would access information necessary for conducting child fatality reviews, explaining that access to information is critical to conduct comprehensive child fatality reviews and identify system learning points for effective changes in public health policy.

The bill passed and the Governor signed it into law on July 29, 2019.

Senate Bill 125, *An Act relative to parental reimbursement for voluntary services provided under the child in need of services (CHINS) programs* SB 125 established, in relevant part, that the cost for any services, placement or programs provided pursuant to a voluntary service plan under RSA chapter 169-D shall not be subject to parental reimbursement under RSA 169-D:29.

On January 29, and April 9, 2019, the OCA testified in support of SB 125. The OCA explained that SB 125 is necessary given that the very reason families petition for assistance under RSA chapter 169-D is a lack of resources to access services for children with problematic behaviors or mental health needs. Improving access to voluntary services helps to eliminate the obstacle of financial burden to already stressed parents and reduces the risk of placing children on a trajectory for long term failure, with increasing cost to the state.

The bill passed and the Governor signed it into law on July 10, 2019.

Senate Bill 274, An act *relative to the newborn home visiting program* SB 274 made home visiting programs for children and their families available to all Medicaid eligible children and pregnant women without restriction.

The OCA appeared at February 12, and April 3, 2019 legislative hearings in support of the bill.

The bill passed and the Governor signed it into law on July 19, 2019.

House Bill 377, *An act relative to the best interests of the child under the child protection act* HB 377 would amend the purpose of the child protection act to require that the best interest of the child be a primary consideration of the court in all proceedings under RSA chapter 169-C. The bill would also amend the language to include a determination of whether preservation of family unity is in the best interest of the child. The bill further provided that RSA chapter 169-C shall be liberally construed to achieve the stated purposes and policies, whenever it is in the best interest of the child, by keeping the child in contact with his or her home community and in a family environment.

The OCA testified at a hearing on HB 377 on March 5, 2019. In addition, the OCA met with leaders on the House Children and Family Law Committee to discuss the bill. The OCA raised questions about whether HB 377 is necessary or whether changes made to the provision in 2017 have yet to be fully adopted by courts and practitioners. The OCA also expressed concern about the "best interest" language given that defining and interpreting the concept of best interest is complex. Additionally, the OCA suggested that there is a need to clarify the meaning of psychological maltreatment. The OCA recommended that the bill be retained in committee for further study.

Subsequently, HB 377 was retained in committee. On September 10, 2019, the OCA testified in support of the bill in concept before a subcommittee work session. Subsequent to the September 10th hearing, the OCA provided written answers to questions posed at the hearing. The OCA continues to question whether the current statute is insufficient in rendering the child's interests as primary or if the 2017 changes have yet to be translated to practice. The OCA encourages the legislature to consider amending the bill to provide some direction in determining best interest of the child that allows flexibility for variations in individual child's circumstances.[37]

House Bill 437, *An act establishing a commission to study parental alienation* HB 437 established a committee to study parental alienation. The committee would study the relationship between parental alienation and domestic abuse, violent crime, substance abuse, and mental illness. It would examine causes, costs, and effects of parental alienation in New Hampshire, and identify preventative measures that may be used to prevent or minimize the effects of parental alienation. Finally, the committee would solicit testimony from any organization or individual with information the commission deems relevant to its study. On February 12, 2019, the OCA testified in support of HB 437. One of the most common calls the OCA receives is about child custody disputes. The Office has no oversight of the courts, where these disputes are processed, but the OCA sees a pattern in disputing parents attempting to engage child protection. There is significant risk for child maltreatment, particularly psychological maltreatment, in the process and parental alienation may be part of that. We know that parental relationships are essential to healthy child development. We also know that loss of a parent is an adverse childhood experience with long-term implications. The OCA believes that a study commission would be helpful to clarify what parental alienation is, how it is assessed, and whether there are effective interventions for prevention or treatment.

[37] On October 31, 2019, majority committee voted to pass the bill with amendment.

Subsequent to the OCA's testimony, HB 437 was amended to establish a commission to study co-parenting relationships. The bill is laid on the table in the Senate Judiciary Committee.

House Bill 521, *An Act establishing a child abuse specialized medical evaluation program in the department of health and human services* HB 521 established 24-hour, 7 days a week access for CPSWs to an on-call experienced health care professional trained in and who can advise on the standardized diagnostic methods, treatment, and disposition of suspected child sexual abuse and physical abuse. The bill further provides for training for CPSWs and a limited number of designated healthcare providers around recognizing and responding to child abuse and neglect.

The OCA testified in support of HB 521 on February 12, 2019. The OCA advocated for the bill to include specialized medical evaluation for psychological maltreatment as well as child sexual and physical abuse. The OCA noted that many cases seen in the office involved psychological maltreatment for which children may present with nonspecific symptoms. Having specialized medical experts to assess and address signs of abuse early on is critical to help to identify abuse, and to help children heal and prevent further incidents of abuse. The OCA also recommended that nurses employed by DCYF receive specialized training on screening and assessments of reported cases of abuse.[38]

House Bill 550, *An Act extending foster care beyond age 18* HB 550 required the commissioner of DHHS to submit an amendment to the state plan required by 42 U.S.C. §671 to the United States secretary of health and human services to implement 42 U.S.C. §675(8) to make federal payments for foster care under Title IV-E directly to, or on behalf of, any person between the ages of 18 to 21 who meet criteria regarding education and/or employment, or who is incapable of meeting the requirements due to a medical condition.

The OCA testified in support of HB 550 on January 29, 2019 for similar reasons as Senate Bill 107. The OCA also recommended that the requirement include persons who, under RSA chapter 169-B, were in custody due to delinquency.

The bill passed and the Governor signed it into law on July 10, 2019.

House Bill 565, *An Act directing the department of health and human services to issue a request for proposals (RFP) for supervised visitation centers* HB 565 directs DHHS to contract with one or more qualified organizations to establish supervised visitation centers in each county.

The OCA presented written testimony in support of HB 565 at a hearing on January 29, 2019. The OCA advocated that supervised visitation centers staffed by personnel trained to understand and be alert for psychological maltreating behaviors, as well as to protect children, and provide guidance to parents would provide a safe space where children can interact with their parents and be protected from improper interactions.

[38] On November 14, 2019, the bill was voted inexpedient to legislate in the House Finance Division III Committee.

The bill was subsequently amended to establish a committee to study supervised visitation centers. It remains in the House Finance Division III Committee.[39]

Senate Bill 295, *An act relative to the office of the child advocate* SB 295 recodifies that statute governing the OCA, clarifies the authority and independence of the office and expands access to the services of the office to a broader range of children receiving services with more state agencies.

The OCA testified in support of SB 295 on February 5, 2019. The OCA also met with a number of leaders in the New Hampshire House and Senate regarding the bill.[40]

Key Point: Expansion of Service Reach

The OCA believes that expansion of the Office's service reach is necessary for equitable access to OCA resources for all children. Expanding the OCA's services to all children touched by any state services is fair, efficient and forward thinking. Currently children involved with DCYF, may benefit from the OCA through our examination of the quality and appropriateness of services they receive or do not receive; and through our advocacy in their best interest. However, there are other children, not involved with DCYF who are not eligible for assistance from the OCA. For example, the OCA has the authority to review the case of a child placed in a residential facility by DCYF. When a child is placed in the same facility by his or her school, the OCA is restricted from helping that child. If the facility is certified by DCYF, the OCA may be able to review policies and procedures in general at the facility, but it is not able to review that child's records to learn about his or her experience. If the child does not receive appropriate care or is harmed, the OCA is not able to investigate and identify a remedy for the child's safety and well-being. This becomes an unfair process. A mechanism for providing oversight of children placed outside of their homes by their schools is not understood.

DHHS together with DCYF, have focused all of their reform initiatives on prevention of children coming into DCYF care. As those efforts evolve, it makes sense for the OCA to be at the table advocating for children before they are abused, neglected, or adjudicated. With an eye on children's needs and informed by the latest practice standards of care, the OCA can assure efficient use of state resource investment in new programs for a future developmentally informed, family-centered, evidence based system of support and care for children and families. This model is based upon the model of Child Advocate offices in other states, including Massachusetts, Connecticut and Colorado.

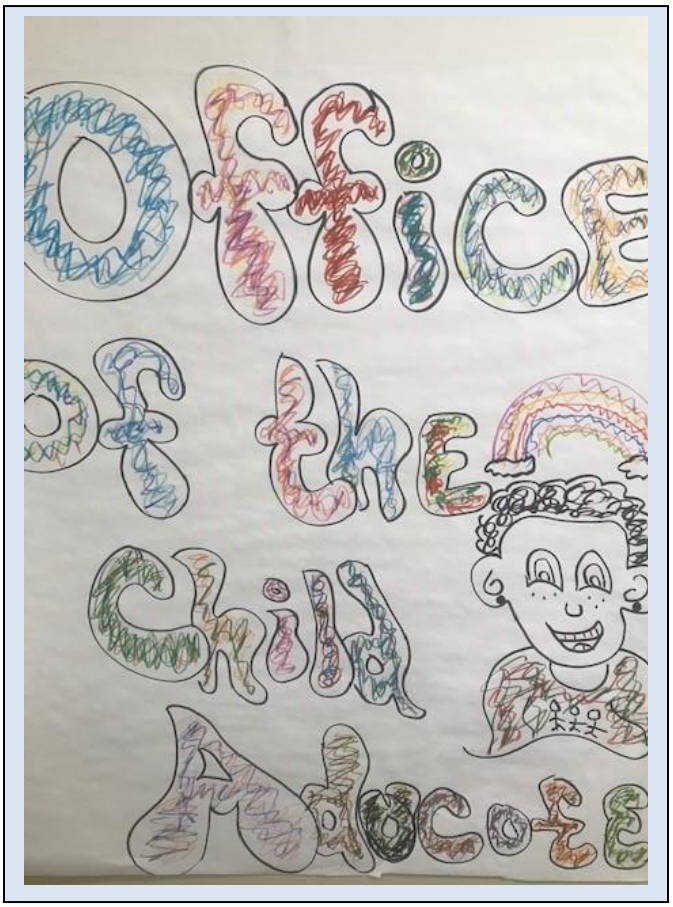
Key Point: Independence

Independence is essential to the credibility of any ombudsman office. In order to enjoy trust with citizens, the OCA it must be free from undue influence and conflict of interest. This was a focus of legislative committee work in the development of the OCA's enabling statute, RSA 170-G:18. Honorable Gail Garinger, a former judge and the first Child Advocate of Massachusetts emphasized the importance of independence to the credibility of operations in her consultation with the committee recommending

[39] On November 14, 2019, the House Finance Division III Committee voted to pass the bill as amended.
[40] The OCA again testified in support of the bill on December 3, 2019. On December 9th, the Senate Judiciary Committee reported that the bill ought to pass with amendment.

establishment of the OCA. The OCA's independence has been called into question due to an appearance that it is part of DHHS. That perception is resolved by moving the OCA to its own statute.

The independence of the Office has also been questioned in relation to the Office of the Attorney General (AG) in several ways. The AG supervises and trains DCYF attorneys, is represented in DCYF special case reviews, is represented in many other DCYF operational meetings, and conducts RSA chapter 126-U investigations of children experiencing serious injury or death during restraint. Because of this intricate involvement in the day-to-day work of DCYF, the OCA has received concerns with the perception of being another arm of the AG or having inherent conflict with the AG. The AG has assured the OCA that there is a "wall" between their work with DCYF and that of the OCA, however, there are constituents who have questioned that.



RECOMMENDATIONS

In reporting year 2019, significant themes emerged across all of the OCA's work, whether from citizen-generated concerns, incident reports, system reviews, issue briefings, and even in outreach and education. In published reports and individual cases, the OCA made recommendations from which consistent themes arose as well. We conclude this year-end compilation of OCA activities by consolidating and reiterating the recommendations as a means for ensuring a strong, functioning, informed system in which children and families can thrive. Themes of recommendations fit into six categories: Knowledge and rapid response, interprofessional understanding, communication, barriers of bias, and service array.

Recommendation: Improve child development knowledge and response time to developmental needs

The OCA has discovered that New Hampshire enjoys a treasure of experts on children. These resources have benefited DCYF and the broader child-serving community with extensive training, especially in child development and trauma. However, training must be constant and constantly refreshed. Advances in brain science over the past decade inform effectiveness of child protection and juvenile justice interventions in ways never imagined. A comprehensive effort to raise understanding of child development that will guide interactions, care and treatment with children across all domains of the system would enhance child outcomes. This includes all levels of DCYF staff, but also parents, providers, law enforcement, attorneys, judges, educators, and the community in general. Deeper understanding of child development, and the impact of trauma, will prompt and ensure rapid response to events such as abuse, neglect or other adverse childhood experiences we now know can deleteriously interrupt child development.

Recommendation: Promote interprofessional understanding

The very nature of child protection and juvenile justice services is interprofessional or interdisciplinary. Teachers, providers, law enforcement, or many others may be the ones to identify a child's needs. DCYF must collaborate with all of them in order to best respond. A consistent theme across all OCA reviews and casework was the obstacle of lack of understanding about the role, obligation and restriction of each player. Misinformed expectations impede communication and may even effect quality of working relationships. The OCA recognized success stories in which purposeful relationships were established to improve system response. The Concord Region Perinatal Community Collaborative – an established entity that aims to educate and support effective practice around care and protection of infants born substance exposed demonstrates the benefit of understanding across professions. In periodic meetings, participants explain their roles and mission. When they later interact professionally, communication and tasks are completed with fewer obstacles. These models represent excellent opportunities for replication. Incorporating the concepts of inter-professional education in core trainings prepares stakeholders for collaboration. This kind of educational effort addresses topical knowledge and strengthens relationships. It also goes far to enhance agency reputation, promoting DCYF as transparent, engaged, partners in the care and protection of children.

Recommendation: Improve flow of communication

The number one complaint the OCA receives reflects problems of communication. Promoting interprofessional education and practice will improve communication. Recognizing parents, foster parents and children as part of the collaborative team will ensure their inclusion in information sharing to the degree appropriate. Simple things such as contact lists, access to communication devices, returned calls, transportation for visits, are all measures that ensure timely case processing and children's needs met. More importantly, nothing solidifies relationships like open communication.

Recommendation: Acknowledging barriers of bias

The work of child protection and juvenile justice is hard. Human nature is complex and persons under distress can be challenging to work with. Heavy workloads and chronic delay of child and family success can impede empathy and understanding. The OCA found evidence that bias may affect decision-making and ultimately child outcomes. It is essential to the work, whether in DCYF, law enforcement, the courts, or health care, that all parties receive training in self-assessment for bias. Supportive supervision that guides staff through a process of examining influences on case decision-making and raises sensitivity to child and family circumstances, will at least ensure awareness of the potential barriers to success that bias holds. Certainly understanding child development, benefitting from inter-professional resources, and open communication will contribute to overcoming bias.

Recommendation: Expand and stabilize the service array

No amount of training or education will equip the system to assist children and families if there are no services or resources available to support them. Senate Bill 14, expanding the community-based system of care, is a critical start. A key requirement of the federal Family First Prevention Services Act is constant assessment of a child's progress. Likewise, as the array of services expands, assessing success and persistent gaps will inform next steps in system development. We can expect the need for recovery programs that accommodate mothers and children. Transitional programs for parents reintegrating with families after incarceration will improve likelihood of successful parenting, in addition to decreasing recidivism. Enhancing supports for foster parents, including debriefing when children move on after being absorbed as part of the family, will sustain that invaluable resource. Ceasing parental reimbursement requirements for voluntary and juvenile justice services will ensure families seek the help they need when they need it most. Whether for an individual or an entire system, assessment of need and effectiveness of intervention will ensure progress towards the best outcomes for children.

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The Child Advocate will:

Listen to YOUR needs

Question what is unfair

Explain what you don't understand

Help you be heard