State of New Hampshire
Office of the Child Advocate

2020 Annual Report

State of New Hampshire

Office of the Child Advocate

2020 Annual Report
Reporting Year Ended September 30, 2020
Pursuant to RSA 21-V:8

Moira O'Neill, PhD, RN, Child Advocate

Governor Christopher T. Sununu, Governor
Michael J. Cryans, Executive Councilor
Andru Volinsky, Executive Councilor
Russell E. Prescott, Executive Councilor
Theodore L. Gatsas, Executive Councilor
Debora B. Pignatelli, Executive Councilor

Cover photo: Debra Cram, (2020). Adoption Day. Seacoastonline.com

Table of Contents

A Message from the Child Advocate 4
RSA 21-V Statutory Duties 6
Mission 6
Selected Achievements of 2020 7
DCYF Response to OCA 2019 Recommendations 8
Citizen Concerns & Child Specific Advocacy 11
- *OCA Case Work* 11
  - *Inquiry Cases: Sources of Referral* 13
  - *Inquiry Case Concerns* 13
  - *Inquiry Case Child Details Age* 14
  - *Individual Child Case Reviews* 15
- *Incident Reports* 17
  - *Incidents Reported by Year* 17
  - *SYSC Incidents Reported by Year* 17
  - *Incident Details: Substance Use* 18
  - *Child Deaths* 18
    - *Undetermined Deaths and Safe Sleep* 20
    - *Suicide* 20
  - *System Learning Reviews* 21
  - *Critical Incident Summaries* 22
- *Facility Monitoring & Reviews* 22

Working Group on Juvenile Justice 23
Issue Briefings 24
Legislative Advocacy 25
OCA 2020 Outreach & Education Events 26
Committees, Task Forces & Councils 27
OCA Staff 28

Children in London wear their gas masks as they skip in the park at their temporary homes on the south coast of England, circa 1940. (General Photographic Agency/Getty Images)

A MESSAGE FROM THE CHILD ADVOCATE – MOIRA O'NEILL, PhD

Just over 80 years ago, as World War II headed for the shores of Great Britain, thousands of children were packed off to the countryside to keep them safe from the bombings. My friend Peter was one of those children. Those were unimaginable times. We have since learned a great deal from that cohort of children. Observing them, Anna Freud made some of the first associations between family seperation and trauma. We also learned about resilence and the capacity of children to adapt. In his 90s Peter still cheerliy called out when you prepared to leave the house, "Got your gas mask?!"

Like the War, the pandemic has been especially difficult and disruptive for children. Adults are scrambling to figure out children's best interest in these circumstances. As we struggle to fill the roles of teachers, coaches, counselors and friends, while still getting a day's work done, we are realizing the importance of every role in the community that raises our children. We are learning and creating new paths to supports and services, many of which are actually better than the way we did things before. Already in the process of shifting from the appearance of a punitive to a family-supportive agency, the Division for Children, Youth and Families (DCYF) was poised to respond to family needs. DCYF's *COVID-19 Family Resource Guide*[1] explains the stress parents feel is normal. It provides the kind of guidance that helps families prevent child abuse and neglect. The Waypoint Family Support Warm Line[2] extends from the guide a live person to call before things at home approach crisis. DCYF also provided lifelines in the dispersion of phones, tablets and even phone service to keep in touch with families at risk. The Office of the Child Advocate (OCA) was an early partner in convening an interagency think tank with DCYF to address concerns about elevated risks for abuse and neglect of children in these disrupted times. Partnerships mark progress.

The daily routine of child protection and juvenile justice services still demands attention, even more so, in the pandemic. When children are not at school under the careful gaze of teachers, school nurses, or guidance counsellors, their distress may go unnoticed. When abuse and neglect referrals dropped precipitously, the OCA used its platform to help prompt community conversations and raise awareness of the children next door. When infection spread in congregate settings among older New Hampshire residents, the OCA reminded DCYF that children too, are at heightened risk in congregate settings. Early on, the OCA recognized a powerful parallel between the experience of living through a dangerous pandemic and living as

[1] https://www.dhhs.nh.gov/dcyf/documents/covid-resource-guide.pdf
[2] https://waypointnh.org/programs/the-family-support-warm-line

a child in out-of home care. The stress and uncertainty we all feel under pandemic restrictions teaches us what children feel when placed away from home. Despite legal mandates and court schedules, they never really know when they will go home, if they will go home, or who will be there for them. This may be the greatest lesson of the pandemic. It underscores the importance of building a system of care in our state that holds families together, strengthens them, and prevents abuse, neglect or delinquency from ever happening.

As this report was prepared, a year and a half after Senate Bill 14 was signed into law, the Department of Health and Human Services (DHHS) was beginning to issue requests for proposals for services that will expand the system of care. The OCA has argued the urgency of getting those community-based services off the ground before and during the pandemic. Historic numbers of children awaiting acute psychiatric services in hospital emergency departments this fall underscores the need for prevention services – not just to address children's distress exacerbated by the pandemic, but also to free emergency departments for the expected rise in COVID-19 cases.

Though the pandemic was a dominating story, it was not the only development this past year. House Bill 1162, as amended and signed into law, included a monumental collection of child protection bills positioning New Hampshire to strengthen families and minimize need for child protective or juvenile justice services. It is now just a matter of implementation. House Bill 1162 also expanded the scope of the OCA to oversee all state and state-funded services for children. The OCA's mission expanded to assist children and families to ensure access to effective and timely services before abuse, neglect or delinquency happen. With expanded reach, the OCA will bring more partners to the table when intervening for a single child or promoting policy change benefiting all children. This legislative change is humbling. After only three years, such a change marks a deep confidence in the OCA and its work.

The OCA has a new logo. The sun rising over the State of New Hampshire and its children is a symbol of light and hope. In a time of pandemic, when doors shut, schools closed, and families separated, the OCA kept the light shining on children's needs, program successes, and opportunities for lasting improvements. In that light we also celebrate the rare moments like Adoption Day and we make a wish for every child: a ride home in a big red truck to the warm embrace of family. As we move forward we have set goals to manage an expanded mandate and shine the light on new opportunities to best serve and support children and their families. In 2021 New Hampshire can expect from the Office of the Child Advocate:

- An elevated voice of children themselves as we move to engage and guide them in self-advocacy
- A focus on early access to supports for healthy childhood and development
- An examination of behavior and its meaning as a form of communication, so that children may be better served and supported
- A review of the "crossover" phenomenon that shifts children from child protection to juvenile justice services
- Continued responsive, attentive, and professional management of citizen concerns and systemic reform in children's interest

Thank you for the honor and privilege of serving New Hampshire's children and families. Thank you also to those partners who work to ensure New Hampshire's children have the best opportunities to be safe, healthy and to thrive. We look forward to our continued work. Stay safe.

RSA 21-V Statutory Duties of the Office of the Child Advocate

- Provide oversight of state child-serving agencies as well as other public and private children and youth service organizations providing services under contract or agreement with an executive agency, except the judicial council or any entity for which the judicial council provides services, **to ensure children receive timely, safe, and effective services and their best interests are protected** (RSA 21-V:2, II(a)-(d))
- Provide advice to the governor, legislators, commissioners, the oversight commission and the public (RSA 21-V:2, II(e))
- Receive and, if deemed necessary, investigate complaints and concerns; DHHS specific complaints are handled by the DHHS ombudsman (RSA 21-V:2, III(a), (b))
- Provide assistance to a child or family, including seeking resolution of complaints (RSA 21-V:2. III(c))
- Strengthen the state by working with child-serving agencies and other necessary parties on cases under review (RSA21-V:2, II(b))
- Regularly consult with executive agencies and oversight commission (RSA 21-V:2, IV)
- Provide information and referral services to the public regarding all child-serving state services, particularly child protection and juvenile justice (RSA 21-V:2, V)
- Perform outreach and education initiatives on child-serving systems (RSA 21-V:2, VI)
- Periodically review facilities and procedures of any and all institutions or residences, public or private, where a child has been placed by a state child-serving agency (RSA 21-V:2, VII)
- Communicate and visit with children served by child-serving state agencies, and assist when needed (RSA 21-V:2, III(a)-(c), RSA 21-V:4, III)
- Have access to (RSA 21-V:4, I-II) and maintain the confidentiality of all case records, third party records, court records (RSA 21-V:5, I), and the identity of any complainant (RSA 21-V:5, II)
- Review/monitor incidents with children in the care and custody of DCYF, including child deaths (RSA 21-V:7)

Mission of the Office of the Child Advocate

In 2020 the mission of the Office of the Child Advocate was to provide independent and impartial oversight of the New Hampshire child welfare and juvenile justice systems to promote effective reforms that meet the best interests of children. It will be re-defined in 2021 in response to the expanded mandate of RSA 21-V.

SELECTED ACHIEVEMENTS IN 2020

COVID-19

The OCA advocated successfully for, or participated in early interventions to respond to children's pandemic-related needs. Selected achievements of the year include:

- A DCYF directive requiring CPSWs and JPPOs to assess each child for safe discharge from congregate settings and heightened risk of exposure to COVID-19
- Individual case reviews of children to determine safest settings for placement that met therapeutic needs and minimized viral exposure
- An interagency leadership team convened for weekly and now bi-weekly sessions addressing public health messaging for COVID-19 and impact on surveillance of child wellbeing
- Weekly COVID-19 response strategy sessions with national colleagues of the U.S. Ombudsman Association's Children and Families Chapter
- Periodic meetings with the other New England Offices of the Child Advocate and Ombudsman to share COVID-19 related concerns and strategies
- Facilitated awarding of a grant from the New Hampshire Charitable Foundation to fund phones and gift cards for homeless youth who would otherwise be out of touch for assistance
- Raised awareness of a heightened risk of child death from unsafe sleep practices in COVID-19-disrupted family routine
- Joined other Ombudsmen across the country in a national statement regarding increased concerns for abuse and neglect during the pandemic

General Operations

The OCA continued to assist children with daily needs unrelated to COVID-19. Successful advocacy and awareness raising lead to the following selected outcomes:

- Boys and girls at Sununu Youth Services Center (SYSC) may now take more than one shower a day to relieve stress, improve hygiene and enhance sleeping patterns
- One child received replacement eye glasses after an untimely delay
- One child is now with a pre-adoptive family after a 7-year delay to permanency
- Two children participated in delayed forensic interviews at child advocacy centers as a means to ensure their safety and set them on a path to healing

Response of a child at SYSC when asked if a shower would help with the child's mood.

"Yeah, kind of can help because if you're all muggy and stuff you just feel bad."

- DCYF is centrally monitoring incidents of restraint and seclusion for the first time, in addition to reporting each incident to the OCA per RSA 21-V:7
- Participated in and assisted with proclamations on *Child Abuse Prevention Month* and *Know and Tell Day*
  - Elevated children's voices in a public service announcement for Governor Christopher Sununu's proclamation for Child Abuse Prevention Month (https://www.nhchildrenstrust.org/prevention-month)
  - Advocated successfully to include a definition of psychological maltreatment in the proclamation
- Listened to and communicated with more children by providing informational posters for residential facilities, holding regular office hours at the SYSC, and embarking on an initiative of listening sessions to engage young people and help them develop their self-advocacy skills

DCYF RESPONSE TO OCA 2019 RECOMMENDATIONS

The OCA makes recommendations and provides guidance on all levels from addressing needs of an individual child to advising adjustments in statute. We incorporate emergent themes from complaints, case and system reviews, and feedback from constituents and policy makers into recommendations to DCYF and other stakeholders. In the fall of 2020, we reviewed 2019 OCA recommendations with DCYF administrators. We received helpful feedback identifying insufficient specificity of responsible parties. One DCYF administrator noted, "When a recommendation is made to everyone, it is to no one… it is more impactful to have a responsible party." This feedback will inform our work going forward. DCYF leadership did note that the OCA's recommendations generally propelled and supported the division's initiatives for system transformation. A summary follows.

Promote Interprofessional Understanding

The theme of interprofessional understanding and collaboration stood out in all of the OCA's reviews in 2018, 2019 and 2020. When different segments of a system do not understand each other's role and limitations, there are missed opportunities. Collaboration is evident in department initiatives, most notably the multidisciplinary NH Child Welfare Systems Transformation - Interagency Team (IAT) and the more recently formed Children's System of Care Advisory Committee (CSOC). This work allows participants to learn each other's roles and build consensus. The next step will be for the IAT and CSOC to promote educational initiatives for field workers from DHHS, Department of Education (DOE) and partner networks.

Improve child development knowledge and response to developmental needs

The OCA recommended widespread education in all fields to address inconsistencies of knowledge about child development that influences decision-making. This gap will become increasingly important to address in the fall-out from interruptions in children's lives caused by the COVID-19 pandemic. The OCA provided training on the topic to judges and promoted the topic in public commentary. The NH Strategic Plan for Early Childhood, a collaboration of DHHS and DOE, provides a good framework for educating a workforce that could be extended beyond early childhood specialties.

Improve flow of communication

Communication is essential to effective services and trusting relationships. Perhaps the greatest enhancement in communication occurred through the success of 2019 Senate Bill 6 that allocated funds for hiring the staff DCYF needs to do its work. The OCA supported the passage of the legislation knowing caseload was a major factor in communication barriers. With more manageable caseloads (decreased from average of 45 to 16 cases), CPSWs have increased time to establish better lines of communication with children and families. Since the pandemic, the OCA has learned that family contacts and communication have increased with teleconferencing that reduces commuting time. The OCA also recommended the use of huddling, brief staff meetings to improve communication and enhance sense of support. DCYF staff at every level: field staff and supervisors, field administrators, and central office staff have begun the use of huddles and report positive effects in team strengthening.

Acknowledging barriers of bias

The OCA recommended acknowledgement of bias directed towards families with chronic needs for child protection and law enforcement intervention. We also observed mothers treated differently than fathers in terms of support. Although seemingly different from the racial and ethnic bias that is in 2020 headlines, the importance and means of addressing *any* biases are similar. It is critical for DCYF to raise sensitivity to the circumstances of others and understand the impact of the division's actions on them. While no specific action was taken on this recommendation, DCYF administrators are contemplating where it belongs, in core fieldwork training. They also acknowledged that the current dialogue on race and ethnicity, one that must happen in state services for children, might distract from contemplation of the other biases the OCA identified

Expand and stabilize the service array

The intent of 2019 Senate Bill 14 was to expand a community-based system of care for children. However, implementation has been slow. Reports from DCYF indicated that shortages in the DHHS contracts office hampered the processing of requests for proposal (RFP) and contracts in a timely way, especially given the increased demand from COVID-19 related issues. The OCA has repeatedly recommended hiring staff for that office.

Eight months into the pandemic, there are more children waiting in emergency departments for psychiatric care than ever recorded. The absence of mobile crisis and stabilization services, provided for in SB 14, underscored the inadequacies of community infrastructure identified in DCYF's *2018 Adequacy and Enhancement Assessment*.[3] In mid-October 2020, DHHS issued the first requests for proposals for services, and DCFY reported that others will follow. This is promising but must move forth without delay to alleviate the back-up of elevated service needs.

In 2019, the OCA introduced MST Services in a community forum whose multi-systemic therapy (MST) is a highly evidence-based alternative to residential care. DCYF administrators report MST is being pursued. Other positive outcomes in service array expansion that the OCA supported include increases in resource workers in district offices to address the need to support foster parents; and licensed alcohol and drug counselors (LADC), nurses and case aides to support the work of each district office. The 2020 House Bill 1162 also removed parental reimbursement

---

[3] https://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf

requirements for voluntary and juvenile justice services a change advocated for by the OCA. This change will ensure families are not discouraged from seeking the help they need for their children.

Amend RSA chapter 169-C to put the child's safety and best interest as the paramount purpose of the statute

HB 1162 amended RSA 169-C:2, I to include within the statute's primary purpose that "[t]h*e best interest of the child shall be the primary consideration of the court in all proceedings under this chapter.*"

Expand voluntary services to reach more families at risk of abuse and neglect

In April 2020, DHHS issued an RFP to contract with providers for delivery of a community-based voluntary services (CB-VS) program on behalf of DCYF. If approved by the Governor & Council, up to 1,000 additional families will be served, expanding prevention of abuse and neglect.

Amend definitions of abuse and neglect in RSA 169-C:3 to better reflect psychological maltreatment as an action known to cause harm and provide multi-system education on the concept and legal implications of psychological maltreatment

HB 1162 added a definition of psychological maltreatment in RSA 169-C:3, the definitions section of RSA chapter 169-C, to provide that "'[p]sychological maltreatment' means pervasive and emotionally abusive behavior, which shall include, but not be limited to, patterns of threatening, berating, or demeaning behavior." The bill also provided that training shall be provided by January 1, 2021 to DCYF child protection staff, Court Appointed Special Advocates, family court judges, and other system partners regarding the implementation of this section.

Provide all families of infants born substance exposed early supports and services and connection to Family Resource Centers

HB 1162 expanded insurance coverage for children's early intervention therapy services and made eligibility inclusive of children born exposed.

DHHS to adopt rules pursuant to RSA 126-U:9, policies and/or practice guidance for reporting incidents, reviewing practices, investigating abuses, ensuring remedial and protective measures, and receiving complaints

DHHS proposed Administrative Rule He-C 900, "Child Restraint and Seclusion Practices."

DHHS to comply with former 170-G:18, now RSA 21-V:7, by providing the OCA immediate access to records, including the shared drive where restraint and seclusion incident data is currently being stored

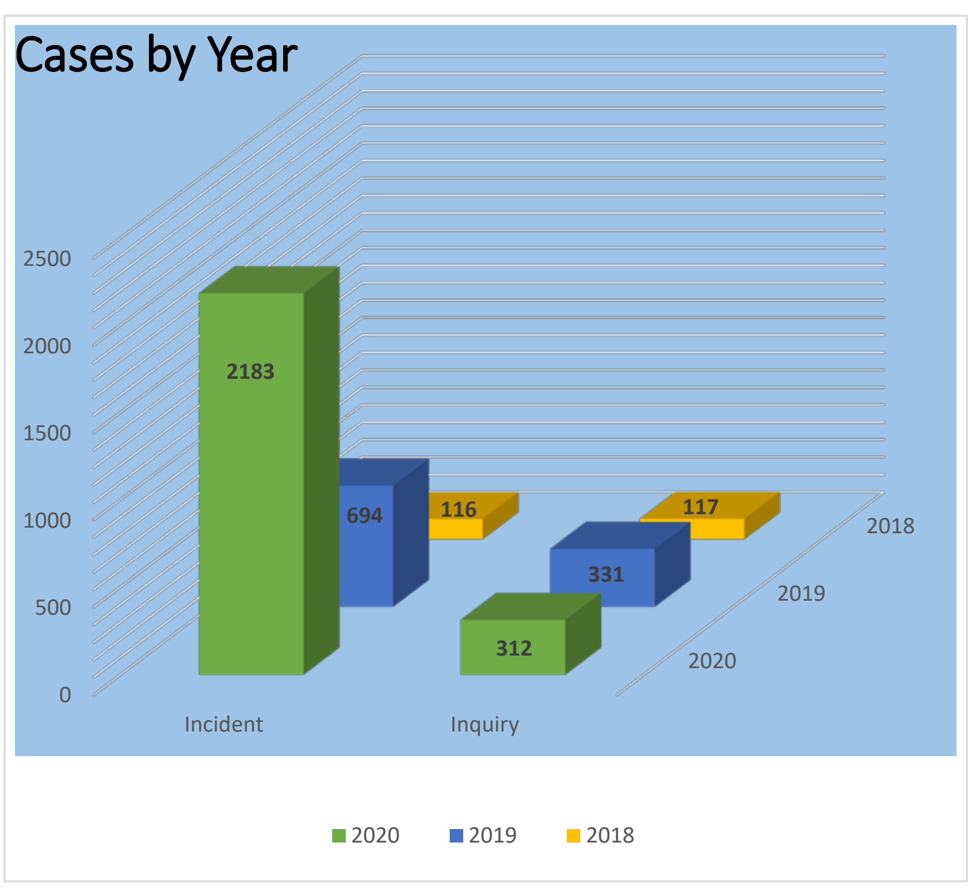
The OCA is still unable to access the DCYF shared drive or intranet. However, DCYF now requires facilities to report restraints and seclusion to the Central Office and provides the OCA with copies of those reports.

CITIZEN CONCERNS & CHILD SPECIFIC ADVOCACY

OCA Case Work[4]

To ensure children receive timely, safe, and effective services and their best interests are protected as mandated by RSA 21-V:2, II(a)-(d), the OCA responds to complaints and system concerns in several ways:

- Information and referral
- Case advocacy
- Individual case reviews
- Critical incident surveillance and summaries
- System learning reviews
- System reviews
- Issue briefings



Complaints, system concerns and incidents received or discovered by the OCA are termed cases. Cases are further delineated in the OCA's case management system as "Incidents" or "Inquiries." Incidents represent the number of reports of incidents the OCA receives and processes.[5] Inquiries represent the number of complaints received or discovered. Inquiries may be handled by providing information and referrals, advocacy on a specific case, or there may be a deeper review conducted either individually or as a system concern. In the three years since its inception, the OCA has processed a steadily increasing number of cases.

---

[4] In October 2018, the OCA commenced collecting and managing data in a case management system. The Department of Information Technology made the system available as a pilot to building a larger enterprise system for all executive state agencies. Typical of any pilot of software platforms, the OCA recognized early on the inadequacy of the system design for generating useful data reports. Requests for redesign were submitted and are pending. Data analysis of OCA casework is therefore limited; however, a general picture of OCA work and identified system issues is presented here.

[5] Prior to December 12, 2019 DCYF had no central monitoring system for restraint and seclusion incidents and was therefore unable to comply with RSA 21-V:7, I mandating all incident reports be reported to the OCA. The data depicted therefor, demonstrates the increase in reporting, not an increase in critical incidents occurring.

OCA Case Status identifies where a case is in the process of management to completion. In 2020, the OCA processed to completion double the number of cases opened and completed in 2019.

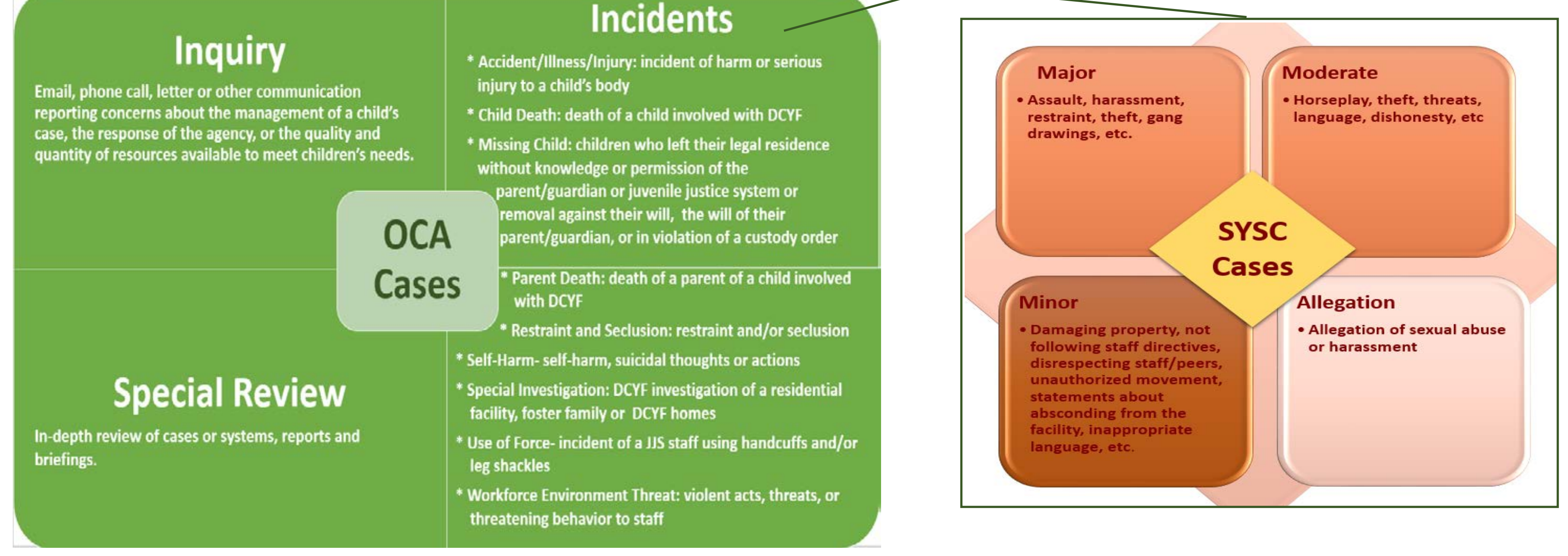
Cases by End-of-Year Status

Status	2020 Cases	2019 Cases
Open	52	82
In Process	76	109
Closed	2331	981
Special Review	34	26
Re-open	1	5
Total	2494	1206

Case Status

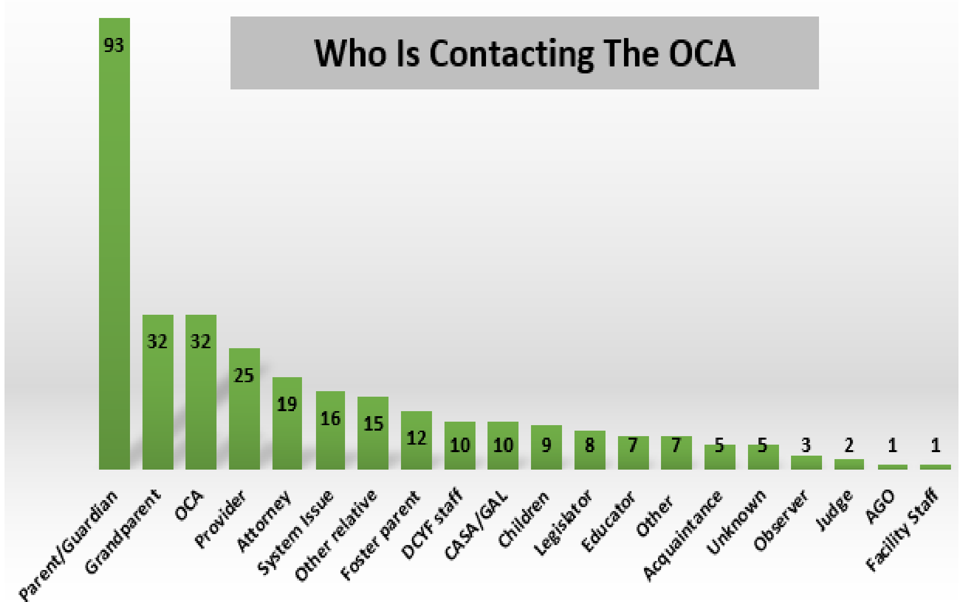
- Open > Case received, entered in case management system
- In Process > Research commenced, advocacy or monitoring
- Special Review > System-level review
- Closed > Case completed
- Re-open > This category is no longer in use. New concerns prompt a new case

When the OCA receives notification from an individual or DCYF, the concerns are categorized as an inquiry, incident or special review. These concerns are then tracked by source, concern, and level of review required.



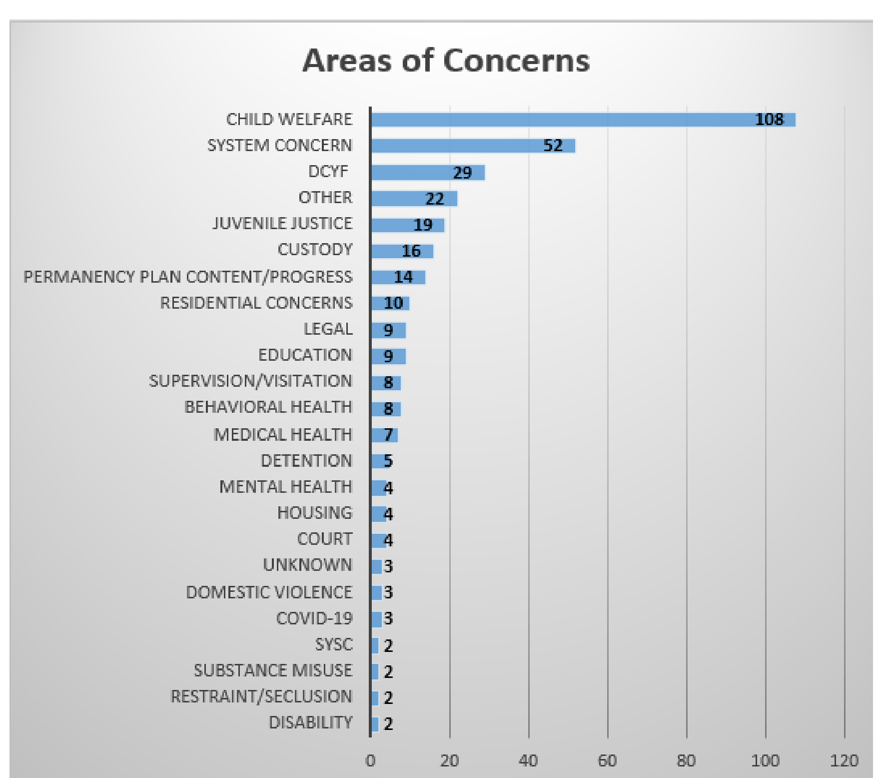
Inquiry Cases: Sources of Referrals

The OCA receives inquiry cases from a variety of sources. Over the past three years, parents and other family members have consistently represented the most common complainant. As the OCA has become better known and established trusting, productive relationships with stakeholders, there has been an increase in referrals from attorneys, DCYF staff, and even judges. The OCA received 312 contacts with concerns in 2020.

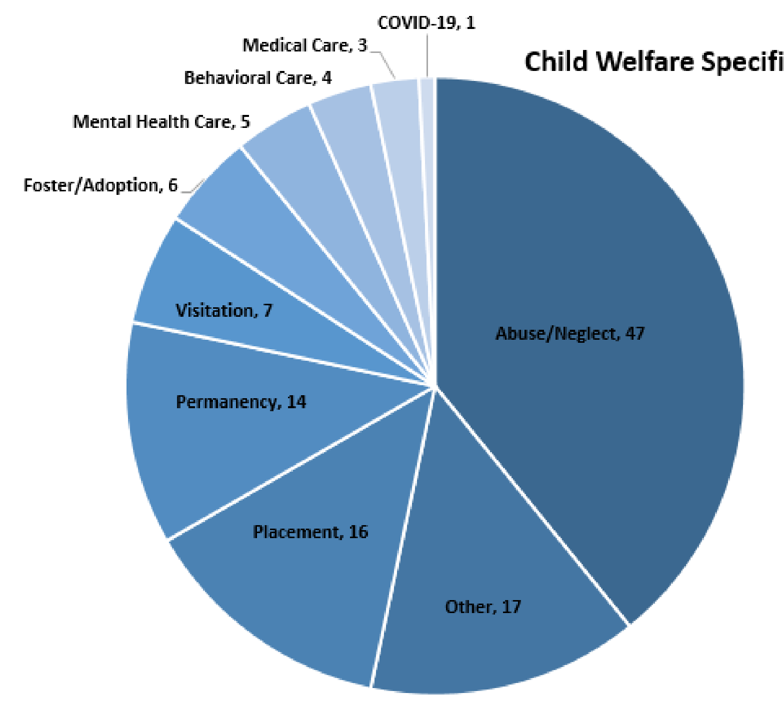


Inquiry Case Concerns

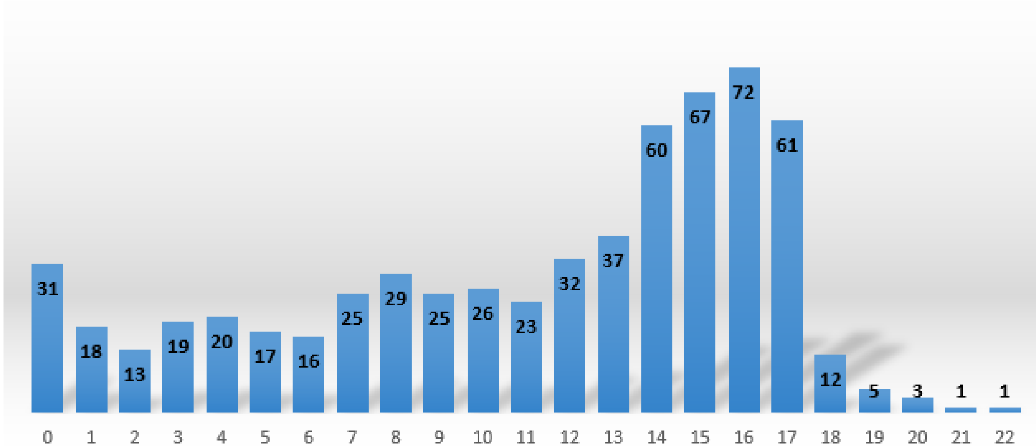
Concerns by broad category



A contact may be calling with multiple concerns. Due to limitations of the case management system, the OCA is unable to track more than one concern with fidelity. In general, however, the data informs the OCA of trends.



Child welfare concerns are further delineated to type of concern within child welfare, with the caveat that the OCA system does not currently capture multiple concerns in the subcategory.



Inquiry Case Child Details - Age

The most common age of children brought to the attention of the OCA ranges between 14 and 17. This is reflective of the number of complex cases that often involve children who have been involved in the system at length and not accessed the most effective treatment or interventions

Individual Child Case Reviews

In 2019, the OCA established a special review process for individual child cases. Cases that qualify for this level of review are those with multi-system involvement, complex needs, and high risk for institutionalization. These in-depth record reviews provide: a comprehensive summary of a child's experience, needs, and access to child protection and/or juvenile justice services; developmental, medical and mental health services, and a general picture of a child's wellbeing and family/relationships.

In 2020, the OCA conducted fourteen individual child case reviews for nine boys and five girls. All fourteen cases reviewed had child protection concerns ranging from two to 51 referrals for alleged abuse or neglect with characteristics as noted in the table below.

CHILD	AGE	# OF CPS REFERRALS	# OF ASSESSMENTS BY LEVEL	# OF OPENED ABUSE OR NEGLECT CASES	# CHINS CASES	# DELINQUENCY CASES	# VOLUNTARY CASES
1	14	4	2 Level II	0	0	1	0
2	15	49	4 Level I, 13 Level II, 9 Level III	0	0	4	0
3	16	21	2 Level I, 1 Level II, 4 Level III	1 Neglect	0	1	0
4	16	9	1 Level II, 3 Level III		2	1	0
5	15	5	2 Level I, 1 Level III	0	0	1	0
6	19	15	0	0	0	1	*Aftercare case
7	16	12	4 Level II, I Level III	1 Neglect	0	1	0
8	18	51	5 Level I, 1 Level II, 6 Level III	2 Neglect	2	4	0
9	17	8	2 Level III	0	2	4	0
10	14	16	4 Level II, 1 Level III	0	2	1	1
11	14	27	4 Level I, 2 Level II, 1 Level III	0	0	2	1
12	15	51	1 Level I, 4 Level II, 5 Level III	0	0	1	0
13	16	10	1 Level I, 3 Level II, 1 Level III	1 Neglect	0	0	0
14	16	2	2 screened out	o	0	1	0

All of the children were in residential care, incarcerated at SYSC, or at risk of placement. The OCA reviewed the cases to determine whether there was justification for continued institutionalization or opportunity for transfer home or to a more homelike setting. An unanticipated finding was the consistency with which the children shared a history of child abuse or neglect concerns that pre-dated juvenile justice involvement.

A child with child protection history, now in the juvenile justice system, explained that in order to be home successfully, a parent needs to work "just as hard" on self-improvement as the child is "working on myself".

The concept of "cross-over youth" reflects the significant population of children who are at risk of, or who do fluctuate between child protection and juvenile justice systems, or whose abuse, neglect, and adverse experiences predict juvenile justice involvement.[6] Trauma-interrupted development may leave a child with limited capacity to navigate social systems such as family, school and community in pro-social, rule-following ways. These children may simply not have the benefit of pro-social role models.

Of the children about whom the OCA conducted reviews, most appeared to have been adjudicated for behavior that was likely a manifestation of abuse, neglect or other adverse childhood experience. Many had special education needs. Cross-over cases shifting child protection to juvenile justice, also shift the locus of accountability from parent to child. The child then carries on their shoulders the weight of responsibility for complex family dysfunction. Unlike child protection, juvenile justice interventions are directed to the child, not the parent. If the child rehabilitates, they may still have family dysfunction or unmet need to navigate.

DCYF is an integrated service delivery agency with both child protection and juvenile justice services under the same roof. They share much training and philosophy. However, as evidenced by the thirteen cases reviewed, a punitive approach in the juvenile justice system lingers. The case reviews are distributed to members of a child's team, including child protection and juvenile justice staff, CASA/Gal, attorneys and judges. The OCA may convene stakeholder meetings to facilitate shared understanding of a child and the child's needs. The purpose is to ensure all parties are fully informed of a child's whole narrative in their decision making process. The OCA plans to examine crossover cases in a system review in 2021 to identify opportunities to strengthen the system's response to children with this dual status.

"I just wanted to tell you that I greatly appreciate how you deliver messages & feedback to the field, you are very transparent, open and engaging! I thought it was another beneficial meeting."

DCYF administrator to OCA staff

[6] https://www.childwelfare.gov/topics/management/practice-improvement/collaboration/juvenilejustice/

Incident Reports

Pursuant to RSA 21-V:7, I, DCYF must report all incidents to the OCA, including child deaths. Until the agency began reporting incidents of restraint and seclusion at residential facilities in December 2019 the majority of reports received were infractions imposed upon children detained or incarcerated at the SYSC. That SYSC data skewed incident surveillance as much came from the one facility and their reports included general child misbehavior that in other settings would not prompt formal reporting. The table below does not include SYSC infractions for three reporting years, as those are tracked separately.

Incidents reported by year

Reporting year	Abduction	Accident Illness Injury	Child Death	Media	Missing child	Parent Death	Restraint / Seclusion	Self Harm	Special Investigation	Workforce threat	Other	Total
2020	2	66	19	17	130	24	1282	14	93	4	2	1653
2019	0	54	16	17	199	39	77	2	80	0	1	485
2018	0	16	10	1	130	6	29	6	Not Reported	1	5	204

The increases in incidents by year are reflective of reporting practices, not necessarily incidence of events. Incident surveillance is intended to be a means for assessing the health of the system serving children. The majority of incident reports received by the OCA involved the use of restraint and seclusion of children in residential facilities. Restraint and seclusion use has both clinical and legal implications. The Centers for Medicare and Medicaid Services (CMS) view the use of restraint as a preventable adverse event, care for complications of which is no longer reimbursable.[7] Legally, RSA chapter 126-U governs the use of restraint and seclusion of children in schools and residential treatment facilities, limiting their use to emergencies only.

Incidents reported from the SYSC are automatically generated to the OCA through an electronic case management system. The steady increase over the past three years also reflect data reporting, the OCA did not receive a full year of data in 2018. However, the occurrence of incidents from 2019 to 2020 requires closer examination because the average daily census has fallen. The facility hired a forensic psychologist this year who is working with staff to better understand children, improve interventions, and minimize incidents.

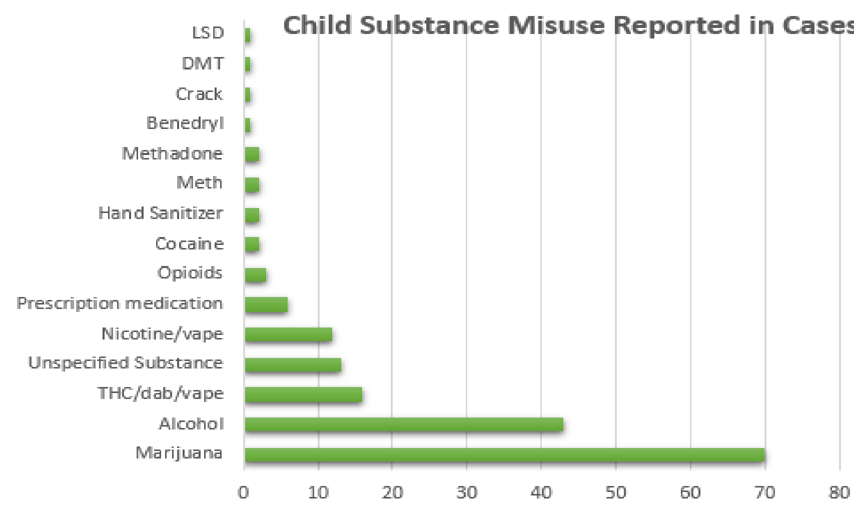
SYSC Incidents reported by year

Reporting Year	Major	Moderate	Minor	Allegation	
2020	239	76	200	14	529
2019	172	59	42	10	280
2018	22	2	NR	NR	24

[7] CMS.gov (July 31, 2008). Medicare and Medicaid move aggressively to encourage greater patient safety in hospitals and reduce never events. Centers for Medicare & Medicaid Services at https://www.cms.gov/newsroom/press-releases/medicare-and-medicaid-move-aggressively-encourage-greater-patient-safety-hospitals-and-reduce-never

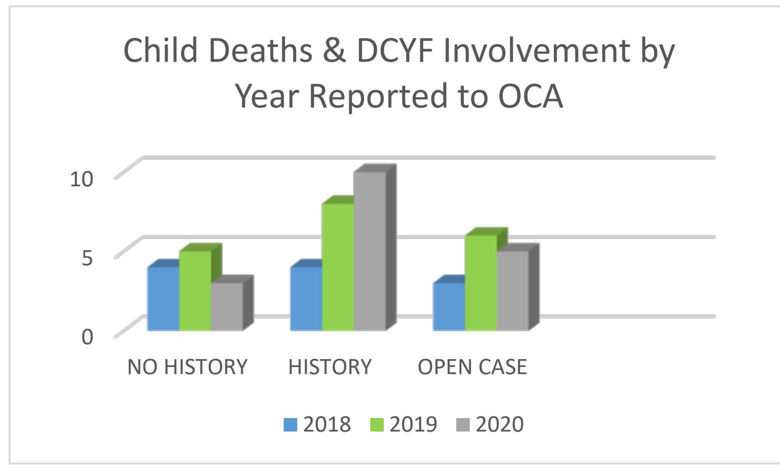
Incident Details – Substance Use

Of the incidents DCYF reported to the OCA, 137 included some indication a child used or was exposed to substances. Most commonly, cases involving children who went missing involved substance use, underscoring the danger of unaccompanied children. Of those with reports of substance use, marijuana was the most common substance used, followed by alchool. There is considerable use of nicotine with vaping. Traditional tobacco use is not routinely reported but is noticible in children's records. Tobacco and vaping are increasingly associated with entry into the juvenile justice system with school suspensions related to posession or use of tobacco products.



Child Deaths

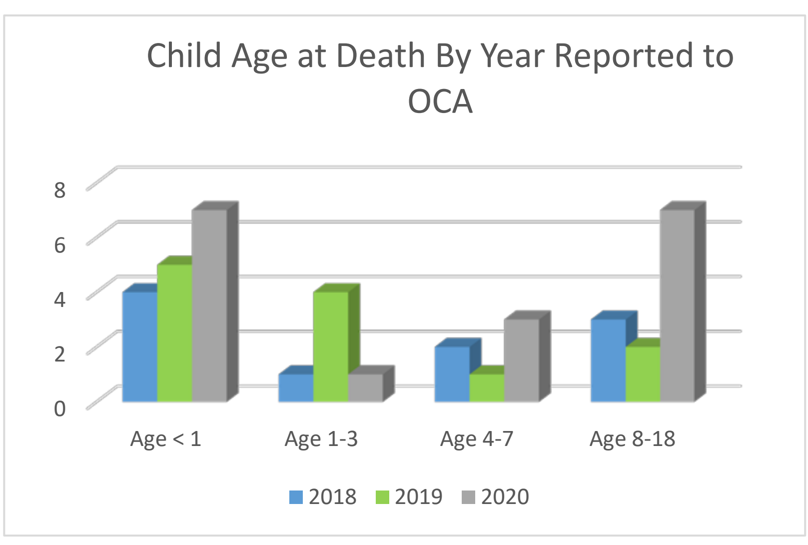
In 2019, Senate Bill 18 codified the Child Fatality Review Committee (CFRC). The purpose of the CFRC is to "conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendation for system changes to improve services for infants, children, and youth," RSA 132:41, I. Located within the DHHS, the CFRC has purview over all child deaths. Alternatively, the OCA, a member of the CFRC, may review child deaths where DHHS services were involved with an independent lens when the Child Advocate deems necessary.

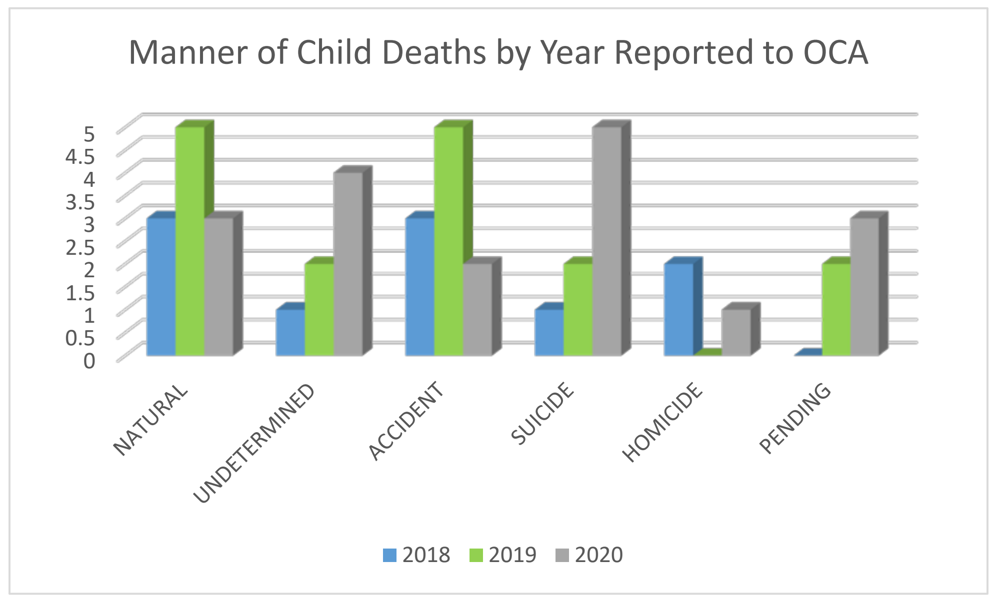


In reporting year 2020, DCYF reported 17 children's deaths to the OCA in accordance with RSA 21-V:7, II. In addition to the 17 reports received from DCYF, the OCA became aware of the death of an additional young adult who recently aged out of DCYF care after four years of involvement. Due to the age of the individual being 18, DCYF would not have received notice of the death and therefore did not assess the circumstances of the death. Because of the close proximity to aging out, the OCA has the case under review and combined it in aggregate for analysis. Of the 17 deaths reported by DCYF, three children had no personal history of involvement with DCYF other than an assessment of their death, although one child's family had a service provider relationship with DCYF at the time of death. Nine children had past history with child protection services (CPS), eight with DCYF and one with CPS in another state. Five children were involved in open active cases with DCYF at the time of their deaths. All of the open cases involved children under the age of five.

Children's age at death ranged from days to 18 years, the two biggest groups being infants less than one year and adolescents over ten years.
Of all 18 deaths that the OCA learned about, noted trends included:

- Unsafe sleep. Four deaths associated with co-sleeping or items in sleep area
- Suicide. Five deaths ranging in age from 14-18
- Gun violence. Three deaths with injuries related to firearm misuse
- Substance exposure at birth. Four children who died were born exposed to substances. While the exposure does not necessarily cause death, it may have long-term effects on a child's health. The nature of substance use may also situate a child in a high-risk environment. Factors including unsafe sleep environments, parental substance use, and exposure to violence may heighten a child's risk of death.





Among the 18 child deaths the OCA was made aware of, the manner of death for three are categorized as pending until the medical examiner receives all testing results. Two of the child deaths in this reporting period are associated with active law enforcement investigations, precluding the OCA from releasing any individual investigative findings per RSA 21-V:5,V(b).

Undetermined Deaths and Safe Sleep

The most commonly occurring manner of death among the youngest children was undetermined (4). Deaths are categorized as undetermined when there are a mix of intrinsic and extrinsic factors and no single one can be pinpointed. Sudden unexplained death of a child associated with an unsafe sleep environment may be categorized as an undetermined manner of death. The OCA published a press release[8] prompting a public dialogue, including with DHHS, to raise awareness of safe sleep practices and the risk associated with disrupted family routines, and reported increase in alcohol use, associated with the COVID-19 pandemic.

Suicide

Of child deaths reported to the OCA, the most common manner of death among older children was suicide (5).[9] The OCA participated in CFRC comprehensive reviews of suicide deaths. Their annual report, with recommendations is pending. The Connecticut OCA issued a public health alert due to a recent and sudden increase in child suicide deaths. The stress of the pandemic and civil unrest has increased uncertainty, isolation, school concerns and other worries, all of which contribute to anxiety and despair. It is important that feelings of grief, loss and disruption be addressed with children. Adults at school and home need to encourage and model open communication and create opportunities for children to discuss their sense of loss. A sense of safety, belonging, and hope are paramount to resilience.

Warning Signs of Suicide

- *Talking about wanting to die, feeling hopeless or having no purpose*
- *Talking about being a burden to others or feeling trapped*
- *Increased use of alcohol or drugs*
- *Acting anxious, agitated or reckless*
- *Sleeping too little or too much*

What to Do

- *Do not leave the person alone*
- *Remove any firearms, alcohol, drugs or sharp objects*
- *Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)*
- *Take the person to an emergency room or seek help from a medical or mental health professional*

[8] https://childadvocate.nh.gov/documents/press/Child-Advocate-Press-Statement-Safe-Sleep-Saves-Infant-Lives-4-24-2020.pdf

[9] **Media Alert**: Journalists are requested to educate themselves on how to safely report on suicide death to avoid contributing toward the risk of contagion by sensationalizing or glamorizing suicide. Helpful guidance is available here: guidance (https://reportingonsuicide.org). Additionally, when reporting on suicide, please include the following resources at the end of articles- *"If you or someone you know is in crisis and needs help, please call 1(800) 273-TALK (8255) or 211 in NH, or text the Crisis Text Line: 741741, and in an Emergency Call or Text 911."*

System Learning Reviews

The OCA continued to conduct System Learning Reviews (SLRs) on critical incidents and deaths over the past year. The SLR 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. These reviews serve as learning opportunities for identifying system strengths and gaps. The SLR process engages front-line staff and their expertise to examine what happened in a particular case and unpack the complexity of multi-system influences on child welfare and juvenile justice decision making. The SLRs have been well received by DCYF staff and administrators.

This year, the OCA conducted three SLRs: a cross-border SLR with New Hampshire and Maine child welfare staff on a near fatality of a child; an SLR on a child with a six-year juvenile justice history with DCYF; and an SLR on a child abruptly removed from relative foster care and placed in a residential facility. The OCA anticipated conducting three additional SLRs, however, obstacles resulting from the pandemic and staffing hindered the ability to do so. Findings from the three SLRs will be released in a separate SLR Summary Report.

"I found it very informative and enjoyed the process."

"It was actually a good experience. As you know, we all try to make the best decisions for [children} and their family despite the lack of services in many areas. There were some definite 'take aways' to bring back to staff from the SLR. . . . I would be more than willing to participate again if you need volunteers."

DCYF staff on participating in an SLR

In September 2020, the OCA presented its unique SLR process to a national and international audience in a webinar sponsored by the U.S. Ombudsman Association's Children and Families Chapter. In addition, the OCA has continued its work with Collaborative Safety, LLC, developers of the SLR, to incorporate safety science into all of our work. We have also been working with Collaborative Safety to expand the process. In January 2021, we anticipate launching the SLR-2 process of incident review utilizing Human Factors Debriefing and System Mapping, including Positive Capacities mapping for a comprehensive, deeper approach to understanding systems.

Critical Incident Summaries

In July 2020, the OCA instituted a new practice of drafting Critical Incident Summaries (CIS) of critical incidents received by the office requiring more in-depth review. The OCA began this practice to ensure consistency in its in-depth critical incident reviews, to identify any concerns for the child's safety going forward and any systemic issues or trends that may impact other children.

Critical incident summary type and systemic issues or trends

Month	Critical Incident Type	Systemic Issues or Trends
07/2020	Parent Death	
07/2020	Parent Death	Relative caregiver support
07/2020	Parent Death	Cannabis use during pregnancy
08/2020	Child Death	Foster family support
08/2020	Infant Death	Safe sleep
08/2020	Missing Child	Lack of treatment options
08/2020	Domestic Violence/Sexual Assault	Children of incarcerated parents and children witnessing domestic violence
08/2020	Near Fatality	Psychological abuse of children
09/2020	Use of Force	CPS/JJS Crossover
09/2020	Homicide/Domestic Violence	Children of incarcerated parents and children witnessing domestic violence

Facility Monitoring & Reviews

When family care capacity and community-based services are not adequate to meet a child's intensive therapeutic needs, they may be placed in a hospital for acute care or residential facility for rehabilitative care. At the beginning of the OCA reporting period in October 2019 there were 21 residential facilities, one acute psychiatric state hospital unit, and the SYSC where children are detained or incarcerated. Throughout the year the census of children in residential care ranged from a high in December 2019 of 341 children (76 out of state) to a low in September 2020 of 308 children (81 out of state). Facility issues included:

- Monitoring DCYF's investigation and removal of children from the Crotched Mountain Mellons Program in response to allegations of neglect and lack of supervision
- In March 2020, the OCA opened a facility review on Nashua Children's Home upon receipt of 13 complaints regarding care of children and use of restraints. The review is ongoing at the time of this report.
- In June 2020, the OCA commenced monitoring a DCYF/DHHS special investigation of the Mount Prospect Academy Enhanced Residential Treatment program.

Working Group on Juvenile Justice

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 to:

- *Review the future direction and needs of the state in terms of youth services including housing of troubled youth as well as treatment*
- *Develop a 10-year program model to modernize the state's youth incarceration program and facilities by studying the latest work of other states*
- *Emphasize the provision of treatment of all levels of care in addition to ensuring adequate resources*

During the 2020 reporting period, the Working Group continued to examine both the current New Hampshire system and best practices developing around the country. Since the pandemic, Working Group meetings have been less frequent. However, four external projects complimented or extended their work. Working Group Subcommittees submitted reports in each area for compilation in a report currently in production. Many of the findings paralleled broader system initiatives, including expansion of the community-based system of care outlined in 2019 Senate Bill 14 and other DCYF budget allocations designed to prepare the State for implementation of the federal Family First Prevention Services Act.

Dartmouth-Hitchcock The Dartmouth Trauma Interventions Research Center presented results of a 7-year project from 2012-2019 entailing the training of DCYF staff on trauma, trauma treatment, assessing for trauma exposure and developing and implementing trauma-informed case planning. The project included trauma mental health screenings of children involved with juvenile justice and child protection services, the outcomes of which grounded and elevated the urgency with which trauma-informed training and re-training is indicated with this population.

The Nelson A. Rockefeller Center at Dartmouth College, Class of 1964 Policy Research Shop presented their report *Evaluating Juvenile Justice Programs in New Hampshire and Across the United States*[10]. The student researchers examined the budget and reviewed effective, evidence-based programs offered in other jurisdictions that could meet needs and address funding issues in New Hampshire. Their most notable finding was the disproportionate allotment of funding used to operate the SYSC ($12.7 million) housing at the time 14 children, while $11.5 million was allocated to serving 2000 children receiving community-based services. Review of effective evidence-based programs offered considerable opportunities for improvements and cost savings for New Hampshire.

[10] https://rockefeller.dartmouth.edu/sites/rockefeller.drupalmulti-prod.dartmouth.edu/files/newjuvenilejusticefinal_0.pdf

The Probation Transformation Team, working with the support of a grant from the Annie E. Casey Foundation and the Georgetown Center on Juvenile Justice Reform, completed and submitted a capstone proposal for probation reform. The proposal expresses a vision for a system that embraces developmentally sensitive, trauma-informed approach to supporting child and family through diversion or individualized rules of probation.

Activating Young Self-Advocates

An extension of the Working Group has commenced engaging young people with juvenile justice experience and their allies in conversations about reform and self-advocacy. This initiative promotes a vision for a grassroots self-advocacy organization that compensates young "expert advisors" for their time and guidance in system reform.

Issue Briefings

In July 2020, the OCA published Issue *Briefing Case Number 2020-01-ISO1 COVID-19 Quarantine for Children in the Custody of DCYF: A Community-based Solution*,[11] examining children's needs and making recommendations intended to minimize the institutionalization of children and maximize their access to appropriate supports while preventing viral spread of COVID-19. Contemplation of remedies to protect children and others from exposure to COVID-19 included establishing space for quarantine in residential facilities. None of New Hampshire's residential providers had space or staffing for quarantine units. DCYF considered opening a wing of the SYSC. OCA recommendations included:

- Engage potential foster parents who desire to assist children but are not able to make long term commitments
- Craft a classification of foster care limited to 14-day stays with enhanced daily rates and intensive in-home therapeutic supports. This model would reward flexibility, and meet children's needs by including the conducting of strengths-based needs assessments in the transition process.
- Use of COVID-19 Relief Funds to enhance DHHS's capacity to speed up the building of infrastructure to support families with preventative services and supports, thus minimizing the need for out of home care and related quarantine of children

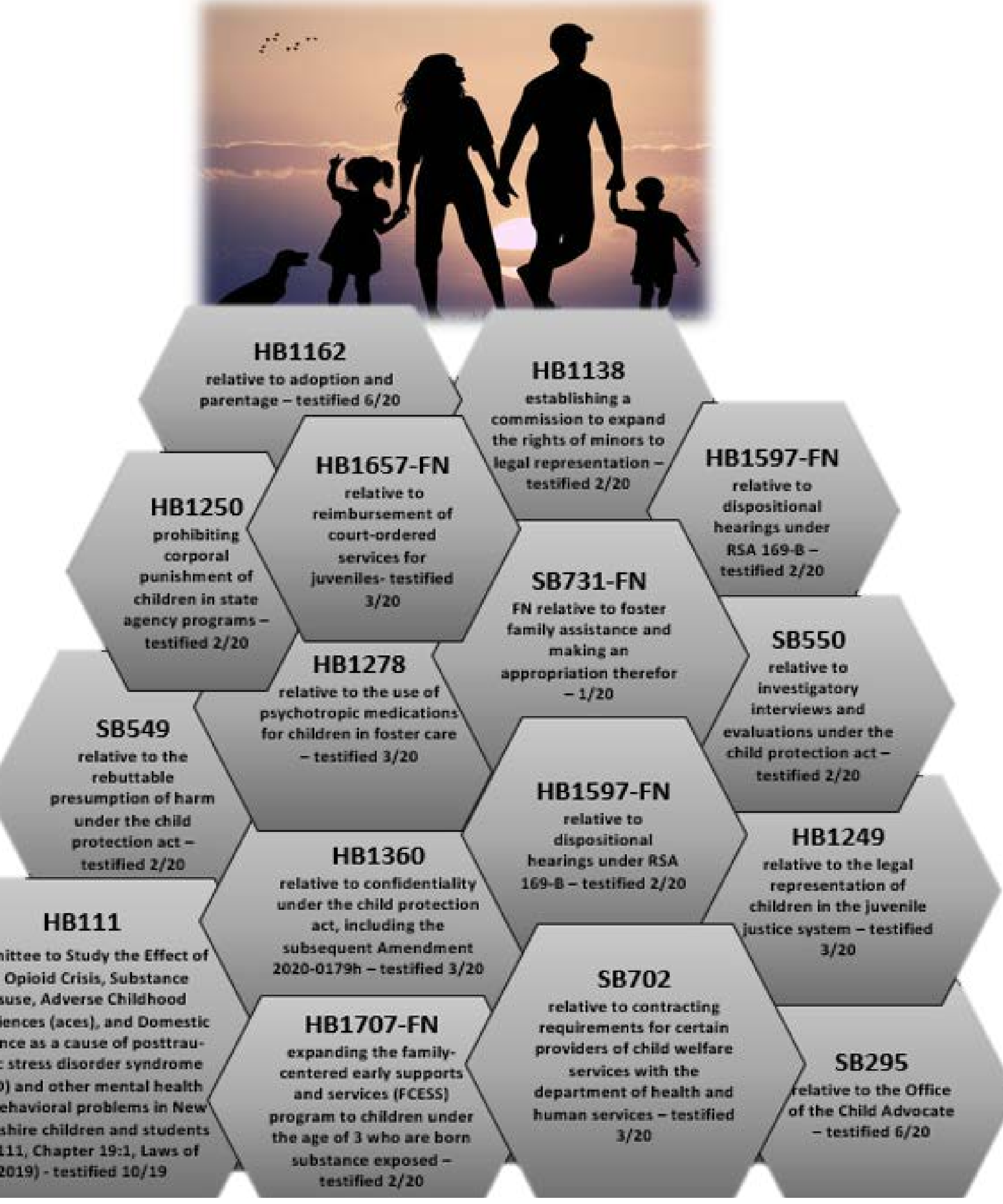
[11] https://childadvocate.nh.gov/documents/reports/Issue-Briefing-Case-Number-2020-01-IS01.pdf

Legislative Advocacy

The OCA's obligation to provide advice to state leaders in RSA 21-V:2, II(e) most commonly manifests in the form of public testimony on proposed legislation. The OCA uses lessons from individual cases and system reviews to inform advice and promote systems changes in children's interests.

"Republicans and Democrats felt that your testimony is fair and to the facts with no agenda spin except for the best interest of the child! Thank you for all you do!"

NH State Legislator



2020 Bills the OCA testified on or was otherwise involved

OCA 2020 Outreach and Education Events

Outreach

- *Children's System of Care Advisory meetings*
- *Central NH Foster and Adoption Parent Support Dinner and Meeting*
- *Film Night re: Incarcerated Parents & Family Connections Center*
- *Met with Department of Education Commissioner Edelblut*
- *Met with Sununu Youth Services Center staff*
- *Concord Zonta Club*
- *Keynote address at event at UMass Worcester Medical School/Nursing*
- *Foster and Adopted Parents Association*
- *Governor's Law Enforcement Commission*
- *DCYF Advisory Committee*
- *Director of the NH Public Defender, Randy Hawkes*

Education

- System Learning Review process presented to:
  - Child Fatality Review Committee
  - Maine Child welfare team
  - USOA Child and Families Chapter
- UNH Carsey School of Public Policy Coffee and Conversation event
- Dartmouth Child Psychiatry Fellows
- NH Circuit Court Judges
- Public hearing on Restraint and seclusion report before Senate Health and Human Services Committee
- The Child Advocate taught a class at UNH School of Social Work
- USOA Children and Family Chapter meeting

Information

- Multiple T.V. and radio interviews
- NH Bar News interview
- The Exchange with the Child Advocate
- Published three OP Eds
- NH Community Conversations
- NHPR interviews regarding System Learning Review Report, Restraint and Seclusion, and the 2019 Annual Report
- Established OCA Twitter account
- Established the OCA Facebook account
- Written materials disseminated:
  - Informational signs for kids at SYSC
  - Informational posters for kids sent to all residential facilities
  - Summer Safety, Scalds and Burns & Keeping Babies Safe informational fliers released
  - Created OCA monthly newsletter in July

Committees, Task Forces, & Councils

- Child Fatality Review Committee
- Attorney General's Task Force on Child Abuse and Neglect
- Perinatal Substance Exposure Task Force of the Governor's Commision on Alcohol and Drugs
- Trauma Informed Care Workgroup

- Probation Transformation Team
- Family Treatment Court Oversight Team
- Child Welfare Systems Transformation Interagency Team
- Children's System of Care Advisory Committee
- NH Children's Behavioral Health Workforce Development Leadership Team

- Know and Tell Advisory Committee
- NCCD Risk Validation Study Steering Committee
- Child Protection Reporting Guide Teams
- US Ombudsman Association Children and Families Chapter
- Bureau of Housing Supports Subcommittee on Youth Homelessness

OCA STAFF

4 Full time and 1 Part time/temporary position
1 Full time position under hiring freeze, appeal pending

Moira O'Neill, PhD, Child Advocate

Emily Lawrence, Esq., Associate Child Advocate

Karen Kimel, Office Coordinator

Jason Tayler, Assistant Child Advocate

Colleen McMahon, Esq., Legal Support Staff

Interns

(Unpaid)
Julie Cotton, Cornell University

Maggie Delaney, College of William & Mary

Susel Jerez, University of New Hampshire

Johnson Hall
107 Pleasant Street
Concord, NH 03301
Phone: 603-271-7773
Toll Free: 833-NHCHILD
childadvocate@childadvocate.nh.gov
Childadvocate.nh.gov

If you think a child is in danger,
call 9-1-1 immediately.
To report suspected abuse or neglect
call 1-800-894-5533