State of New Hampshire

Office of the Child Advocate

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Summary of 2020 System Learning Reviews: Opportunities to Improve and Build on Strengths of the Child Welfare System Through Examination of Critical Incidents

Executive Summary

Family is paramount. The best resource for a child is family. When family are unable or unwilling to care for children, the State has an obligation to step in and determine how to help strengthen and keep the family intact. Intervention with a family and removal of a child from his or her home when necessary is in itself an adverse childhood experience. It also shifts responsibility and accountability and all of the complexity of care for a child's wellbeing to the State. Therefore, continuous careful assessment and strengthening of State services is essential to ensure the benefit of potential intervention with families exceeds the cost. One method of system assessment is to examine critical incidents involving children in the care or supervision of the State with the goal of learning from the adverse events and informing prevention. Whether a death, an injury, or a child gone missing, critical incidents represent the magnitude of challenges facing child welfare systems and the children and families themselves. Critical incidents highlight the need for a child welfare system, but also the challenges within the system itself.

In 2019, the Office of the Child Advocate (OCA) launched a process for examining child fatalities and other critical incidents grounded in Safety Science. Safety Science is an evaluative science applied in safety critical industries including aviation, nuclear power and healthcare. The OCA's System Learning Review (SLR) engages the experts– field staff, supervisors, administrators and specialists - in case review. The focus is the system and system accountability. Specifically, the process moves away from blame, and instead prioritizes systemic learning and improvement. The SLR process represents the OCA's effort to provide a mechanism for productive examination of where the system might be strengthened and opportunities to better meet children's needs.

In 2020, the OCA facilitated three SLRs with personnel from the New Hampshire Department of Health and Human Services (DHHS), Division for Children, Youth and Families (DCYF), and one SLR with a team from DCYF, a border state's child welfare public agency and that state's child welfare ombudsman,[1] on four unrelated cases:

- A near-death injury
- A disrupted relative foster placement
- An 80-minute prone-positioned restraint
- A suicide attempt

All four cases involved children who had experienced the loss of family. Each relied upon the State as interim parent while working toward a return to family or a new family. In the process of examining case circumstances and system influences on case decisions, the SLR teams discovered prevailing themes that transcended case types, district offices, and state borders. The key finding was that child and family wellbeing are dependent upon a network of essential relationships. In alignment with the science of child development, the SLR teams found that relationships between children and consistent, caring adults are crucial. Those adults, in turn, need positive relationships with agencies to feel supported and build capacity to best care for the children. Providers, when caring for children, must demonstrate commitment to children to build trust and engage in effective treatment. And when children move across state borders,

[1] Pseudonym use for the border state is at the request of that state.

state agencies benefit children best when good working relationships exist. Relationships are dependent upon communication and commitment. Effective communication and meaningful commitment rely upon all levels of a workforce being adequately trained and supported. They should be equipped to be responsive to children with traumatic pasts, understand developmental stages, and embrace interdisciplinary team approach. Time is the factor of which there will never be enough, however, it can be accommodated with quality, reliable and collaborative, committed relationships.

The four case reviews prompted recommendations for system change. Several are already being implemented. The findings confirm the urgent need for changes outlined in Senate Bill 14 of 2019 and DCYF budget allocations in state fiscal years (SFY) 2020 and 2021. Those changes include independent assessment of children's needs and matching them to appropriate care; special assistance coordinating care for children transitioning out of institutional settings; a redesign of institutional care that includes training and support for staff and reduction of the use of restraints and seclusion. Budget allocations also included more child protection staff. Increasing staffing lowers caseloads, facilitating more time to attend to child and family needs. However, there have been delays in rolling out the new services. Capacity within DCYF is also at risk as the legislature determines whether there is adequate revenue to fund the 2022-23 budget with or without cutting 22 child protection case workers (CPSW) just as the agency is reaching manageable caseloads. The experiences of the children in the four cases and the findings of the SLR teams are testimony to the urgency with which the 2019 legislation and SFY 2020-21 budget allocations must be implemented without further delay and with limited lapse of allocated funds.

The SLR teams identified other system changes not yet addressed. Largely they include securing and nurturing relationships for children and all parties, as well as among and between DHHS, foster parents, relatives, and border state sister-agencies. Creating consistent, responsive supports for grieving foster parents who have experienced disrupted child placements will go a long way in preserving them as the critical resource they are. Adequate reimbursement for behavioral psychologists and analysts will also address a gap identified in care for children with developmentally based conditions.

This summary report tells the story of what we learned from four children's experiences through the lens of the people who endeavor to help and protect them: caseworkers, juvenile probation and parole officers, supervisors, administrators and specialists. The OCA convened SLR teams and provided them with tools and the children's narratives. The SLR teams examined the narratives, explored the features of their work environments, and contemplated adjustments to the system. The considerations resulting from the team's work aim to inform system strengthening and improve outcomes for children and families.

Summary of Recommendations for System Improvements

System improvements identified by the four SLR teams for DCYF and BCBH include:

- Prioritize pro-active, purposeful engagement and exchange of information between border state child welfare agencies, providers, foster parents and children
- Sustain children's relationships with relatives in natural roles of extended family
- Provide debriefing and grief support to foster parents when children's placements disrupt
- Ensure pro-active transitional planning for all children out of residential care
- Place children in care of qualified providers trained in trauma-informed, developmentally sensitive models of care who are adequately trained, supported and reimbursed
- Prohibit the use of prone-positioned restraint
- Educate providers on the negative effects of dual-purpose socially separating spaces for punishment and calming
- Establish adequate reimbursement for and promote the use of behavioral psychologists and technicians: increase access to functional behavioral analysis and associated treatment

Glossary of Terms

AAG – Assistant Attorney General
ACE – Adverse Childhood Experience
BCBH – Bureau of Children's Behavioral Health, in the Division of Behavioral Health, a division of DHHS
CASA/GAL – Court Appointed Special Advocate / Guardian Ad Litem
CAT – Comprehensive Assessment for Treatment
CME – Care Management Entity
CPSW – New Hampshire Child Protection Social Worker
DCYF – New Hampshire Division for Children, Youth and Families, a division of DHHS
DHHS – New Hampshire Department of Health and Human Services
FAPA – Foster and Adoptive Parent Association
GAL – Guardian Ad Litem
ICPC – Interstate Compact on the Placement of Children
JPPO – Juvenile Probation and Parole Officer
OCA – Office of the Child Advocate
RSA – Revised Statutes Annotated
SLR – System Learning Review
TPR – Termination of Parental Rights
TRECC – Transitional Enhanced Care Coordination

Statutory Authority of the Office of the Child Advocate to Report

RSA 21-V:5, V. *Notwithstanding any provision of law to the contrary, if the child advocate determines that the health, safety, and welfare of children are at risk, the child advocate may publicly disclose the details of investigation findings, subject to the following limitations:*

(a) Names, addresses, or other identifying information of individuals who are the subject of any confidential proceeding or statutory confidential provision shall not be released to the public.

(b) Investigation findings shall not be released if there is a pending law enforcement investigation or prosecution, except as provided in paragraph III.

Summary of 2020 System Learning Reviews

Introduction

A near death injury, a disrupted relative foster placement, an 80-minute prone-positioned restraint and a suicide attempt each represent critical incidents in the lives of children and the work of a child welfare system.[2] In this report and the process that produced it, we seek to honor the children's adverse experiences by learning and contributing to a system of prevention. The personal tragedy of deaths or other critical incidents can be lost in bureaucratic detachment, blame and shame of state actors, family dysfunction, and politics. It is up to the child welfare system to soothe the family loss, demonstrate accountable standards of practice, deal with political fallout, and cope with the close proximity of tragedy.

Since the 1970s, organized child fatality review teams have reviewed critical incidents involving child deaths. The purpose has largely been preventing other similar deaths.[3] The outcomes of those reviews have been difficult to measure. Findings historically emphasized personal responsibility with punitive solutions such as dismissals and lawsuits. In 2013, the federal Commission to Eliminate Child Abuse and Neglect Fatalities recommended a shift in the review process to incorporate safety science.[4] As an evaluative science, safety science depends upon recognition of common goals, and collaboration with system stakeholders to identify disconnects, obstacles, and gaps preventing goal achievement. Once acknowledged, overcoming obstacles makes way for a stronger, more effective system. The hallmark of safety science is empowerment. Empowering child welfare personnel to identify system influences that may inhibit their work and the best outcomes for children, motivates them to own solutions and make them happen.

In 2019, with the support of Casey Family Programs, the OCA embarked on a venture towards collaborative and transparent examinations of system performance. Guided by evidence-informed consultants from Collaborative Safety, LLC, the OCA adopted the safety-science-based SLR. The SLR evaluates events to promote learning in a practical, engaging and immediately useful way. For an SLR, the OCA prepares materials and provides a safe space for DHHS personnel to walk through and learn from a child's critical incident. Committed to learning before fatal tragedies occur, the OCA made the decision not to limit SLRs to deaths of children alone. The SLR may examine all critical incidents or other significant events involving children receiving state or state-arranged services.

It is helpful to review what constitutes a critical incident. The OCA's enabling statute RSA 21-V:1, III identifies the incidents that must be reported to the Office.

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[2]Child welfare system: The New Hampshire Division for Children, Youth and Families provides both child protection and juvenile justice services. Given the dual role and the shared needs and experiences of children in each system, the term child welfare system is operationalized here as inclusive of both.

[3] Douglan, EM & McCarthy, SM, (2011). Child fatality review teams: A content analysis of social policy. Child Welfare 90 (3): 91-110. http://eds.a.ebscohost.com/eds/pdfviewer/pdfviewer?vid=0&sid=9cd70a28-46a0-40ec-ac0b-737afc139305%40sdc-v-sessmgr03

[4] Institute of Medicine. 2000. Briefing. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf.

RSA 21-V:1 Critical Incidents

- *A fatality or near fatality of a child*
- *Abduction of a child*
- *Human Trafficking of a child for any purpose*
- *An accident involving a child and staff or provider*
- *Parent or guardian fatality*
- *Suicide or attempted suicide by a child*
- *Rape or other sexual assault of a child*
- *Serious physical or psychological injury of a child*
- *An inquiry from the governor or commissioner*
- *Circumstances resulting in reasonable belief DCYF failed to protect a child resulting in imminent risk of, or serious bodily or emotional injury or death*
- *A media report of a child*
- *Restraint or seclusion of a child*
- *Any other incident that may seriously affect a child's health and well-being*

Review of the list of potential critical incidents generates an understanding of many levels of associated grief and loss. The OCA is rarely in close enough proximity to process directly with a child, family or staff. While we mourn the loss, we do not impose in such a personal and intimate role. Nor do we process loss experienced by staff beyond advocacy for adequate staff supports. The SLR process is system focused. In our effort to separate system analysis from personal tragedy, we regret any perceived insensitivity to the impact on individuals. The emphasis on system analysis is apparent in the focus of an SLR: the learning point. Learning points, for purposes of the SLR process, are identified in the child's case summary and history with DCYF. They are actions or decisions that stand out as:

- Deviations in policy or practice
- Work outside best practice
- Other areas of practice that would benefit from study

A child's case gives context to child welfare practice. A learning point gives a point of reference to examine the context of the system with the expectation that many conditions of the system will influence practice and decision making. Although it may seem distant from the personal tragedy, the learning point is an anchor of analysis in a multifaceted and chaotic situation. This summary report is the result of four SLRs that DHHS employees conducted and own with OCA facilitation and guidance.

2020 System Learning Reviews

Details of the four SLR cases are outlined below with an account of the precipitating incidents, the child's narrative with background context for the incident, an identified learning point that guided case examination, emerging themes from SLR team discussion, and recommendations.

Summary: Four Cases[5]

Three of the four children whose cases were the subject of SLRs came to the attention of the OCA through critical incident reports. One was the subject of a complaint to the OCA. The children ranged in age from 2 to 17 years. Only one child had an involved father. All of them had absent mothers or unstable relationships with their mothers. One child, who experienced a near-death injury, began the journey under the care and supervision of a border State. Of the other three, one child was restrained while in the care of an institution, one was removed from a relative foster home, and one was hospitalized for a suicide attempt at a residential program. In this section, each case review includes:

- The child's narrative summarized from DCYF and other records
- The learning point chosen by the SLR team around which to focus the review
- An account of what the SLR teams learned from their considerations of the narratives in the context of what they know about the work environment, organized in prevailing themes
- Recommendations made by the SLR teams

CASE I. Communicating Across Borders

System Learning Review Incident
Toby was born in a border state to New Hampshire. He came to live with his father in New Hampshire around the time of his second birthday. Shortly thereafter, Toby suffered massive head trauma when pushed from a high chair. That incident brought him into the care of NH DCYF, and to the attention of the OCA.

Toby's Story
Toby's father Kevin, was 23 years old at the time Toby was injured. Kevin was expelled from school in the 9th grade. Shortly after, he was reportedly homeless. He found work, a place to live, and later had encounters with three women relevant to this case. One gave birth to a daughter in 2013. They lived together briefly. Separated, Kevin's daughter visited him every other weekend and they appeared to have a good relationship. Unbeknownst to Kevin, the two other women each later gave birth to children: Toby in a border state in 2016 who ended up under the care of the border state's child welfare agency, and twins in New Hampshire in 2017 who came into care from birth under DCYF. Over eleven months in 2018, Kevin found himself sharing custody of one child and a potential custodial parent to three additional children, while maintaining a full time job.

When Kevin first learned of the twins, he informed DCYF he could not care for them. However, shortly after, Kevin said he wanted to raise them. He sought help from family and friends for housing, childcare, and supplies. Financial hardship was a constant concern. The twins' court appointed special advocate/guardian ad litem (CASA/GAL) and foster parent expressed concerns about progress of his visits. The child protection service worker (CPSW) began looking for in-home support services for Kevin. After about three months, Kevin told DCYF he was "incapable of providing care to the twins." At the same time, the border state's authorities confirmed Kevin's paternity for Toby.

In Spring 2018, Kevin's attorney represented at a *Bill F.* hearing[6] that Kevin was prepared to take the twins home that day, even though Kevin appeared to express otherwise. The day after that, Kevin texted the

[5] All names and some clearly identifiable characteristics were changed to protect the identity of individuals. Pseudonyms maintain and honor the sense of events occurring in the lives of real people.
[6] A *Bill F.* hearing is a hearing for parents who have not been charged with abuse or neglect regarding that parent's ability to provide care for, and obtain custody of, their child. *See In re Bill F.*, 145 N.H. 267, 274(2000). . RSA 169-C:19-e codified the hearing procedure outlined in *In re Bill F.*

CPSW that he did not have the means to provide formula and diapers for visits with the twins. His vehicle could not accommodate the twins and his daughter.

The twins had been in foster care over two years, well beyond the policy for permanency within 12 months. The same time pressures were underway in Toby's case as well. The drive to visit Toby was long and Kevin missed work. Kevin's attorney described him as being, "Caught between a rock and a hard place." With Toby's arrival from the border state down to a few weeks away, the NH attorney requested a slow transition for the twins. Kevin was setting up doctors, looking for childcare, purchasing cribs and other items. He had clothes for the twins from family members but could not find any clothes for Toby. He arranged for Toby's paternal grandfather to provide childcare on workdays, adding two hours of travel to his commute each day for drop off and pick up. From mid-to-late summer through late fall, Kevin did not visit with the twins. He took a second job and intended to focus on Toby, with whom he demonstrated an attentive bond. Kevin was advised to get baby gates for the stairs. Unable to afford them, Toby had a fall. The NH CPSW expressed concerns for the stress the single father with four children was under, with financial problems and not able to reunite with the twins fast enough.

At some point in late fall, Toby went to live with Kevin. An undated letter from Toby's grandfather/child care provider described Toby as demanding, crying a lot, and hard to understand due to a speech problem. Not long after his arrival, NH DCYF received three referrals alleging abuse of Toby by Kevin. Toby had suffered massive head trauma. Kevin disclosed to police at the hospital that he was feeding Toby who was refusing to eat. He hit the child on the chest causing Toby to propel from the high chair and land on the tile floor. After Toby's injury, Kevin told the NH CPSW his father's ability to provide childcare had been interrupted (date unspecified).

CASE I. What we learned from Toby's Story

Because Toby's story crossed the state border, the SLR team included child protection staff from both states and an AAG from the border state.

Learning Point: Communication/information sharing across borders

Toby's cross border case is not unique. The northern New England borders are fluid to extended family and employment migration with which children often flow back and forth. The SLR team made up of child protection professionals from two neighboring states discovered they were not well familiar with each other's systems and did not have established clear lines of communication.

Communication is dependent upon relationships

The SLR team found communication closely related to relationships. Within a same-state system of relatively small states, staff know whom to call between district offices for information because of readily available contact lists and established relationships among supervisors and regional administrators who network routinely. The team noted that there are some relationships with neighboring child protection offices close to the border, however, those relationships do not necessarily exist between people in all offices across state borders, and especially offices located a substantial distance from one another. Similarly, purposefully building relationships, thinking of people involved in a case as members of the same team, opens lines of communication. For example, thinking of the parent aids who worked with Toby's father in New Hampshire, as members of the team and potential sources of information and support. The SLR team also wondered if there were, or could be, a relationship between each state's guardian ad litem, both of whom had important information relevant to each case.

In addition to knowing with whom to speak, the SLR team noted cross-state and within-state inconsistencies on what *can* be shared. Confidentiality laws are either unknown, misunderstood or so

complex that staff are reluctant to share information. When sharing information across borders, staff are often not clear on what authorization they have, or need to get, and from where.

State systems have different processes and speak different languages

When the two states do communicate, there may be confusion because each state has its own child protection language and processes. New Hampshire courts "find" for reports of abuse or neglect[7] while in the border state, the courts determine "jeopardy" to a child's safety. The border state's caseworkers may not understand New Hampshire's child protection court processes and procedures, for example, a "*Bill F* hearing" to determine Toby's father's fitness for parenting as a non-offending parent in order to reunify him with his other children. Information gleaned at a hearing could be a resource to another state intent upon placing a child with a parent subject of such a hearing.

Limits on time equate to limits on information sharing and holistic thinking

Short timelines may not accommodate time needed to find the right contacts and wait for records or answers to questions from another state. The SLR team described commonly short-staffed, busy offices in which few were available to answer phones on either side of the border. The person who answers the phone may not have familiarity with a case. Pressed for time, staff may ask for minimal information from the record. The emphasis on assuring child safety takes precedence over learning the processes of the other system. The pressure of time extended to follow-up with collateral contacts as well. A caseworker focuses on readying for court hearings or other deadlines rather than pursuing collateral contacts to attain background information on the parent.

Time limitations may also have effected communication in terms of listening. The SLR team noted several themes that stood out about the father's communications. They noted that he presented as wavering on whether he wanted to, or could, care for his children; he consistently expressed concerns about his capacity to parent, describing stress and financial difficulties, especially as related to having all three children.

Under the pressure of time, the SLR team acknowledged field staff tend to focus attention on children's immediate needs. Confirming safety and immediate wellbeing in terms of stable housing, food, and access to services, is prioritized. There may not be time to take a long view and anticipate needs holistically. For example, what does it mean for a twenty-three-year-old male with a ninth grade education to take on parenting of three children at the same time with few resources? As one SLR team member noted, Toby's father suddenly had "three kids, and he never had a baby shower."

The SLR team also discussed the notion that people have a right not to be under the scrutiny of child protection, to get on with their lives. Responding to the pressure to move a case along to free a family from that discomfort might be a trade-off for taking time to gather all available information that would ultimately situate a family safely.

Even without functional relationships, each state agency trusts the other has their back

When a child reunifies with his biological father from another state, the Court would dismiss the case and end any jurisdiction for follow up to be sure he settled in safely. The team noted, however that with the receiving state having an open case, there might be a presumption of protection by a sister child protection agency supervising the other children. One participant noted, "It would have felt like one of ours was watching."

CASE I. SLR Team Recommendations

[7] NH RSA 169-C:3, XIII-a defines "Founded report" as "a report made pursuant to this chapter for which the department finds by a preponderance of the evidence that the child who is the subject of such report is abused or neglected." http://www.gencourt.state.nh.us/rsa/html/XII/169-C/169-C-3.htm

Although the two state agencies' staff did not know each other well enough for easy access to information, they did recognize each other as allies or sister-agencies. They have a presumed trusting relationship that is a strength for establishing better lines of communication and engaging in inter-agency learning and team meetings.

The SLR team identified the following as recommendations stemming from the review. These considerations are directed at both NH DCYF and border states to undertake:

- Both State child welfare agencies: establish proactive, communicating relationships
    - Identifying a point of contact in each state's central office to coordinate exchange of information between all district offices
    - Routinely share contact sheets for district offices and any specialists that may be useful (nurses, parent aids, domestic violence specialists, etc.)
    - Holding periodic interstate-agency meetings to nurture relationships, update new programs and resources, and discuss trends in cross-border issues
    - Establishing procedure of holistic planning and sharing local resources with any cross-border transition (e.g. family resource centers, child care, parenting support, after school programs and school contacts)
- NH DCYF and bordering state child welfare agencies: establish policy for cross-border cases to
    - Invite both state's teams to family treatment meetings. Be all-inclusive according to children's needs (GAL, providers, schools, etc.)
    - Require a "warm hand-off" or assist with access and introduction for services to child development/parenting support/voluntary services for all reunification cases involving new parent-child relationships across borders
- Legal counsel for each State's child welfare agencies: clarify information each State can share with the other and disseminate among field staff

CASE II. Continuity and Consistency of Children's Relationships

System Learning Review Incident

Nine-year-old Joseph was having difficulty settling into his relative foster home. It was his second time there between lengthy institutional placements. His relative foster providers requested respite and were offered one night. DCYF staff informed the relatives after Joseph was gone that he would not return.

Joseph's Story

Joseph suffered extensive early childhood trauma by parent and grandparents. He and his family were subjects of 36 referrals to DCYF and 11 assessments by the time he was 9-years old. Those assessments involved allegations of physical, psychological, and sexual abuse, and neglect while in the care of his mother. His father was never in his life and reportedly often incarcerated.

Joseph has been in the custody of DCYF since early 2016. In that time, he has had four different CPSWs. In 2016, Joseph left a foster home for emergency respite after demonstrating aggressive behavior. Both Joseph and the foster parent expressed desire for his return. However, DCYF placed him in an institution for crisis stabilization instead. He did not see the foster parent again and remained at the facility for nearly two years. In that time, Joseph received visits and demonstrated a strong bond with his mother. Despite the bond, she was determined to be unable to provide for him. The Court terminated her parental rights in 2017 and they did not see each other again. During the summer of that year, relatives expressed interest in Joseph living with them and they commenced visits. They requested he move in with them by early the following year to align with school resumption after the holidays. Records reflect the relatives advocating

for in-home and school-based services, as well as evaluations prior to Joseph arriving in their home. Joseph did not move until spring of the following year. The services were not in place.

Soon after arrival, extreme and potentially harmful behaviors required Joseph's hospitalization. The relative caregivers expressed frustration with DCYF and reported they could not take Joseph back. After hospitalization, Joseph moved to another institution. Over the next year and a half, Joseph did well at the facility. Having expressed a desire to remain a part of his life, the relatives continued visits. Things went well enough that they eventually asked that Joseph move with them again and, despite some expressed reluctance by DCYF staff, he was matched and moved back with the relatives in late 2019. Joseph struggled with problem behaviors in the home and the caregivers sought help. They did not get immediate response from calls to DCYF. Approximately one month later, they expressed to the DCYF CPSW that they were having "issues" with Joseph and needed respite. Records document Joseph's in-home provider encouraging them for advocating for their needs. DCYF arranged for Joseph to spend one night at his most recent institutional facility, encouraging the relatives to rest and enjoy the time, but making it clear that this was not an extended option. At the beginning of 2020, Joseph went to respite. DCYF, in conjunction with a therapist at the facility, decided that it would be best for Joseph to remain at the facility. DCYF informed Joseph's relatives that Joseph would not be returning to their home. It was several days before Joseph learned that he would not be returning. Six months later, at the time of the SLR, Joseph remained at the facility. He had had one supervised conversation with his relatives by phone in the six months since leaving their home.

CASE II. What we learned from Joseph's story

The SLR team noted a theme of disrupted relationships in Joseph's life.

Learning point: Continuity and stability of a child's relationships.

Maintaining relationships and meeting care needs can be mutually exclusive

The SLR team considered continuity and stability of children's relationships from the perspective of safety, treatment needs, and placement decisions. Despite the strong bond Joseph had with his mother early on in DCYF care, she was determined to lack capacity to provide his care consistently. Joseph did not have the option of maintaining a relationship with his mother and receiving care and treatment through other caregivers at the same time. Legal obligations interrupted the parent child relationship in order to free Joseph for a safe, stable home. Appropriate care and relationships appeared to be mutually exclusive. Similarly, the team found that access to care is prioritized over relationships, as noted in removal from the foster homes without maintaining contact between child and caregivers.

The team postulated that the decision to remove Joseph from the first foster home was likely due to a conclusion he needed a higher level of care thought only available in an institution. In his first placement with his relatives, the relatives agreed with DCYF staff that they did not have capacity to meet Joseph's needs without requested intensive services. In his first removal from the relatives, Joseph maintained a visiting relationship. After returning and removal a second time from the relatives, Joseph did not have the opportunity to see them again. The SLR team discussed the possibility that decision makers assumed seeing the relatives would make it difficult for Joseph to settle in to the institutional routine where he would receive a higher level care. Avoiding upsetting interactions and exacerbation of disappointment may have been the basis of the decision to limit communication with the child's relatives.

Maintaining relationships appeared to carry less weight as a priority than accessing treatment or living in a setting assumed to meet the child's needs. The SLR team noted Joseph's repeated experience of loss of relationships contributed to his trauma and it manifested in problem behaviors in a cycle that repeatedly opted for treatment exclusive of meaningful, consistent relationships with caring adults. Within that cycle, behaviors worsened, which influenced decisions for the higher level of care.

The SLR team observed the institutions where Joseph was placed prioritized his acclimation to the institutional regimen as a means to facilitate his availability for treatment. Limiting communication with family members was thought to be a trade-off for his stable behavior at the facility at the cost of his sense of committed relationships. The SLR team also expressed the impression that institutional providers tend not to support extended family visits. The back and forth from family to facility may cause behavioral disruption and therefore disruption of treatment. Children and families or foster families in the process of reunifying are often limited to weekend visits that are artificial in terms of the pressures of daily schedules including school and work. Prioritizing acclimation and stability in institutional settings limits children and families' ability to acclimate to a natural routine at home and may lengthen the institutional stay. The team agreed that bonding deepens through hardships and successes, but until caregiver and child know each other well, the hardships may overwhelm, prompting longer institutional stays or re-admissions as Joseph experienced.

System pressures interfere with maintaining relationships

The SLR team noted the importance of maintaining relationships in Joseph's life. His mother's maltreatment was the reason he was in DCYF care. His loss started there. However, the record documented a strong bond and good relationship between Joseph and his mother while he was in State custody. Despite that, her parental rights were terminated and they did not see each other again.

The case for termination of parental rights (TPR) can be clear. Federal law demands children have permanency of living and family arrangements within 12 months to minimize trauma and interruption of healthy development. There may be parents who are not willing or struggle to engage. There are also many obstacles to assisting parents in their engagement towards reunification. The SLR team noted CPSWs encounter significant conflict in timelines and competing objectives when a case is on track for TPR. The pressure to meet legal demands in the 12-month permanency schedule collides with a multitude of tasks, including: coordinating with parents, providers, parent educators, transportation, housing, employment assistance, childcare; negotiating with schools, or whomever is involved to ensure a child's complex needs are met; while at the same time helping a parent do what they need to do to reunify, which may include accessing treatment themselves, and transportation to appointments, securing stable housing, employment, and building skills in parenting. The pressures of case management can monopolize time allotted to exploring creative options for nurturing a child's relationships.

The SLR team noted that these kinds of timeline pressures, along with competing needs of other cases[8] might influence how quickly a CPSW may respond to phone calls, E-mails and other attempts by parents or caregivers to reach them. Those same pressures could have delayed Joseph's departure from the first institution by four months and interfered with establishing home services or school arrangements in time for his arrival at the relative caregivers. Eventually, the pressures and demands that influence delays in unreturned phone calls or case progress are ultimately the pressures that influence relationships between caregivers and agency field staff. The same competing demands might also influence the rapidity with which Joseph was placed in institutional care each time he left foster or relative care. Responding to complex, sometimes-dangerous behavior with an institutional placement actually relieves the CPSW of many demands compared with returning a child to relative care and being tasked with making referrals to, and follow up with, community providers, coordinating in-home services, ensuring access to transportation, health services reimbursement, and accessing parent training. The fact that Joseph had four CPSWs in a short period also suggests each CPSW was under pressure to become expert in Joseph's narrative, needs and plan, in addition to establishing a trusting relationship with the boy.

[8] At the time of mother's termination DCYF CPSWs had caseloads at peak levels well over the recommended average.

The SLR team also noted that relative caregivers do not receive the same level of training and preparation that licensed foster parents do. That lack of preparation, in combination with a CPSW's competing pressures and a child with complex behavioral needs, all influence decisions to interrupt a relationship for an institutional placement that seems to be the best decision at the time.

Perspectives shape relationships

The SLR team noted that the relative foster care parents' perceived lack of response to requests for assistance and services for Joseph during both placements likely contributed to the family feeling frustrated and angry with DCYF. In the first placement, when CPSW caseloads were higher, competing needs of other cases may have influenced the CPSW's timing for returning phone calls or setting up in-home services and a school program in anticipation of Joseph's arrival at the relative's home. As noted above, delays in getting in-home services set up may have been a by-product of a heavy workload and the consideration of institutionally-placed children as less work-intensive. The sense Joseph's immediate needs were being met may have tempered any sense of urgency for discharge and set-up in the relative home.

Joseph's subsequent hospitalization and the relatives stating they could not care for him at home could have been understood from two perspectives. Because they did not receive the services they felt they needed, they lost trust that the agency could support them to keep Joseph home safely. Their refusal to take the child back could have been perceived by DCYF as a lack of commitment and disappointment for the child. The two perceptions inhibited a working relationship. When Joseph's second placement became problematic, the DCYF may have viewed rapid removal as protective of Joseph from a reoccurrence of disappointment. Alternatively, the relatives may have seen it as disruptive to their relationship with the boy, further negatively affecting their relationship with the agency. The SLR team noted that this kind of rocky relationship often impedes caregivers from asking for help or working through difficult circumstances.

Investment in adult relationships pays off in children's relationships

The SLR team agreed that in the process of DCYF taking action to protect Joseph and access treatment for him, he experienced a great deal of loss. When he was removed from his home due to neglect or abuse, he not only lost his mother, but he lost his sibling and his extended family who had helped care for him. Later, when it was determined he needed a higher level of care, he lost a foster parent he appeared to care for. Because DCYF was experiencing a high turnover of staff at the time, his assigned CPSWs changed four times. Although being in a permanent home with family is the best place for a child to be, he likely left behind friendships with children and staff at the two institutions where he was placed. At the time of the SLR, he had not seen his relative caregivers again, or had a private conversation with them. The relative caregivers sustained a deep distrust and anger with DCYF. The SLR team identified that there are limited resources and attention dedicated to preserve and repair relationships between caregivers and the agency. The SLR team was not able to describe any resource designed to help foster parents and relative caregivers process crises they experience, such as the disruption and loss of a child placement. In this case, the anger and grief the relative caregivers experienced was yet to be resolved. With Joseph's mother and his relative caregivers there was no time or mechanism to explore the value of their relationships or whether Joseph could maintain some form of connection to them.

The SLR team noted that licensed foster parents undergo a home study and examination of supports available to children placed with them. Relative caregivers do not typically undergo the same scrutiny on the same timeline and may be less well known when children move in with them. The SLR team also noted the emphasis on primary caregiving roles when seeking family connections for children, leaving out opportunities to promote natural "aunt/uncle" type relationships as an alternative to full-time parenting if not deemed achievable. They identified a need for resources to help support and solidify relationships

with relative caregivers as an investment that would pay off in the child's relationships and therefore the child's healthy development.

CASE II. SLR Team Recommendations

Caring, consistent relationships are key to any child's long-term health and wellbeing. They are an essential ingredient of recovery and resiliency for children like Joseph with adverse childhood experiences.[9] Therefore, putting preservation of relationships front and center of children's care in family case management is a promising approach to successful outcomes.

The SLR team's recommendations on this case are directed to DYCF family case management services in partnership with the care management entities (CME), the NH Foster & Adoptive Parent Association (FAPA), and the Bureau of Children's Behavioral Health (BCBH), the agency responsible for assessment, matching and provision of institutional and community-based care. The following six considerations would be realized through adjustments to case management policy, practice and training. Some of the changes may be naturally realized as caseloads decrease with the hiring initiative still under way. The agency's proposed budget for FY 2022-23 at the time of this writing excluded 22 CPSW positions and other DCYF positions are unprotected from DHHS-wide position cuts made by the House Finance Committee.

- DCYF Family Services CPSW & Resource Workers – Promote aggressive assessment, preservation, and nurturance of relationships with relatives and other key figures in children's lives. (Educate about mediated adoptions, promote the value of maintaining aunts and uncles and other family members as extended circles of support even if not full-time caregivers)
- CPSW casework policy and training – Refer children transitioning from institutional care to transitional enhanced care coordination (TRECC) to ensure responsive care management and family support (with understanding the program is still new, hiring staff, and not yet fully implemented in March 2021).
- CPSW casework and policy, FAPA supports and education – Anticipate the need to educate foster parents and relative caregivers about the use of mobile crisis and stabilization care if/when 2019 Senate Bill 14 is implemented establishing those services across the state
- DCYF Bureau of Foster Care & Adoptive Services and FAPA – Require debriefing and referrals to grief care or other indicated resources for foster or relative caregivers who experience a child's placement disruption. Include foster parents and relative caregivers in the design of the debriefing and referral system to ensure an effective approach that heals and repairs relationships
- DCYF – Require all children transferring to the care of foster and relative caregivers be referred to in-home services for transition, stabilization, and if indicated, ongoing supports
- Bureau of Children's Behavioral Health (BCBH)– Require institutional programs to provide after care for a period of time with all foster or relative caregivers to ensure uninterrupted care with familiar providers until settled in relationships with community providers (This was included in a 2021 request for proposal RFP-2021-DBH-12-RESID for procurement of residential services.)

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[9] Sege, RD, Harper Browne, C, (2017). Responding to ACEs with HOPE: Health Outcomes from Positive Experiences. *Academic Pediatrics*, 17: S79-S85.

CASE III. Extended Duration and Positioning of Physical Restraint

System Learning Review Incident

Vape paraphernalia were found in 17-year-old Anthony's room at an institution where he was placed. He was taken to the facility's "Quiet Room." Anthony stated if he were in the Quiet Room long he would "freak the f*** out". After about ten minutes in the Quiet Room, Anthony stood and walked toward the door. A staff person stepped in front of him, they struggled and the staff took Anthony to the floor in a facedown position. He remained in that position, held by 2-3 staff, struggling for 80 minutes until police arrived and arrested Anthony. New Hampshire law governs how and when children may be restrained.

Anthony's Story

Anthony experienced a chronically disrupted childhood. From age five he spent nine years with caregivers other than his mother. His father was absent from early on. There were seven abuse/neglect referrals on his behalf from the age of seven. Allegations included sexualized behavior, sexual assault, emotional mistreatment, medical neglect, and exposure to substance use. All were unfounded with the exception of a neglect case. In early summer 2019 he moved in with his mother and her other children for the first time in 12 years. In the fall, the two had a number of arguments. Anthony did not consistently attend school and his mother reported he met adults from the Internet for sexual acts. Arguments with his mother prompted three arrests and a neglect petition for protective supervision when his mother refused to bring him home from the police station. Under the delinquency petitions, Anthony was placed in an institution and the neglect case closed.

New Hampshire RSA 126-U:5 Limitation of the Use of Restraint to Emergencies Only. –
I. Restraint shall only be used in a school or facility to ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or others. The determination of whether the use of restraint is justified under this section may be made with consideration of all relevant circumstances, including whether continued acts of violence by a child to inflict damage to property will create a substantial risk of serious bodily harm to the child or others. Restraint shall be used only by trained personnel using extreme caution when all other interventions have failed or have been deemed inappropriate.
II. Restraint shall never be used explicitly or implicitly as punishment for the behavior of a child.

Anthony did generally well at the institution. He had one incident with a peer for which he was directed to the Quiet Room. He refused and left the facility. The police picked him up shortly after. In early 2020, Anthony was suspended from school for lack of attendance. The CPSW documented that he had a good therapy session with his mother, was in good spirits, and was looking forward to a home visit. There appeared to be certain staff he did not like, trying to avoid them by staying up all night and sleeping in the day. A later monthly report described him as "increasingly angry" and that his mother did not attend therapy.

Less than a month later, vape materials were found in Anthony's room and he was taken to the Quiet Room against his objections. The Quiet Room is comprised of a wall of small stalls with built-in hard seat. In front of the stalls is a desk. Anthony sat in a stall facing out. A staff person sat in a chair at the side of the desk near the door. After a short time, Anthony stood and walked toward the door. The staff person stood, blocked Anthony and shut the door simultaneously. Anthony attempted to continue to the door. Video surveillance of the incident shows the staff person grabbed him on the upper body, pushed him towards the back wall, and maneuvered him to the floor in a face-down, prone position. The restraint lasted 80 minutes during which time Anthony's pants were below his buttocks exposing his underwear.

By video his right hand can be seen reaching for his pants waist through much of the restraint. Three staff rotated holding him down sometimes two and three at a time with one or two persons straddling him or holding him from the side. The police arrived, handcuffed Anthony, and spoke with staff while Anthony was still on the floor. They then lifted him to a standing position during which his pants were pulled up. They left the room. Anthony was charged with assault of staff and resisting arrest. He was placed at another facility upon request of the first institution's staff to invoke a dual order.

CASE III. What we learned from Anthony's story

Because Anthony's critical incident occurred in an institution and he had both juvenile justice and child protection cases, the SLR team included DCYF field staff and administrators from juvenile justice and child protection services, facility staff, and representatives of the DHHS Bureau of Learning & Quality Improvement and the Bureau of Children's Behavioral Health. Several things about Anthony stood out to the SLR team. They noted his problematic relationship with a mother who had left him with others for many years. Despite adverse childhood experiences and trauma, Anthony did not demonstrate problematic behavior until recent months prior to arrests and institutional placement. The team noted a potential relationship between his sexualized behavior and history of being sexually assaulted as a young child. Behavioral triggers at the facility appeared to be non-preferred staff and possibly having his pants fall. The team noted that his coping mechanism appeared to be physically acting out by attempting to leave stressful environments. The team also noted his behavior appeared to be associated with being removed from his peers. The SLR team wondered about child residents' understanding of the Quiet Room and its use. It had dual purpose, both for punishment and for taking calming space. They identified prone restraint for 80 minutes being outside usual practice as the learning point.

Learning Point: Prone restraint for 80 minutes is outside of usual practice

Perception of harm by facility staff may prompt action to protect themselves and other resident children

The SLR team noted that facility staff own an obligation to keep children safe. Several features of the situation suggested the three staff who restrained Anthony did so to keep him safe. His history of leaving the facility once before and a history of being sexually trafficked, put him at risk of harm were he to leave. Anthony himself could have been perceived as dangerous to the staff and the other children by continuing to struggle. Reaching for his pant waist could have reflected a perceived threat revisiting past trauma of sexual assault and trafficking. But in a heightened state, the staff could have perceived the movement of his hand as an aggressive gesture. Prior to placement in the institution, he had been charged with simple assault, therefore there may have been a perceived history of aggressive behavior. These factors could have influenced staff's decision to continue to restrain Anthony for 80 minutes.

Working conditions and lack of policy structure for de-escalation may influence staff decisions to restrain

The SLR team discussed common working conditions in institutional care. They expected that most staff earned low pay and therefore might work long shifts, have more than one job, and suffer fatigue. This, the team felt, could influence decision-making capacity under stress. Other features of institutional work the team discussed included limited training and depth of experience, and a high emotional tax of the work. The team imagined the staff would be experts in day-to-day interactions with children but have little practice or time for training in effective de-escalation. For example, common symptoms associated with trauma include hypervigilance and tactile defensiveness or hypersensitivity to being touched.

The SLR team learned that the facility has no policy requiring hands-on intervention if a child attempts to leave a room. Facility staff are encouraged to use their own discretion, and make their own decisions about physically restraining children. Staff may consider the child's age and intent when determining how to respond. Given previously mentioned features of staff conditions, the SLR team discussed the lack of preparation and support the institution staff may have had to inform their own discretion.

Restraint as a default approach

The work conditions combined with a situation in which a teenager is intent on leaving a room may influence decisions about the use of restraint that are not fully aligned with the law. The SLR team noted that the law allows for use of physical restraint in emergencies only. In a therapeutic setting, by design, use of restraint would not be a goal. However, the SLR team noted that when staff are tired or overtaxed with competing needs of children, the decision to restrain may be viewed as a shortcut to managing the situation. In this case however, Anthony's restraint lasted 80 minutes, monopolizing the time and attention of three staff, each at risk of injury.

Disagreement on the legality of prone positioned restraint

The SLR team discussed the position Anthony was in during the lengthy restraint, face down on the floor or prone, as out of expected practice and not a position most staff intend to use. The team learned that staff hesitate to use prone restraints; however, things happen quickly in intense situations and may not evolve the way staff intend. SLR team members did not agree on whether the use of prone-positioned restraint is legal under RSA 126-U:4.

126-U:4 Prohibition of Dangerous Restraint Techniques. –
No school or facility shall use or threaten to use any of the following restraint and behavior control techniques:
I. Any physical restraint or containment technique that:
(a) Obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing;
(b) Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child;
(c) Obstructs the circulation of blood;
(d) Involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or
(e) Endangers a child's life or significantly exacerbates a child's medical condition.
II. The intentional infliction of pain, including the use of pain inducement to obtain compliance.
III. The intentional release of noxious, toxic, caustic, or otherwise unpleasant substances near a child for the purpose of controlling or modifying the behavior of or punishing the child.
IV. Any technique that unnecessarily subjects the child to ridicule, humiliation, or emotional trauma.

Reliance on police for control

The SLR team explored various potential influences on the exceptional length of the restraint (80 minutes). An additional reason for its length, the team determined, could have been that they were waiting for police to arrive to control the situation. Police, in this scenario are a resource to manage complex situations such as a resisted restraint. Alternatively, as the locus of responsibility shifted to law enforcement, the pressure shifted to police to resolve the situation. Although police later reported they did not believe charges were necessary because Anthony had calmed down and expressed remorse, when staff called the police and filed charges, the police became responsible for the situation. The police de-escalated any physical threat by handcuffing Anthony. They then removed any potential threat at the facility by responding to the staff's charges and invoking a dual order that allowed Anthony be removed and immediately placed at a different institution.

Dual orders inhibit commitment necessary for therapeutic relationships

A dual order is an order from the Court for placement at an institution with permission to remove and place at another institution if the child fails to follow all facility rules. It is a means for the Court to make an advance decision about whether the child can be terminated from a program and/or placed elsewhere without a Court hearing. A member of the SLR team noted that a dual order may take away the motivation to invest in the child's treatment. Effective treatment relies upon a committed, trusting relationship. That relationship relies upon the child knowing the provider is committed. Commitment to treatment reflects a provider's valuing of the child and belief in potential for rehabilitation. It motivates and gives incentive to a child to participate in treatment. A team member described the dual order as an "escape valve" to commitment.

The practical side of a dual order was explained as DCYF having an imbalance of supply and demand for places to house children. DCYF generally has a limited available array of services for a child with this type of trauma. In certain scenarios, DCYF may need the placement and be willing to negotiate when the facility is reluctant to accept a child who may present with difficult behavior. The dual order becomes a back-up plan in case the institutional provider determines they cannot safely care for the child.

Dual use of quiet room may be incongruent with therapeutic intervention

The SLR team examined the conflicting message and interpretation of a dual-purpose quiet room. The room was described as a voluntary de-escalation resource *and* as an involuntary physical placement for punishment. This dual use is out of practice standard and could be a trigger for negative behavior. Anthony warned that he could not tolerate being in the room and he had avoided it previously by leaving the facility, both times at the threat of police being summoned. If he perceived the room as intolerable punishment, being there could have contributed to his inability to calm (although being physically handled, given his history of trauma, would also have exacerbated his autonomic nervous system fight or flight response[10]).

The SLR team speculated that the institution might have limited space on units and limited access for extra staff in emergencies, making a separate room necessary for managing crisis situations. This thinking is tied to the demands on the staff to protect all children on the unit, thus limiting the ability to return a child in a heightened state to the unit. However, staff questioned whether Anthony initially needed to be in the Quiet Room. The facility did not appear to have a crisis care plan for Anthony.[11]

CASE III. SLR Team Recommendations

Children arrive in institutions with a significant history of trauma and adverse childhood experiences (ACE), placement out of home included. The SLR team recognized the need for appropriately matched care and a workforce equipped, trained and supported to meet children's complex needs.

The SLR team recommendations are directed to DCYF, BCBH, the Legislature and the Governor. Recommendations include:

- DCYF & BCBH – Place children who have experienced trauma in the care of staff trained in trauma-sensitive care

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[10] Sherin, JE & Nemeroff, CB, (2011) Post-traumatic stress disorder: The neurobiological impact of psychological trauma. Dialogues in Clinical Neuroscience, 13(3): 263-278. doi: 10.31887/DCNS.2011.13.2/jsherin https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3182008/

[11] NH RSA 126-U:3, I, Post Admission Planning in Facilities, "As soon as possible after admission to a facility, the treatment staff of the facility, the child, and the child's parent or guardian shall develop a plan to: (a) Identify the child's history of physical, sexual, or emotional trauma, if any. (b) Identify effective responses to potential behavior or situations which will avoid the use of seclusion and restraint. (c) Identify health conditions which may make the child vulnerable to injury while at the facility."

- Legislature and Governor – Assess need for rate increases for providers and update provider rates to meet the need
- DCYF, BCBH and Legislature – Call upon residential providers where children are placed to ensure adequate pay, training (trauma-informed, developmentally sensitive; de-escalation techniques), guidance, policy and supervision. This would require the legislature allocating funds for adequate rates
- DCYF, BCBH, the Court & Providers – Explore the use of dual orders as therapeutically contraindicated and potentially in violation of due process
- DCYF, BCBH & Providers – Clarify the legality of prone positioned restraints. Include prohibition of prone-positioned restraint of children in future contracts for services. In the meantime, provide education and training about the potentially lethal and trauma-inflicting risks of prone restraints to the providers continuing its use
- BCBH, DCYF, OCA, Providers – Examine all institutions for dual use of socially separate spaces for punishment and de-escalation. Provide guidance on the negative consequences of dual use and prohibit placing of children in such spaces.

Recommendations in Action

Much of the SLR team's recommendations in Case III are addressed in Senate Bill 14 of 2019 and its implementation, along with other SFY 2020-21 DCYF budgeted items. That includes the request for proposals from residential providers active at the time of this writing,[12] in concert with the care management entity (CME), the comprehensive assessment for treatment (CAT) for children's behavioral health,[13] also the subject of an active RFP, and general expansion of the behavioral health system of care pursuant to RSA chapter 135-F. In general, the policy changes seek to establish State contracts for services with institutional providers[14] who will be required to minimize the use of restraints and ensure appropriately matched trauma-sensitive evidence-based care. The CME and CAT will assess children's needs and match to services in appropriate settings independent of DCYF, eliminating the conflict of interest that both consumes services, resolves the need for accommodation of children, and regulates the institutions. Anthony's experience confirmed the urgency for the polices and services to be implemented.

CASE IV. Limited communication with out-of-state facilities

System Learning Review Incident: Jordan came to the attention of the OCA because of chronic and repetitive incidents. During six years of DCYF custody, he experienced institutional placements, incarceration, and multiple hospitalizations for serious psychiatric illness including repeated suicide attempts. In 2019, 17-year-old Jordan was at an institution out of state when his delinquency case closed by a law limiting children's time in State custody. He returned home with no services in place, later became dysregulated, was hospitalized and placed in an institution where he attempted suicide and was hospitalized again.

Jordan's Story

Jordan spent the first years of his life with his mother and her boyfriend. There are no apparent child protection records from then except reference to a neglect case in a marital matter before the court. Reports indicate he was victim of chronic abuse and neglect by both adults, and exposed to substance use

[12] RFP-2021-DBH-12-RESID Residential Treatment Services for Children's Behavioral Health. https://www.dhhs.nh.gov/business/rfp/rfp-2021-dbh-12-resid.htm

[13] RFP-2021-DBH-03-COMPR Comprehensive Assessment for Treatment (CAT) for Children's Behavioral Health https://www.dhhs.nh.gov/business/rfp/rfp-2021-dbh-03-compr.htm

[14] Currently the State has only one contract for specific services with a residential treatment provider. Institutions are only certified for reimbursement purposes.

and domestic violence. Around age 5, Jordan went to live with his father under a no contact order placed on his mother. He stayed with his father until age 10 when his father left the state and his grandmother assumed guardianship. Four years later, at age 12, Jordan's first delinquency petitions were filed for punching the wall and assaulting a police officer. He had the first of three lengthy hospitalizations in that period. Diagnoses included ADHD, anxiety, mood disorder, and rule-out bipolar disorder. A few months later, triggered by a confrontation about tobacco use, he was involved in another assaultive incident with his father and police, prompting 18 delinquency petitions. Jordan was detained at the Sununu Youth Services Center (SYSC). This began 6 years of institutional care and incarceration. At each institution, Jordan made little progress and had frequent acute psychiatric crises requiring hospitalization.

Jordan made several suicide attempts while at SYSC. The psychiatrist at SYSC suggested he was locked in a cycle of never getting ahead, with staff who were not equipped to meet his needs in a manner that enabled safe and successful behavior. The psychiatrist predicted if the cycle continued he would "become progressively stuck here as he will never demonstrate safety for a reasonable period of time such that he will be appropriate for a transition to a different setting." After a suicide attempt, Jordan was admitted to New Hampshire Hospital (NHH). He stabilized and did well for several months. While there, he was the subject of an abuse/neglect referral based on his disclosure of being a victim of sexual assault at a younger age. There was no forensic interview conducted. The abuse/neglect assessment closed incomplete with a note DCYF was unable to assess the allegations fully.

Jordan moved to an institution out of state from NHH. Early on, he was assaulted several times and on suicide watch. His Juvenile Probation and Parole Officer (JPPO) had difficulty reaching him for weeks at a time and in five months was only able to visit Jordan one time. The facility reported Jordan's behavioral issues were reduced but he was not engaged in school. It is not clear on what basis, but there was a sense among DCYF personnel that Jordan was doing well there. After five months, Jordan's delinquency case automatically closed by law [15] and he returned home to his grandmother without services in place. The last notes of that case documented Jordan's grandmother seeking guidance for whether it would be in Jordan's interests for him to spend time with his mother, given the long history of her absence, abuse, and no contact order.

A little over three months later, DCYF received a referral on Jordan because he had run away from his mother, with whom he had reunited after more than 12 years. He was found and no assessment was opened. A few days later, DCYF received another referral from a hospital. His mother brought him in for problem behavior including running away, not taking medications, and suspicion of using drugs. The hospital reported his mother was abandoning him there after an argument. DCYF opened an assessment for neglect. In the emergency department, Jordan screened positive for THC. Diagnosed with unspecified depressive disorder, substance misuse and PTSD, he was admitted to an in-patient treatment center. After a few days, he was involved in an altercation with another patient, resulting in his termination from the program. When his mother arrived, she refused to take him home and left. The staff were attending to other patient crises and left Jordan alone with a week supply of medication meant for discharge. He ingested the medicine and ended up transported to a Boston hospital. During that time, the assessment CPSW worked with his mother monitoring his care. He later transferred to NHH. NHH moved Jordan to an adult unit, where he became assaultive prompting application of charges from the earlier altercation to justify his removal to SYSC. Within two months, Jordan left SYSC on his 18th birthday for his mother's home. He went missing shortly after and was last reported as homeless.

[15] NH RSA 169-B:31-c, I, Dispositions and Case Closure in Certain Cases, "Notwithstanding any other provision of this chapter, the court shall close all cases other than those involving serious violent offenses no later than 2 years after the date of adjudication. This section shall not apply if, with the assistance of counsel, the minor consents to continued jurisdiction."

CASE IV. What we learned from Jordan's experience

In reviewing Jordan's case summary and timeline, the SLR team noted several features that stood out. It was remarkable that he experienced such significant early childhood trauma without coming to the attention of child protective services. They noted the difficulties in matching treatment for children with co-occurring mental illness and problem behaviors, often referred to as conduct problems. Jordan's behavioral needs set him apart therapeutically and, at times, excluded him from accessing mental health care. In the six years he spent in institutions and at the SYSC, he demonstrated little therapeutic progress, other than when he was in the hospital for long stays. The SLR team expressed frustration with the law that required his delinquency case end, regardless of where he was in treatment. After six years of institutional living, he returned to his grandmother's with no services, supports, or case management. The team discussed whether Jordan may have made progress in the most recent out-of-state facility. However, they also noted it was difficult to know because it is difficult to communicate with out-of-state facilities. This difficulty of communication and disruption of treatment caused by the law was combined as a learning point.

Learning Points: Difficult communication with out-of-state facilities

New Hampshire is not equipped to help children with dual developmental and mental health needs

The team discussed Jordan's combination of needs born out of trauma, related developmental disruptions, and mental illness. In addition to addressing behavior as a developmental condition, the SLR team recognized the need for evidence-based treatment with trauma screenings and referrals to trauma therapy in-state. As more services in New Hampshire are embracing trauma-informed models, the SLR team noted a persistent lack of resources for children's developmental disabilities. The team noted that it is a challenge to find clinicians to do functional behavioral analyses, an assessment that determines what a child is communicating through behavior and informs detailed re-conditioning treatment to pro-social behavior. They attributed children's placements out of state to the lack of behavioral care and inadequate reimbursement rates for behavioral psychologists and technicians in New Hampshire.

Distance impedes communication

The SLR team explained that the further away a child is, the harder communication is with and about the child. One obstacle is a school or treatment schedule, sometimes complicated by different time zones, that precludes time for phone calls from responsible field staff.

The SLR team described when DCYF field staff are unable to reach facility staff or a child out of state, they will often have to elevate the issue and "go up the chain." This means they might inquire with the DCYF program manager who certifies the facilities, to find out what is going on.[16] That can take time, further delaying contact with the child or obtaining relevant information about the child's care and safety. The child's relationship and attachment is at risk the longer communication is interrupted.

When responsible field staff succeed in contacting children, the SLR team noted that they are often not able to have open, private conversations with the child. One explanation is that the facilities lack the staff to accommodate a private conversation in the midst of other children's competing needs. The SLR team explained that children also want privacy or confidentiality from other children, without which they will not be forthcoming in their conversations about their experience or concerns. At the time of this SLR, the COVID-19 pandemic had not yet affected modes of communication as it has since.[17] The SLR team then lamented about means for communication with children and institutional staff being limited to telephone

[16] *See* DCYF Policy 1590, Practice Guide at https://www.dhhs.nh.gov/dcyf/documents/dcyf-policy-1590.pdf

[17] Due to the COVID-19 pandemic and related social distancing requirements, frequently with lock-down conditions prohibiting in-person visits of any kind, most institutional settings have expanded capacity for video meetings. Presumably, the issue of limitations of privacy, availability and access to the children persist.

and E-mail, neither of which were consistently responsive. Some facilities were starting to conduct visits using video-conferencing, but even with that technology, the imposition on privacy persisted. The team noted that other state's confidentiality laws may also be prohibitive of certain communications

The regulatory infrastructure, interstate compact for the placement of children (ICPC), does not adequately support communication with, and oversight of placements

The SLR team expressed frustration with a lack of support or supervision required of out-of-state entities by the interstate compact for the placement of children (ICPC). That directly impacts communication. When children are placed out of state at a distance, DCYF practice is to visit in person (and during the pandemic, remotely) every three months due to the cost and time consumption for long-distance travel. The team did not feel the ICPC allows or requires lines of communication to and about residential programs or adequate supervision of New Hampshire children by the receiving state, particularly when the child is placed by juvenile justice services. Supervision of a child's placement includes communicating with and about the child as a means of monitoring progress and assessing quality of care and safety. The SLR team did not feel the regulatory mechanism contributed to maintaining adequate communication in those ways.

Communication-dependent transition planning is impeded by the pressures of limited time

The SLR team expressed belief that the 2-year rule in RSA 169-B:31-c, enacted to protect children from lengthy incarceration or institutionalization for minor offenses, impedes transition and ongoing care. The team noted all cases must close within the 2-year period, regardless of ongoing service need, unless they involve serious violent offenses. The team viewed the time limits as sometimes out of sync with treatment needs. The trade-off for being out of the juvenile justice system is that children lose access to DCYF services, court oversight, or what the team referred to as "safety."

The SLR team expressed a belief that the 2-year limit on probation interrupted Jordan's out-of–state institutional placement, and precluded any follow-up community-based supports. There appeared to be confusion about the ability to plan for Jordan's transition home despite the anticipated hard end to his court supervision. The need for transitional planning and the requirement of a 90-day transition plan to best prepare children like Jordan approaching the two-year limit is impeded by the distance and lack of communication with and about the child in a timely manner. One district office now tracks high intensity needs cases to ensure regular reviews and timely planning for departure from the system. The SLR team reported that DCYF could offer voluntary services to a child at the end of the 2-year period. However, they were not clear of the eligibility requirements, or how it would work. They further noted that voluntary services require child and family willingness to participate, something that is not always the case.

CASE IV. SLR Team Recommendations

The SLR team noted the lack of services aimed at developmental conditions for children like Jordan, suggesting in his six years in state custody he may not have been matched to the treatment he needed. Children are sent out of state for institutional placements on the premise of accessing appropriate services unavailable in New Hampshire. However, obstacles to communication with both the children and the facility staff can preclude confirmation of needs being met or that children are safe. Unreliable lines of communication also impede planning for discharge and ongoing care.

The SLR team made the following recommendations to DCYF and the BCBH:

- DCYF – Investigate whether the ICPC process can be changed or procure services for local supervision and relationships with a child placed out of state in an institution
- DCYF – Prior to placing a child in an out-of-state institution, confirm access and procedure to communicate with children, staff and any other necessary persons responsible for the care of a child for whom DCYF is responsible

- DCYF & BCBH – Limit out-of-state placements through the use of needs assessments including identifying developmental needs and treatment with a functional analysis of behavior. Include any indicated behavioral treatment or conditioning in treatment plans
- BCBH – Promote engagement of clinicians to provide applied behavioral analysis and other related therapies to address the behavior needs of children like Jordan.[18] Examine adequacy of reimbursement rates for behavioral psychologists and behavior analysts who conduct and implement functional behavioral analyses
- DCYF & BCBH – Establish procedure for concurrent transition planning immediately at admission or adjudication
- DCYF District Offices – Replicate the model of tracking high intensity needs cases to prompt regular reviews and planning for departure from system that one District Office has adopted

Recommendations in Action

As with Case III, some of the SLR team's recommendations in Case IV are addressed in Senate Bill 14 of 2019 and its implementation, along with other SFY 2020-21 DCYF budgeted items. Noted above, the CME and CAT will assess children's needs and match to services in appropriate settings independent of DCYF. In addition, the DCYF service array redesign will provide for increased opportunities for community-based services negating the need for institutional placement. There is also transformation of probation underway that will affect who needs deeper end accommodation. Proposed Senate Bill 94 relative to juvenile diversion programs is a product of the Juvenile Probation Transformation project lead by a team consisting of DCYF, the Child Advocate, a Public Defender, the District Court Associate Administrator, the coordinator of the NH Diversion Coalition and a Manchester prosecutor. The intent of the project is to limit the number of children coming into JJ Services at all levels. It instead will focus on identifying children's needs and determining whether, if needs are met, risk to community would be mitigated. SB 94 proposes a pre-petition, evidence-based assessment of strengths and needs. If the assessment identifies an intervention that could mitigate need and therefore risk, the arresting authority will be advised not to file petitions on the child. The child or family will then be referred to appropriate services. A second goal of the transformation is to revise the rules of probation (conditions of release) to be individualized and guided by the needs assessment. Studies show that treating children with their families at home will have better outcomes.[19] Senate Bill 94 would situate more children to receive effective intervention outside of JJ Services to avoid exacerbating harm of exposure to the system.

Summary of findings: Emerging themes for child wellbeing

Despite the differences in child experiences, the SLR teams identified prevailing themes across all four cases examined. With the exception of gaps in service availability, all of the themes linked to a network of relationships affecting the circumstance and trajectory of children. Relationships were seen as essential to child and family wellbeing and agency functioning. Time and communication are essential to tend to all

[18] OCA Note: Jordan underwent a Functional Behavioral Analysis at NHH at the request of the OCA during his stay at NHH after a suicide attempt. His probation and SYSC team were at NHH reviewing the test results and recommended plan of care while he was transferred back to SYSC. The SYSC were not apprised of the treatment recommendations. Within a few days, he made another serious attempt on his life and was returned to the hospital. Upon his final discharge from NHH to SYSC before his 18th birthday, Jordan's discharge records included detailed recommendations for behavioral treatment, including descriptions of his triggers and proposed coping strategies. The NHH records further indicated the prescribed behavioral treatment was not available at the NHH.

[19] Annie E. Casey Foundation, (2018). Transforming Juvenile Probation: A Vision for Getting it Right

the tasks associated with building and preserving the relationships that nurture and preserve child wellbeing.

Relationships built on trust and consistent communication
Healthy, productive relationships are dependent upon trust born in commitment and consistency of communication. Time is a critical ingredient in effective care of children. In complex, chaotic human events and systems, there may never be adequate time. That inadequacy can be accommodated or overcome through the efficiency of collaborative relationships committed to reliable communication for children's best interest and outcomes.

Evidence-based, trauma-informed, developmentally sensitive, individualized care
Implementation of public policy and allotted resources through a complex bureaucracy may lack the sensitivity or fluidity necessary to respond to variations in human conditions. In recent years, interests have aligned for significant investments in New Hampshire children's mental health services. An emphasis on trauma has spurred widespread initiatives that have trained personnel and altered policy and procedure to promote trauma-sensitive care. There has not been similar investment in understanding, assessing for, and treating behavior that is a symptom of developmental conditions, such as disorders of communication. The SLR teams noted the lack of services for children who are dually encumbered with mental health and developmental conditions. In other cases, appropriate services may have existed but, due to other pressures, were not accessed. Programs that incorporate behavioral experts, assessment and interventions and educate and train staff to create developmentally appropriate milieu, sensitive to the effects of trauma, will achieve greater success with child outcomes. Those outcomes will be evidenced as healthy relationships between children and families, and eventual reduced reliance on State systems.

The SLRs confirm New Hampshire's direction in system transformation

The New Hampshire child welfare system is undergoing transformation. Several of the recommendations that emerged from the four SLRs already appear to be in the process of resolution.

- Children who are facing difficult transitions from institutional facilities or foster homes may now benefit from Transitional Enhanced Care Coordination (TRECC) offered through the care management entities (CME) and the Bureau of Children's Behavioral Health. As the program becomes fully operational, the TRECC model will promote better communication and planning with careful attention to the needs of children and parents or caregivers.
- On December 11, 2020 DCYF published RFP-2021-DBH-12-RESID Institutional Treatment Services for Children's Behavioral Health.[20] The RFP seeks proposals for high-quality behavioral treatment services in institutional settings. It represents a re-design of institutional care that would respond to some of the recommendations of this SLR Report. The RFP calls for five key components of institutional services including:
    - Trauma-informed care
    - Evidence-based practices
    - Normalcy in treatment settings
    - Focus on transition with independent oversight of a child's progress
    - Talent strategies that ensure institutional staff are trained and supported adequately to provide effective treatment

  Other features of the RFP addressing findings of the SLRs include an independent comprehensive assessment for treatment (CAT) provider who will determine appropriate care for each individual

[20] https://www.dhhs.nh.gov/business/rfp/documents/rfp-2021-dbh-12-resid.pdf

child. Providers will be required to demonstrate they can deliver matching care prior to admission, ensuring a commitment and capacity for care that should address the use of dual orders for placement. The RFP also documents the department's commitment to reducing the use of restraint and seclusion. It will require providers to incorporate the "Six Core Strategies for Reducing Seclusion and Restraint Use" © in their restraint and seclusion policies, and develop a method of review that will support the reduction and elimination of restraint and seclusion" (page 16).

The four SLRs demonstrate and confirm the need for changes sought through RFP-2021-DBH-12-RESID. However, the RFP was significantly delayed in release. The longer the wait to implement the changes mandated in Senate Bill 14 of 2019 and the allocations of the DCYF SFY 2020-21 the further loss children experience in relationships, development, and wellbeing. Communication and demonstration of commitment remains essential, including at the policy level.

Growing relationships among State Child Advocates and Children's Ombudsmen

In the past three years the OCA has invested in partnerships with neighboring child advocates and ombudsmen. These relationships have been fruitful as resources for support, expertise and information sharing. As the number of independent oversight offices grows across the country, another layer of protection and system oversight represents opportunities for ensuring the best interests of children.

Post Script

The Office of the Child Advocate is grateful to New Hampshire and the border state's personnel who generously gave time to participate in the four SLRs and those who reviewed drafts of this report for trustworthiness. Through their hard work we honor and improve the lives of the children whose experiences we examined and those who follow in their paths. We also trust that these learnings will support the difficult work field staff encounter in responding to and ensuring children's safety. We have learned from the four critical incidents that child protection and juvenile justice services respond to complex family situations in chaotic systems of care driven by fluctuating environmental and political support. Learning about points for improvement in the system is helpful but it also presages more work to bring responsive change. We look forward to collaborating on the next steps.

We are also grateful to Casey Family Programs for support in making the safety science consultants from Collaborative Safety, LLC available for this important work and allowing us to review these four cases utilizing a systems-focused safety science approach.