State of New Hampshire

Office of the Child Advocate

Moira O'Neill
Child Advocate

ADDENDUM TO 2019-01 SYSTEM REVIEW: RESTRAINING AND SECLUDING CHILDREN

INTRODUCTION

In January 2020, the Office of the Child Advocate (OCA) released the report *System Review 2019-01: Restraining and Secluding Children*
. Using RSA chapter 126-U as a starting point, the OCA examined compliance with the law that restricts use, and mandates reporting of, all restraint and seclusion of children in the care of the State, child day care or residential care, or at schools. The report carefully examined the danger associated with restraining children that prompted New Hampshire to establish the protective law. It comprised a review of child development, interruption of brain development and function caused by adverse childhood experiences, including the experience of physical restraint. The report also noted the recognition in the health care industry of negative effects of restraint that have prompted restrictions in Medicaid–Medicare reimbursements. The Centers for Medicare and Medicaid Services categorize the use of restraint, when not associated with emergencies of safety, for which RSA 126-U allows, as a human error.[1]

The surveillance of these practices falls to the OCA pursuant to RSA 21-V:7, I,[2] requiring the Division for Children, Youth and Families (DCYF) report all incidents to the OCA.[3] The mandate to report to the OCA prompted DCYF to centralize collection of incident reports for the first time in December 2019. Prior to that, field staff filed reports in individual children's records. RSA 126-U also requires an annual report of all incidents to the legislature. The annual report has historically included only aggregate data submitted DCYF received from providers. In reviewing those reports, the OCA's immediate finding was that, without the detail of the individual events, the numbers had little meaning. Of approximately 20,000 incidents over a 5-year period, there was no way of knowing whether they involved the same child, the same staff, the time of day, any related treatment that may not be effective, or any other factor that would illuminate the reasons children were restrained or secluded. That kind of information could inform efforts to eliminate the practices and align New Hampshire residential care with treatment goals, best practice and children's rights.

This Addendum Report examines the impact of the 2019 review highlighting promising system change and initiatives promoting elimination of the use of restraint and seclusion. It also describes trends in reported incidents, demonstrating the value of incident surveillance and potential for improving children's care. Most importantly, this addendum demonstrates the power of data when collected and analyzed. It identifies questions to answer to ensure the system is responding to children's needs. Some system problems may not be as big as they seem. Solutions emerge when time and analysis gives meaning to surveillance of practices in children's care.

---

[1] 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.

[2] On September 18, 2020, RSA 170-G:18 was repealed and replaced with RSA 21-V.

[3] RSA 21-V:7 Incidents and Fatalities. I. The division shall provide the office with a copy of all critical incident reports or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department of health and human services, including but not limited to reports related to the restraint and seclusion of any child under the care and protection of the division, not later than 48 hours after the occurrence.

RESTRAINT & SECLUSION DEFINED

- Restraint is statutorily defined as "bodily physical restriction, mechanical devices, or any device that immobilizes a person or restricts the freedom of movement of the torso, head, arms, or legs. It includes mechanical restraint, physical restraint, and medication restraint used to control behavior in an emergency or any involuntary medication. It is limited to actions taken by persons who are school or facility staff members, contactors, or otherwise under the control or direction of a school or facility." RSA 126-U:1, IV. "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." RSA 126-U:5, I. "Restraint shall never be used explicitly or implicitly as punishment for the behavior of a child." RSA 126-U:5, II.

- Seclusion is statutorily defined as "the involuntary placement of a child alone in a place where no other person is present and from which the particular child is unable to exit, either due to physical manipulation by a person, a lock, or other mechanical device or barrier. The term shall not include the voluntary separation of a child from a stressful environment for the purpose of allowing the child to regain self-control, when such separation is to an area which a child is able to leave. Seclusion does not include circumstances in which there is no physical barrier between the child and any other person or the child is physically able to leave the place. A circumstance may be considered seclusion even if a window or other device for visual observation is present, if the other elements of this definition are satisfied" RSA 126-U:1, V-a.

Response to 2020 OCA RECOMMENDATIONS

The OCA 2019 System Review included six recommendations for action to eliminate the use of restraint and seclusion and improve the surveillance of the practice. We list each below with updates of any actions taken in response.

2019 Recommendation: Minimize children's trauma in general by implementing the expansion of a community-based system of care that will prevent need for residential placements, and enhance department staff training in child development, including the impact of trauma on children's brains.

Update: The OCA's first recommendation addressed the broader system as a means of prevention of the placement children placed in residential facilities with subsequent risk for restraint or seclusion.[4] The 2019 Senate Bill 14[5] expanding the system of care, along with DCYF system redesign allocations in the SFY 2020-21 budget, were the impetus for wide ranging system reform. Implementation has been slow. Although effective in June 2019, the governor's budget veto was not resolved until September. Most relevant to prevention is mobile crisis response and stabilization services (MCRSS) established in Senate Bill 14. As a mode of care, MCRSS demonstrates prevention of acute hospitalizations, cost effectiveness, and greater family satisfaction.[6] In October 2019, DHHS published a request for information (RFI) seeking input on the design of mobile crisis system RFI-2020-DBH-01-MOBIL. A year later in October 2020, a request for proposals (RFP) for a crisis operations center was released RFP-2021-DBH-01-BEHAV. MCRSS for children are not yet established in New Hampshire.

---

[4] Note: Children who are institutionalized have the highest risk of being restrained. See Roy, C., Castonguay, A., Fortin, M., et al. (2019). The Use of Restraint and Seclusion in Residential Treatment Care for Youth: A Systematic Review of Related Factors and Interventions. *Trauma, Violence, & Abuse*.

[5] 2019 Senate Bill 14 An Act relative to child welfare. Final bill text amended.

[6] Substance Abuse and Mental Health Services Administration, (2016). Services in support of community living for youth with serious behavioral health challenges: Mobile crisis response and stabilization services. The National Technical Assistance Network for Children's Behavioral Health

Other community supports have strengthened in the past year with establishment of community-based voluntary services, the addition of a second care management entity (CME) with expansion of the Fast Forward program, a family coordination service. The CMEs are also now providing transitional enhanced care coordination for preparing families and guiding children out of residential facilities. Though slow, New Hampshire's progress is steady and there are persistent advocates, including bipartisan members of the legislature, championing the progress of a community-based system of care.

The current movement for expansion of community-based services and supports is promising. Delays compromise the wellbeing of many children, especially during the extreme stress of the COVID-19 pandemic. This is evidenced by historic numbers of children in emergency departments seeking acute psychiatric care and continued reliance upon residential care for children who do not have access to community-based supports. Parallel to the expanding community services, there has been significant raised awareness of child development and the effects of trauma through several initiatives. The OCA has not received reports, however of specific enhancements to DCYF staff training in response to the recommendation.

2019 Recommendation: Promote the elimination of restraint and seclusion in residential care by adopting and clarifying language in contracts, guidance, policy, procedure and adopted rules to clearly articulate the expectation of eliminating the practices and, as per RSA 126-U, prohibiting restraints that equate to holding a child prone or face down.

Update: The department is taking action to reduce the use of restraint and seclusion, but its actions have been subtle. Though there has been no definitive prohibition of restraining children in policy or decree, the department has acknowledged the harm associated with the physical restraint of children in the language of a request for proposals for procurement of residential services RFP-2021-DBH-12-RESID. The residential RFP requires the incorporation of the Six Core Strategies© for reducing restraints and seclusion, a program of the National Association of State and Mental Health Program Directors.[7] The RFP also includes metrics for both scoring proposals and eventually for measuring contractor performance for demonstrated commitment to reduce use of restraint and seclusion. This is a significant shift in care of children. Rather than focusing on finding a "placement" for children, DHHS will now be procuring specific care that relies upon effective therapeutic interventions and eliminates use of harmful restraints.

In February 2021 DHHS received approval to accept federal Family First Prevention Services Act implementation funds to contract for technical assistance in implementing the Six Core Strategies© program of restraint and seclusion reduction in residential facilities. This resource will be available immediately to current residential providers, a strong demonstration of intent to eliminate the practice of restraining children.

In November 2020 the department adopted rules for how it reviews records maintained by facilities regarding the use of restraint and seclusion as required by RSA 126-U:9, I(a). The rules further establish a uniform process for how the department receives and investigates complaints about the improper use of restraint and seclusion in facilities per RSA 126-U:9, I(b).[8] The rules require an accounting of, among other things, "… actions taken to address the emotional needs of the child during and following an incident" and "[a] description of future actions to be taken to control the child's problem behaviors." N.H. Admin. rules, He-C 901.05(e) (10), (11). These rules articulate an expectation of assessment of restraint incidents, and identification of alternatives to helping children in a way that avoids the need for restraint.

---

[7] Husckshorn, KA (2006). *Six Core Strategies for Reducing Seclusion and Restraint Use* ©. National Association of State Mental Health Program Directors. Alexandria, Virginia. See also National Association of State Mental Health Program Directors (2006). *Six Core Strategies for Reducing Seclusion and Restraint Use ©*.

[8] NH Admin. Rules, He-C 900 et seq.

The department has not prohibited the use of prone restraints as recommended. In 2019, DHHS issued an advisory statement to residential providers recommending against the use of prone restraints, but not forbidding it. Because the language of the law does not include the word "prone", the OCA has heard disagreement among administrators about whether RSA 126-U prohibits the physical restraint of children in a face down prone position.

2019 Recommendation: Incentivize culture change by facilitating access to training in trauma-sensitive, developmentally informed treatment. The OCA recommended the department capitalize on the educational infrastructure of the DCYF-Granite State College child welfare education partnership (CEWP) training programs and sponsor educational opportunities in child development, trauma, and trust-based relational interventions for residential treatment staff.

Update: The department continues to offer residential provider staff training in trust-based relational interventions (TBRI) training, a trauma-informed engagement and calming program with varying participation. The OCA did not learn of any other child development or childhood trauma education offered to the providers though CWEP training programs. The department did make funds available to residential providers to pursue accreditation, a requirement for federal reimbursement under the Family First Prevention Services Act. Accreditors require evidence-based models of care that are trauma-sensitive; therefore, residential staff are receiving relevant training in the accreditation process. Performance measures built into contracts subsequent to RFP-2021-DBH-12-RESID for procurement of residential services will also require certain standards of staff training, including trauma-sensitive care.

2019 Recommendation: Establish a system of meaningful surveillance of restraint and seclusion use. Adopt rules required by RSA 126-U:9 for reporting, reviewing, and investigating incidents of improper use of restraint and seclusion in facilities. Add findings from individual facility reviews pursuant to RSA 126-U:9, II. to the annual report. Create a web-based reporting mechanism to ease and standardize reporting and analysis, and accommodate school-based incident reporting.

Update: The department has adopted rules, as noted above. The annual 2020 report continues to include only aggregate numbers without any details from individual incidents or explanation of trends in characteristics of restraint and seclusion uses, other than a general downward trend in use. Thus, there is still little value in the data. The OCA initiated discussion with DCYF and the Department of Information Technology (DoIT) about a web-based incident reporting mechanism. All agreed on its merits and planned for development. A web-based reporting system would standardize and streamline the process. Both DCYF and OCA would also experience cost savings as currently each has at least the equivalent of a full time staff doing the same data entry. Unfortunately, programmers on the State's Salesforce platform project shifted to COVID-19 DoIT needs causing the web-based reporting mechanism to be deferred. If and when it is taken up again, the OCA is recommending the web-based system include reporting of restraints and seclusion in schools and other child care settings, also governed by RSA 126-U.

2019 Recommendation: Establish a collaborative review of restraint and seclusion use, including the OCA, the Disability Rights Center (DRC)[9], DCYF, individuals who have experienced restraint and seclusion, and families.

Update: Shortly after the release of the OCA 2020 System Review on restraining and secluding children, the Senate Committee in Health and Human Services convened a hearing for its review. There was no

[9] Disability Rights Center - PL 106-402 Developmental Disabilities Assistance and Bill of Rights Act requires every state have a protection and advocacy agency for persons with developmental disabilities. The agencies are authorized to protect through investigation and advocacy of the treatment of persons with developmental disabilities.

other follow up with the OCA about the data collection. In February 2021, the OCA met with DHHS administrators from DCYF and the Division for Behavioral Health in one meeting and with the DRC separately. The meetings were productive. The DHHS administrators noted the value of the data analysis that identified trends in use. They proposed using it in individual provider reviews to raise awareness of opportunities for care improvements. They also invited the OCA to present the data to a residential provider meeting. Through the provider meeting, the OCA was able to demonstrate the difficulties of inconsistent reporting and incorporate provider input for this report. Personnel from the DRC also found the information gave context to their role in protecting children with disabilities and investigating incidents involving sustained injuries. The DRC were concerned to learn that the Sununu Youth Services Center (SYSC) is one of the two facilities still reporting use of physical restraints in facedown prone position. They had received a communication from DHHS indicating the practice was no longer in use.

The OCA will convene similar meetings periodically for timely review of data. There were no restraint-specific discussions with persons who have experienced restraints or seclusion on a systemic level as of yet. The OCA does meet regularly with children who have the experience or witness the practice. When discussing restraints, children generally describe the experience of restraint or witnessing peers restrained as frightening. Some associate the experience or witnessing of restraint use as an expected characteristic of residential care milieu.

2019 Recommendation: Examine and address the logistical obstacles to the department's mandate of reporting incidents to the OCA within 48-hours of the incident occurrence under RSA 21-V:7, I (formerly RSA 170-G:18, IV(a)).

Update: The average time from incident of restraint to the OCA receiving a report is 15.5 days. In 2020 substantial changes were made to the OCA's governing statute. However, the department did not recommend changes to the reporting mandate despite difficulty in meeting the 48-hour mandate. Department officials agree with the potential benefits of creating a web-based portal for incident reporting, including resolving the timing issue with OCA access to reports. The OCA does not advocate for slower reporting, however does endeavor to contribute to systems through which the department meets its mandates without undue burden.

DATA ANALYSIS

This report used two sources of data: the DHHS 2020 annual aggregate report required by RSA 126-U and the individual reports of incidents or seclusion that the OCA received from providers through DHHS. The OCA also identified a number of un-reported incidents in the course of record review. There were several complications of reporting that undermine overall incidence in this report. They include the manner of DHHS reporting, children included in DHHS reporting, and the consistency of individual provider reporting.

In 2020, DHHS changed their reporting year to align with the State fiscal year (SFY). The 2020 annual report included data from July 2019 to June 2020 where previous years they reported from November to October. Having collected the first full year of reporting to the OCA by November 2020, the OCA is reporting for the period December 2019, when receipts of incident reports commenced, to November 2020. The OCA was able to access DHHS' data they have not yet reported for the months July to November 2020 for purposes of comparison. That data may not yet be complete, and is only suggestive of general trends. A second inconsistency with DHHS data is that it includes *all* children restrained in residential programs regardless what authority placed them. The OCA only receives individual reports of children placed by New Hampshire DCYF. The OCA does not yet have a mechanism to receive individual reports on children placed by school authorities or privately, other than through complaints. No one in New Hampshire centrally monitors the restraint of children placed here from other states. The OCA does not receive reports of incidents involving children placed in out of state institutions. Currently, there are 79

children placed out of state for whom there is no centralized surveillance of exposure to restraints or seclusion.[10]

Comparing data was further complicated by the reliability of residential providers submitting individual incident reports to DHHS. There is inconsistency in mandate between two laws. As noted above, RSA 21-V:7, I. mandates DCYF report all incidents, including of restraint and seclusion, to the OCA. Residential providers are not governed by RSA 21-V:7, I. They are governed by RSA 126-U:7 I-II, that requires providers "make reasonable efforts to verbally notify the child's parent or guardian and guardian ad litem whenever seclusion or restraint has been used on the child ... and… within 5 business days after the occurrence, submit a written notification … to the director or his or her designee…." Historically, providers submitted written notifications to the director's designee in the form of the child protection social worker (CPSW) or juvenile probation and parole officer (JPPO), who then filed the report in the child's record. In order to accommodate compliance with RSA 21-V:7, I, on November 18, 2019 the department sent a communication to residential providers requesting incidents be reported to a central E-mail. The department provided forms for recording information about restraints as an option, not a requirement.[11] In general, it is not clear that all providers understand the request as an expectation that all individual restraints be reported to the DHHS central E-mail. Inconsistencies arise in the comparison of data reported by DHHS in the annual report and reports to the OCA that are not accounted for by children's origin. This suggests that there may be some residential providers not consistently reporting.

TRENDS IN REPORTED SECLUSION INCIDENTS

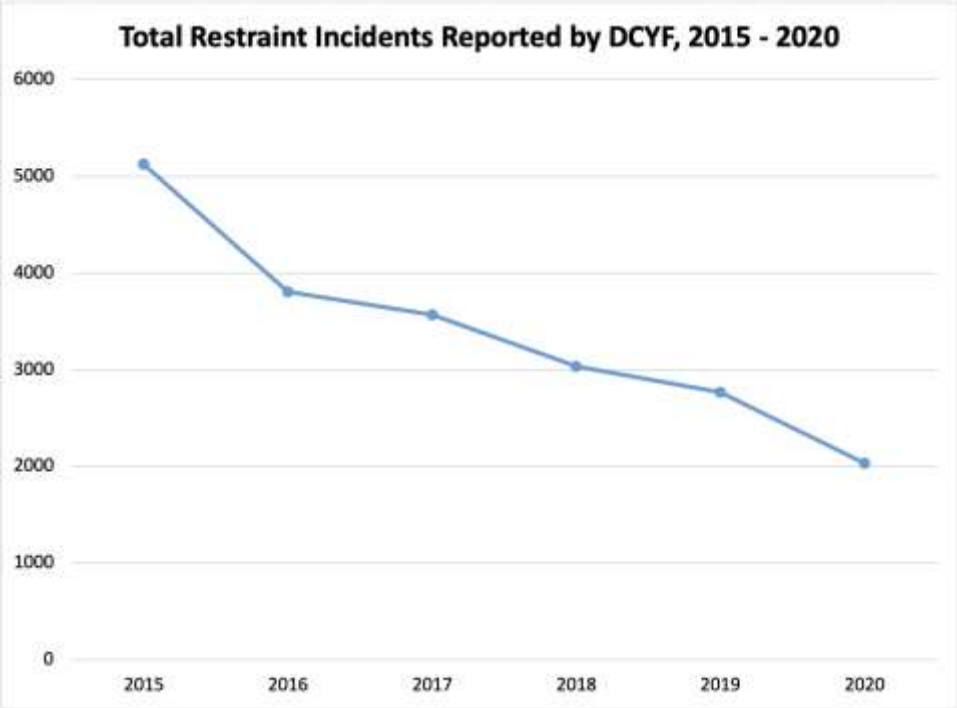
The use of seclusion in New Hampshire residential facilities has been steadily decreasing. This is a good sign assuming it reflects alternative therapeutic strategies to meet children's behavioral needs and not reporting inconsistencies. Because of the change in DHHS reporting year for 2020 and inconsistencies with reports received or not received by the OCA, data analysis of this practice is not valid at this time. The OCA notes that reporting requirements may not fully reflect the practice of separating children from their peer community and therapeutic milieu. How facilities categorize and document seclusion may be slightly misaligned with the definition in RSA 126-U as defined above. Children who are separated from their community of peers for punitive reasons may not technically meet the threshold of the definition if, for example, a staff member were present in the room where a child is sent. Due to restrictions of the COVID-19 pandemic, the OCA has not been able to visit facilities and observe related practices in 2020. It will be a priority of the OCA to review conditions of children's placements once restrictions lift.

Because of the inaccessibility of data on the use of seclusion, analysis of incidents in this addendum focus on use and reporting of restraints only. A separate review of the use of seclusion may occur subsequently as resources allow.

[10] Concerns about the use of restraint and seclusion are not limited to New Hampshire. The Michigan Office of the Children's Ombudsman 2020 Annual Report highlighted an investigation of the death of a child in a Michigan residential program ruled a homicide. The child was restrained in prone position for 10 minutes. In response, Michigan has instituted a near-ban of restraint use effective 2022 and instituted technical assistance in the Six Core Strategies © program for providers.

[11] Copy of DHHS communication to residential providers received by the OCA on December 27, 2019.

TRENDS IN REPORTED RESTRAINT INCIDENTS

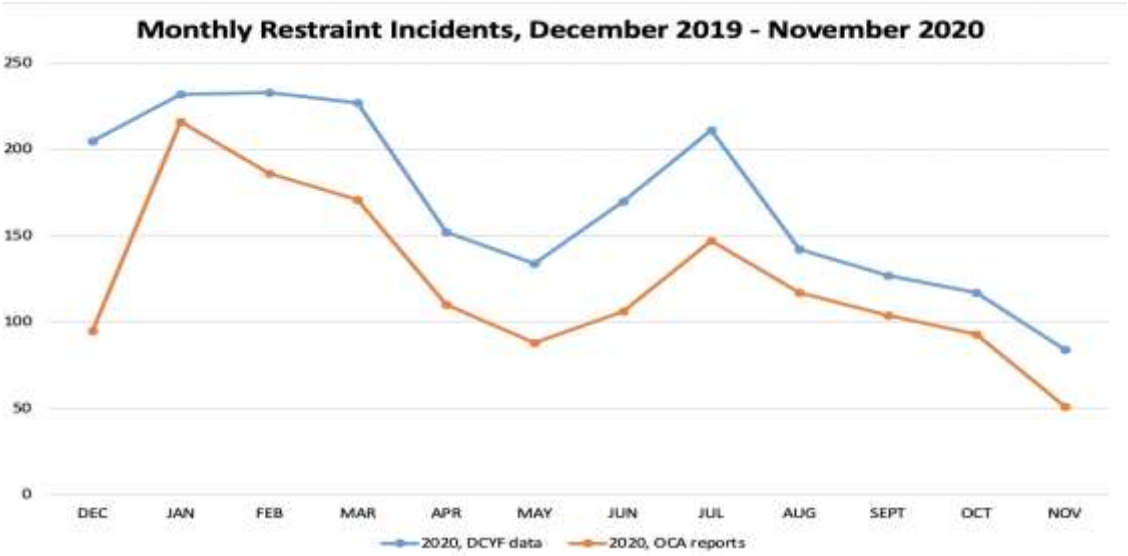


DCYF annual reports required by RSA 126-U have demonstrated downward trends over the past six years. The year 2020 reported total does not represent a full year's incidents due to changes in DCYF reporting period. However, the trend persisted. Several factors may affect the reduction of reported restraints:

- Actual reduction due to improved treatment modalities and staff training
- Changes in reporting
- Changes in the population of children in residential care

All Incidence of Restraint by Year and Month

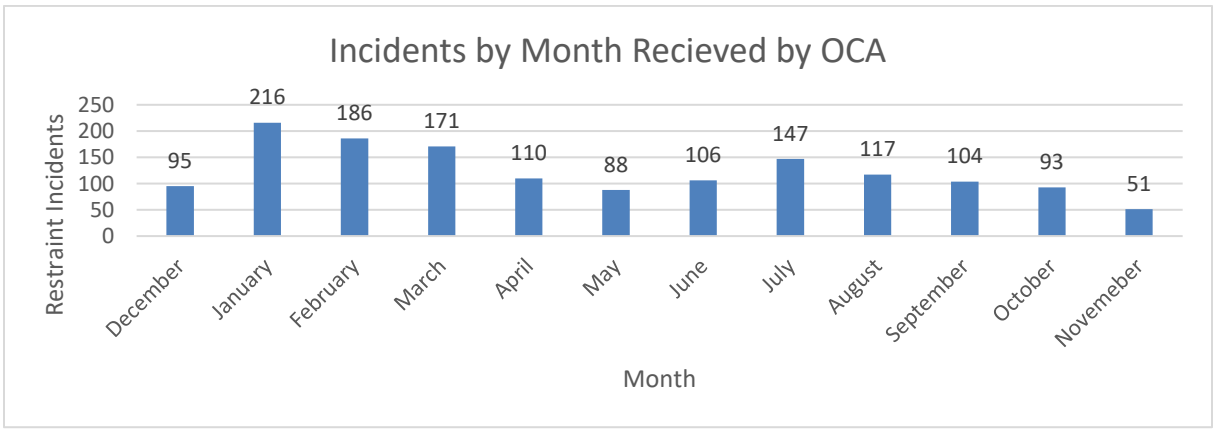
The DCYF data, as reported in the DHHS annual aggregate report, includes all provider reports of restraints of children, including those placed by their schools, privately by families, or by other states. Providers report to DHHS periodically and in aggregate. The OCA data only includes incidents involving children in the custody of DCYF. The difference between the two data sets reported, besides the total population, is that the OCA receives and reviews individual reports of incidents. The data the OCA receives, however, is inconsistent both generally in reporting all incidents and in the quality of reports. DCYF does not require residential providers use any specific form. Thus, each provider uses their own form and completes data entry differently. Therefore, the data analysis is not precise and may not be complete. Analysis below is of the universe of reports that the OCA did receive. Of the reports the OCA received, trends are evident and helpful for contemplation of children's experience and needs in residential facilities.



Between December 2019 through November 2020 the OCA received reports of 1,484 physical restraints of children from 17 residential facilities and the SYSC. A low incidence in December reflects the slow start-up of reporting individual incidents centrally, for the first time. While deeper review would be necessary to understand all influences affecting the restraints of children and fluctuations in the practice, visible trends prompt questions to ask when deeper review occurs. For example:

- Is the spike in restraints during January and February related to post holiday distress? Some providers have noted a common manifestation of distress and dysregulation among children with histories of trauma and separation, or elevated sense of abandonment, after the winter holidays.
- If April and May were early months in COVID-19 pandemic restrictions on visitation, is the drop in incidence during those months somehow related to stable routine or lower census with more staff time to attend to children?
- Does the spike in June and July mark the end of school and unstructured time with few options for activities during COVID-19 restrictions?
- What is happening in the fall as incidence drops consistently? Is it effective treatment? Staff training? Return to school routine?

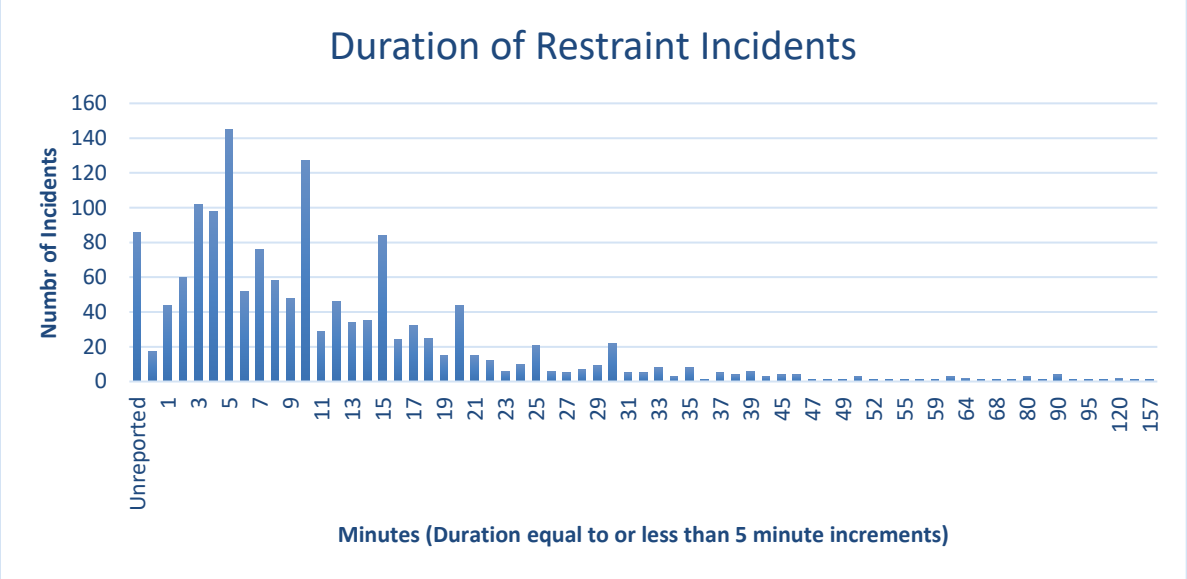
To reiterate, these are not findings, but queries to keep in mind as we collect more data and review circumstances of children and the facilities where they are restrained. A bar graph provides a clearer image of the January, post-holiday spike, keeping in mind that December data was not complete; it is possible that incidence has consistently dropped with only that spike in July.



DURATION OF RESTRAINTS

Duration of restraints reflects a child's response to physical management, the risk of injury to child and staff, the compromised time and attention of staff away from other children, and the general experience of physical restraint. In 2020:

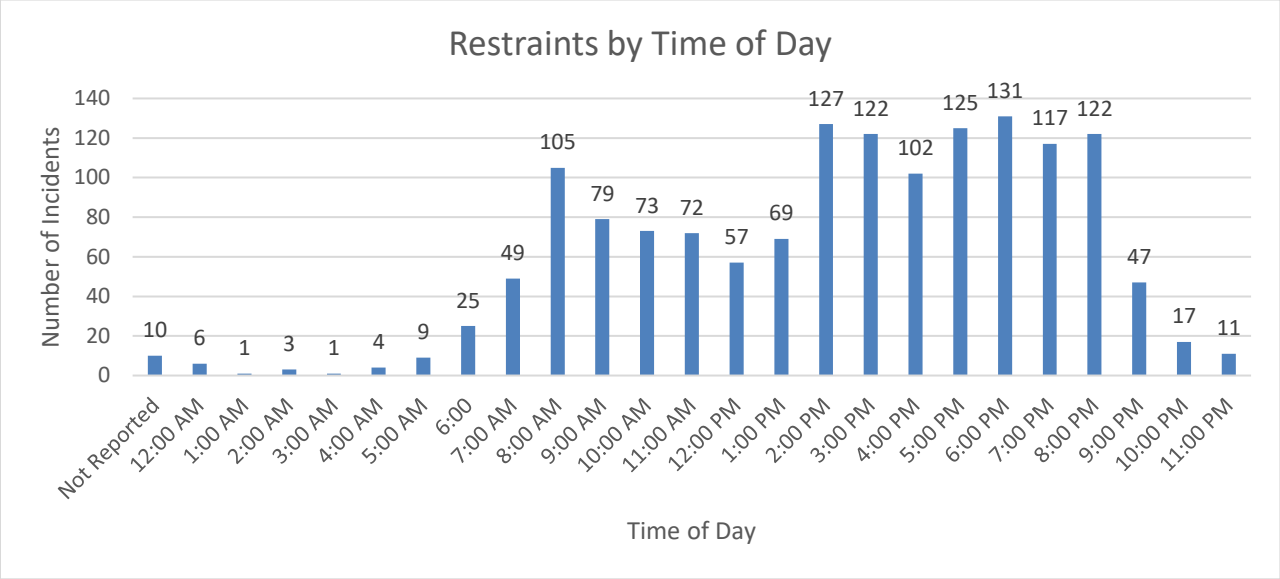
- 86 of the 1,484 reports received did not indicate how long the child was restrained
- The duration of restraints ranged from 1 minute to 157 minutes
    - 466 restraints were 5 minutes or less
    - 361 were 5-10 minutes long
    - 224 were between 15-20 minutes
    - 89 incidents were over 30 minutes
    - 23 restraints lasted over 60 minutes
- Of those 23 restraints that were over an hour, they involved 13 children at 9 different facilities
- Of those 13 children experiencing lengthy restraints
    - 9 were male
    - 4 were female
- Inconsistent reporting practices includes incidents that may represent a cluster of restraints, thus appearing lengthier than average, while others might each be recorded separately appearing shorter.



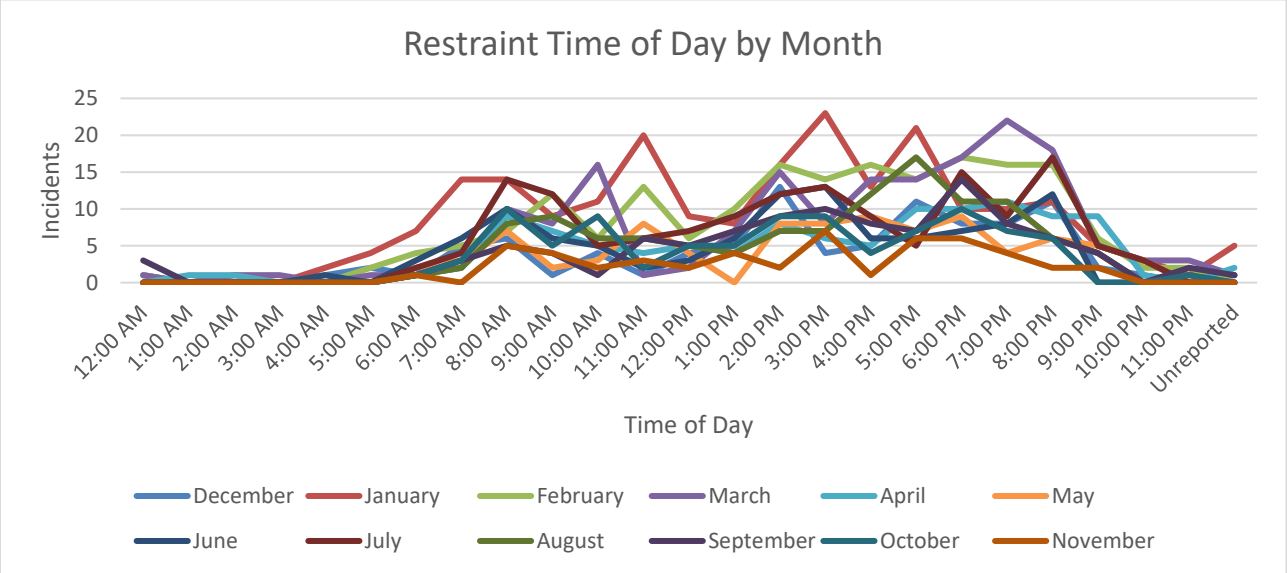
TIME OF DAY

Restraint incidents trended by time of day. Children were restrained more during times of transition, such as between waking up and school, after school, and at bedtime. Examination of select data bears this supposition out.

- 184 restraints during morning transition to school (8:00 to 9:00)
- 249 restraints during transition from school to residence/after school activity (2:00-3:00)
- 582 restraints during entire school day (8:00 to 2:00)
- 126 restraints in middle of school day (12:00-2:00)
- 57 restraints during lunch period
- 169 restraints during transition to bed (8:00-9:00)



Examining time of day by month appears to demonstrate persistence in these trends.



DANGEROUS RESTRAINT TECHNIQUES

Due largely to wide concerns about lethal restraints on children and adults in the face-down, prone position, New Hampshire law, RSA chapter 126-U:4, I expressly prohibits use or threatened use of, "[a]ny 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."

The law further prohibits the infliction of pain or use of noxious, toxic, caustic, or otherwise unpleasant substances to control or modify behavior. RSA 126-U:4, II, III. RSA 126-U:4, IV, prohibits "[a]ny technique that unnecessarily subjects the child to ridicule, humiliation, or emotional trauma."

Having left the term "prone" from the statutory language, the legislature placed the burden of knowledge of advanced anatomy and physiology on residential staff. Anatomically, prone position impairs breathing and increases a child's risk of asphyxiation, cardiac arrest, and death.[12] In 2010, former Chief Medical Examiner Thomas Andrew, MD testified before the New Hampshire Senate Health and Human Services Committee contemplating creation of the statute. He described the physiology of prone positioning, explaining, "Both muscular aspects of ventilation are impaired" in a prone restraint, and "there's a measurable and significant difference of that impairment if weight is placed on the person's back," which causes compression of the chest.[13] Even without added weight of another person involved in restraining, "there is measurable impairment of respiratory function" due to the risk of asphyxia and sudden cardiac arrhythmias.[14]

In 2020, only two facilities reported the continued use of prone-positioned restraint: Nashua Children's Home and the Sununu Youth Services Center (SYSC). The OCA has brought this practice to the attention of providers and DHHS administrators. The SYSC has committed to reducing the use of this restraint positioning. DCYF officials report they promote the practice of transitioning from prone restraint to sitting position once the children are mechanically restrained with handcuffs. The OCA has observed this practice in some videos of individual restraint incidents at SYSC.

The OCA discussed the limits of prone restraint use outlined in RSA 126-U with both the Nashua Children's Home executive director and the facility's Board of Directors. The executive director, who presented and was present for testimony in the crafting of RSA 126-U, believes that prone-positioned restraints are not illegal in New Hampshire. In communications on other matters that included concerns about restraining children face down on the floor, the Board of Directors responded that they are "not in a position to second-guess" … the executive director and staff as the executive director, "is the person with the most direct knowledge to speak to NCH's position relative to the same." The board did, however, "recommend that as part of the annual staff training to occur (and as part of new staff orientation), that the employees be informed of and reminded of the prohibited outcomes outlined in RSA 126-U to ensure that they are aware of the same and the importance of Nashua Children's Home's lawful compliance with statutory requirements."[15] Since that communication, the facility continues to report incidents of prone-positioned restraints of children.

Reporting of prone restraints is inconsistent in that the reports document different terminology to describe the position. To identify incidents of prone restraint, the OCA reviews reports and other supporting documents. In the 2020 reporting period, there were 146 restraints identified as face-down, prone-positioned restraints.

---

[12] Disability Rights California (2002). *The Lethal Hazard of Prone Restraint: Positional Asphyxia*. https://www.disabilityrightsca.org/system/files/file-attachments/701801.pdf.

[13] Andrew, Thomas, New Hampshire Chief Medical Examiner (2010). Statement before the New Hampshire Senate Committee on Health & Human Services. *Hearing on SB 396-FN, Feb. 9, 2010*. http://gencourt.state.nh.us/SofS_Archives/2010/senate/SB396S.pdf.

[14] Andrew, Thomas, New Hampshire Chief Medical Examiner (2010). *Supra note 63.*

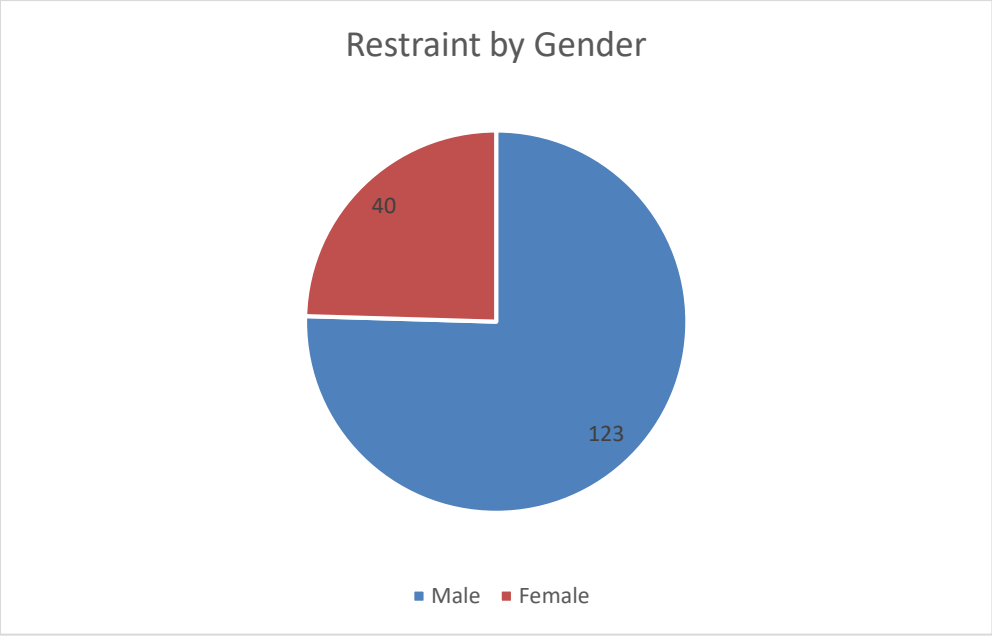
[15] Nashua Children's Home Board of Directors personal communication 11-23-2020.

146 Reported Prone-positioned Restraints by Term

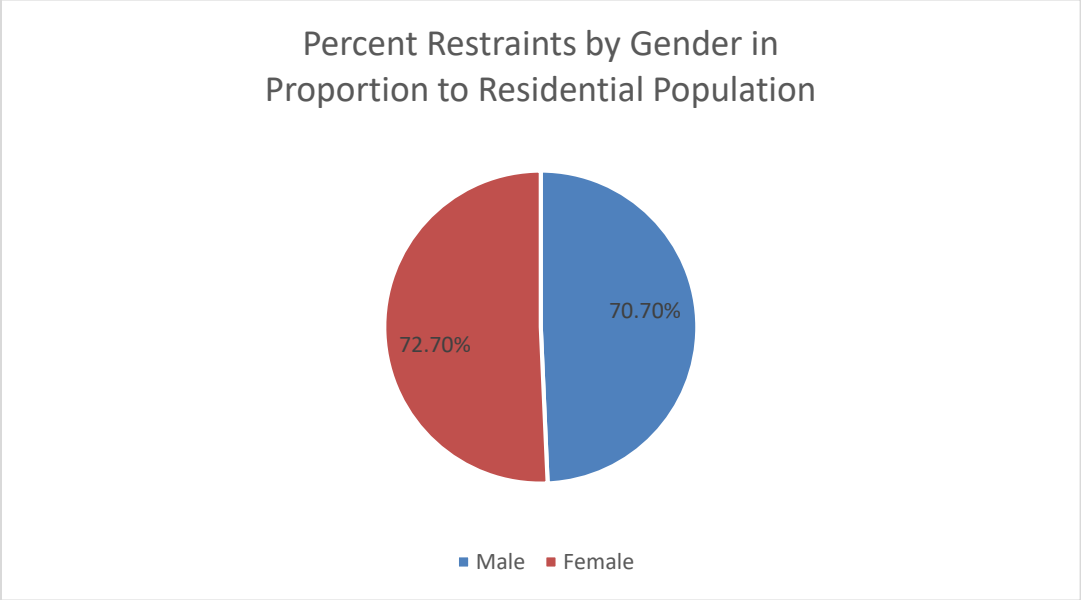
Restraint Term	Incidence	Description
Prone	18	
MACH 2	49	(strength in entry-level hold, moves a subject in a forward direction)
PRT Neutral	65	(Primary Restraint Technique)
Tripod Stand	9	(Device used to rest restrainer's upper body weight. In video observation, OCA noted device placement was not stable)
Other	5	(As determined by record review)

GENDER

Of 1,484 incidents, only 163 children were involved in restraints. Of the 163 children, 40 were girls and 123 were boys. While it appears boys are more likely to be restrained, the ratio of boys to girls in residential placements is also disproportionate. In the 2020 reporting period, there was an estimated average of 55 girls and 174 boys placed.[16] Considering the population, restraints were slightly more likely to involve girls than boys (72.7% girls compared to 70.7% boys involved in restraints). That may not be a statistically significant difference; however, it does dispel the impression restraints are more likely to involve boys than girls.

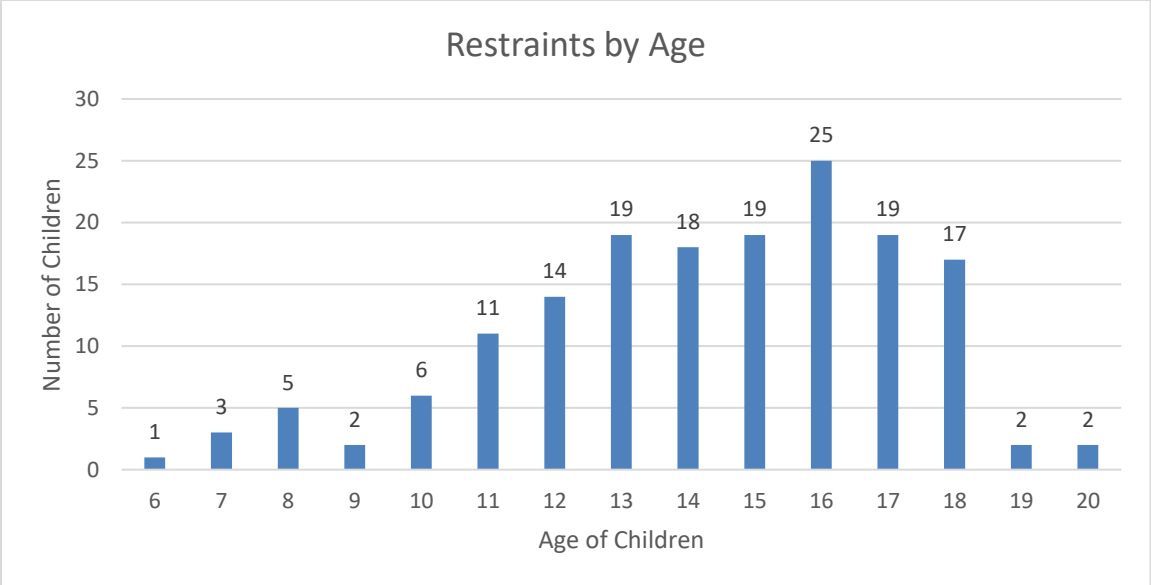


[16] DCYF monthly residential data reports.



AGE OF CHILDREN RESTRAINED

The ages of children being restrained ranged from 6 to 20 years-old. The majority of restraints occur on children between the age of 13 and 18 years, with 16 being the most likely to be restrained. Children placed by DCYF in residential care range in age of 5 to 20 years old. Approximately 50 percent of children in residential care are between the ages of 13 and 17 years old. Therefore, the higher incidence of restraint in those age groups generally aligns with the characteristics of the population.



INDIVIDUAL CHILDREN EXPERIENCING RESTRAINTS

As stated, the 1,484 incidents of restraint reported to the OCA involved 163 children. Not all children placed in residential programs are restrained. At this writing there are just over 300 children in residential programs and the SYSC. Therefore, approximately half have the experience of being restrained. Looking closely at the restraint data by child is an opportunity to identify children with exceptional needs. A

persistent routine of restraint may signal a need for therapeutic program adjustment or a new program. A close look at the 163 children reported restrained, revealed:

- 56 of the 163 children experienced only 1 restraint, meaning 107 is the target population to examine for eliminating restraint use
- 1 child experienced restraint over 200 times
- 37 children experienced 10 or more restraints
- 15 of those 37 children experienced 25 or more restraints

Narrowing down who is more frequently restrained is an opportunity to reduce the practice over all. The OCA is piloting an alert mechanism for high-frequency reports of individual children restrained. The idea is to alert the provider and review the child's circumstances, response to needs, and adjustments to treatment plan. As the State rolls out independent monitoring of children's progress in residential programs under the federal Family First Prevention Services Act requirements, they too may find restraint data useful in measuring child outcomes and success in program. The benefit of eliminating the use of restraints is not just for the individual child who is restrained. All of the children are witnesses to restraint. Children view restraint by professional caregivers as aversive, which impedes therapeutic effect of the milieu.[17] Identifying positive behavior conditioning interventions both eliminates the risk associated with experiencing and witnessing a restraint. It also improves the experience and safety of the staff.[18]

REPORTERS AND REPORTING

During the 2020 reporting period 17 facilities, 2 hospitals, and SYSC each submitted reports of restraint incidents to DCYF, who then forwarded them to the OCA. The OCA has direct access to the SYSC electronic data system from which reports automatically generate to the OCA. Facilities reported a range of 0-833 restraints. Five facilities reported 30 or more incidents of restraints. Six facilities reported fewer than 15. The inconsistencies of reporting preclude the OCA from displaying data by facility due to the risk of inaccurate conclusions about care of children. An administrator of one facility with a high incidence of reported restraints expressed concerns about the integrity of the OCA's data. The administrator explained that they reviewed the reporting form of another facility. The form was so different; they determined they could dramatically reduce reported restraints simply by using the other facilities form. The facility administrator noted, among other things:

- There is no systematic or standardized reporting criteria for incident reports
- There are different interpretations of the "restraints" law and what constitutes a restraint
- The interpretation of data is accepted as true and accurate, however, it is likely that each provider responds differently and reports differently
- There is no opportunity to do a case presentation or technical assistance on difficult cases

The OCA made similar observations in the 2020 report. That a provider would express these concerns reflects the effect of the OCA's independent oversight and the absence of surveillance of restraints until now. The new scrutiny could be a disincentive to report restraints, a dangerous outcome. Therefore, in addition to calling attention to high incidence, both the OCA and the department must scrutinize unusually low incidence of restraint use at facilities to confirm it is reflective of changes in practice and improvements in child outcomes. Until reporting is standardized and more carefully overseen, use and reporting of restraints on children will be a practice of concern.

[17] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6, (p.3).*

[18] Substance Abuse and Mental Health Services Administration, (2011). *The Business Case for Preventing and Reducing Restraint and Seclusion Use*. HHS Publication No. (SMA) 11-4632. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SUMMARY OF TRENDS

Overall, the data indicates that New Hampshire residential providers are making progress towards decreasing the use of restraints. There is a ways to go to eliminate fully their use. However, the availability of data opens a door to that possibility. Data tells a story and leads to goal achievement if it is reliable and valid.

The OCA is only able to report on the data received. Despite that, analysis reveals patterns about the use of restraints and the children who are at risk of restraint. For one thing, although there are far more boys in residential programs, girls are slightly more likely to be restrained. Understanding gender differences in relation to lived trauma and developmental tasks may help identify ways of therapeutic engagement and effective coping strategies to teach. The implications of post-holiday despair among children with history of trauma demonstrates a predictability that represents an opportunity for improving care and supports.

The majority of restraints involve teenagers between 13 and 18 years old. Developmentally, teenagers are predisposed to challenge authority and test their identity. Control and independence are conceptual focus areas for that age group.[19] Rigid institutional routines and seemingly arbitrary rules, common in congregate living, are incongruent with those developmental challenges. Restraints happen most at times of transition throughout the day, such as in the morning when readying for the day's program and at bedtime. Anyone who has ever had or been a teenager is familiar with the struggle to rise in the morning and go to bed at night. Even children with histories of trauma, mental illness, or developmental disabilities have underlying normal biological schedules.[20] Transitions in the absence of a committed parent or the comfort of a familiar home may be more disruptive to a child's emotional stability and exacerbated by the noise and motion of congregate living. The themes that emerge from the data equip residential providers with guidance to re-think care of children and provide DCYF the opportunity to examine whether a program is meeting a child's needs.

The DHHS is steadily improving the array of services for children that will ultimately limit the need and use of residential care. The inclusion of the Six Core Strategies © for eliminating the use of restraint and seclusion in anticipated procurements of residential programming is promising. The DHHS has acknowledged the harm that restraining children can cause, and appears committed to make the necessary changes. That includes attaining federal Family First Prevention Services Act Implementation Funds for technical assistance to be afforded to residential providers incorporating the Six Core Strategies©. Much will depend upon contract implementation, appropriate support and guidance for providers, oversight, and accountability.

Though the data here reported is limited, this addendum makes clear the value of collecting and analyzing data on the use of restraints on children. Children are in residential programs to heal and to learn pro-social, safe behaviors. Much of the success in eliminating the use of restraints will depend upon the education of facility administration and staff about brain development, trauma and expressive behavior, and incorporating that knowledge in interactions with child residents. As residential programs sign new contracts, become accredited, and comply with expectations for standards of staff training, monitoring the adequacy of staff support will be essential. The DHHS has not yet committed to creating consistent educational and training programs for residential staff. Such programs would be cost-saving resources for the providers while ensuring quality care.

---

[19] Orenstein GA, Lewis L. *Eriksons Stages of Psychosocial Development*. [Updated 2020 Nov 22]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing

[20] Crowley, SJ, Acebo, C, & Carskadon, MA, (2007). Sleep, circadian rhythms, and delayed phase in adolescence. *Sleep Medicine*, 8: 602-612.

The limits of the OCA's restraint data underscore the absence of a standardized, systematic reporting system to capture all incidents of restraint and their characteristics. In addition to being potentially misleading, incomplete and inconsistent data reporting misses opportunities to improve services and children's outcomes. The current system is burdensome for providers, DHHS and the OCA. It is also not comprehensive. There is no meaningful centralized surveillance of restraining children placed in residential programs by schools or other states, nor of New Hampshire children sent to programs in other states. A web-based, standardized reporting system could capture all incidents of children restrained regardless of where they are or who sent them there. Such a system would bring DCYF into compliance with RSA 21-V:7, I, requiring the reporting of incidents to the OCA within 48 hours by having them simultaneously submitted electronically to DCYF and the OCA. Digitalizing the collection of data will also afford better, more meaningful reporting and analysis of restraint use. Currently only the OCA is conducting analysis of the individual incidents.

The persistent use of prone-positioned restraints is dangerous, both physically and emotionally, to children and staff. Prohibition of its use, regardless of individual interpretation of the law, would benefit children and reduce risk of harm and litigation.

NEXT STEPS

This report focused on broad themes in the data. The next steps will include deeper examination of individual children's experiences, needs, and effective treatment options. Learning from working with the most affected children will inform progress with others. We will also examine reporting mechanisms and the process of periodic review, under RSA 126-U, that mandates DHHS visit and ensure compliance with the record keeping aspects of 126-U that are intended to prompt diligence in re-assessing children's needs. All of this, we will now equally apply to the use and reporting of restraint and seclusion as the law applies to education under the OCA's recently expanded jurisdiction to include all State provided or arranged services for children. We look forward to continued collaboration with all parties for safe care and positive outcomes for children.