



State of New Hampshire

Office of the Child Advocate

Moira O'Neill

Director

SYSTEM REVIEW BRIEFING

System Review 2019-01

Restraint and Seclusion: Practice and Reporting

September 24, 2019

Authority & Jurisdiction of the Office of the Child Advocate

The mission of the Office of the Child Advocate (OCA) is to provide independent and impartial oversight of the New Hampshire Division for Children, Youth and Families (DCYF), the state agency responsible for child welfare and juvenile justice services, and to promote effective reforms to assure that the best interests of children are being protected. The OCA has independent access to all DCYF records to review and investigate concerns, and to make informed recommendations.

RSA 170-G:18 is the OCA's guiding statute. Under RSA 170-G:18, III(i), the OCA shall "[u]pon its own initiative or upon receipt of a complaint, review and if deemed necessary, investigate actions of the division for children, youth and families, or any entity that provides services to children under contract with and at the direction of the division, and make appropriate referrals. Findings of all investigations and responses to all complaints received shall be summarized in the annual report of the office of the child advocate."

RSA 170-G:18, IV (a), mandates the Department of Health and Human provide the OCA "... a copy of all incident or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department not later than 48 hours after the occurrence ..."

The OCA does not have the authority to:

- Investigate allegations of abuse or neglect
- Review or investigate complaints related to judges, CASAs, or guardian ad litem
- Overturn any court order or DCYF decision
- Offer legal advice

Purpose of System Review Briefing

When a system Review is initiated, the OCA will conduct a comprehensive, independent study of relevant facts, records, and witness statements. If necessary, the OCA will also conduct independent research on evidence-based practice to offer informed, educated recommendations. Upon completion of the review, the OCA will make a determination about whether to issue recommendations or share any key points for system improvements. If the OCA determines that recommendations are needed, or there are key points learned from the System Review, it will issue a Systems Review Report and/or include its findings in the OCA Annual Report.

If the OCA determines that a System Review requires additional resources and/or time beyond a standard of 60 business days before recommendations can be made or a report issued, the OCA will release a **System Review Briefing**. The System Review Briefing will identify the issue of concern, planned additional review activities, and an estimation of time to completion. The System Review Briefing is designed to hold the OCA accountable to the public and to ensure transparency of the OCA's work within the confines of mandated confidentiality.

System Review Number: 2019-01

I. Service Area and Summary of Identified Concern

SR # 2019-01	Area of Concern: Practice and Reporting of Restraint and Seclusion
--------------	--

The OCA is reviewing the use of restraint and seclusion of children placed by DCYF in residential treatment facilities and the Sununu Youth Services Center (SYSC). The OCA does not regularly receive individual reports of restraint or seclusion incidents from the department as mandated by RSA 170-G:18, IV (a), other than those events occurring at the SYSC.

A 2018 Disability Rights Center—NH report examined the use of a restraint on a child at SYSC that resulted in a serious injury to the child. That investigation prompted wider questions about improper or excessive restraint and seclusion practices at other locations around the state, occurring amidst a national concern about public schools under-reporting their restraint and seclusion incidents to the U.S. Department of Education.¹

RSA chapter 126-U, the New Hampshire statute governing restraint and seclusion, limits use to only when there is a “substantial and imminent risk of serious bodily harm to the child or others.”² Even though providers are legally limited to using restraints in emergencies only³ and seclusion when behavior poses imminent risk of harm⁴, there have been over 20,000 reported incidents of restraint and seclusion at DCYF-certified facilities since 2014.⁵ The numbers demonstrate an extraordinary number of emergencies, suggesting a widespread inability to meet children’s behavioral needs and de-escalate situations leading to restraints and seclusions.

There is no therapeutic benefit to the use of restraint or seclusion, and the U.S. Department of Education states that “[t]here is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques.”⁶ Experiencing restraint or seclusion is physically and emotionally harmful to children, many of whom

¹ Testimony before the Subcommittee on Early Childhood, Elementary and Secondary Education, Committee on Education and Labor, U.S. House of Representatives, (2/27/2019). Jacqueline M. Nowicki, Dir., Education, Workforce and Income Security, U.S. Government Accountability Office.
<https://www.gao.gov/assets/700/697114.pdf>

² RSA 126-U:5, I, RSA 126-U:5-a, I

³ RSA 126-U:5

⁴ RSA 126-U:5 a, I

⁵ RSA 126-U:9, II requires the commissioner provide an annual report to legislative committees of cognizance. The sum 20,000 plus was arrived at by adding all reported incidences of restraint and seclusion from the commissioner's reports between 2014 and 2018.

⁶ U.S. Department of Education (2012). Restraint and Seclusion: Resource Document. Washington, D.C. Accessed at <https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>.

already have a history with abuse and other trauma. Application of restraint also affects staff members, including physical injuries and psychological harm.⁷

In 2010, the NH legislature passed SB 396, *An Act Limiting the use of Child Restraint Practices in Schools and Treatment Facilities* (Laws 2010, Chapter 375). The law was further amended in 2014 by SB 396 (Laws 2014, Chapter 32). Codified at RSA 126-U, the legislation prohibits the use of dangerous restraint practices⁸ in schools and treatment facilities, established certain notification requirements when a restraint is used,⁹ and requires the Department of Health and Human Services (the Department) to report annually on the number and location of reported restraints and the status of any outstanding investigations.¹⁰ Additionally, the law requires the commissioner to adopt rules for regular review of records maintained by facilities regarding the use of seclusion and restraint.¹¹

The OCA currently only receives regular electronic reports of restraint and seclusion from SYSC. Incident reporting of events in all other facilities where DCYF places children is limited to one annual report of restraints and seclusion in aggregate¹² and occasional reports associated with DCYF Special Investigation Unit cases. The annual aggregate report does not include specific incident information, such as fidelity to treatment plan, precipitating events, staff involved, time of day, or any other information that would afford meaningful analysis. There is no evidence that DCYF monitors this data for trends in effectiveness of treatment or potential improper use of restraint and seclusion. Nor does DCYF regularly forward to the OCA individual restraint and seclusion reports on children placed in facilities.

Proper review of restraints and seclusion is necessary, not just to fulfill a statutory responsibility, but to ensure the health and safety of children under the care of DCYF. Only in comprehensive analysis of detailed incident reports can insights and helpful recommendations be made. As part of this review, the OCA seeks the actual incidence of restraint and seclusion use. Although it appears to be high from the 20,000 reported incidents, the true numbers are unknown. Equally as important as the number of times children are restrained and secluded, the reasons for the interventions are essential to understanding children's needs, effectiveness of treatment, adequacy of staff training, and commitment to positive outcomes for children.

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

⁷ U.S. Department of Health and Human Services (2010). Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services. Accessed at https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf.

⁸ 126-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.

⁹ RSA 126-U:7, 126-U:7-a

¹⁰ RSA 126-U:9, II

¹¹ RSA 126-U:9, I(a)

¹² As specified in RSA 126-U:9, II.

In May 2019, the OCA began reviewing the use of restraint and seclusion in state facilities and related reporting procedures with the intention of producing an Issue Briefing. As the OCA learned more about practices and reporting patterns, the decision was made to conduct a full system review.

System Review questions include:

- Is RSA chapter 126-U sufficient to protect children from improper use of restraint or seclusion?
- Does RSA chapter 126-U provide adequate guidance for reporting practices?
- What other New Hampshire and federal laws and policies impact the practice and reporting of restraint and seclusion in residential facilities?
- What are the trends in the number of restraint and seclusion incidents for children in DCYF care or custody since the 2014 enhancement of reporting requirements?
- How often are dangerous restraint techniques, as defined by RSA 126-U:4, used in facilities?
- What staff training around restraint techniques is required? Must it be regularly renewed?
- Is there consistency in restraint and seclusion practices and incidence? If not, why?
- How do other states govern restraint and seclusion of children in residential facilities and juvenile hardware-secure facilities?
- What changes will the federal Family First Prevention Services Act bring to residential facilities with regard to restraint and seclusion?
- How is the use of restraint and seclusion associated with effectiveness of treatment?

II. Summary of Preliminary and Ongoing Research

To date, the OCA has conducted the following research:

- Review of relevant policy and law
 - RSA chapter 126-U, the New Hampshire law governing the use of restraint and seclusion on children in schools and treatment centers
 - DHHS He-C 4000 administrative laws pertaining to child care licensing rules
 - SYSC Policy 2083 *Restraint* governing the use of restraint in SYSC
 - Federal law related to the use of restraint and seclusion on children in facilities that receive Medicaid funding
 - Laws and policies in other states related to the use of restraint and seclusion on children
- Interviews
 - Residential staff from three facilities responsible for monitoring and reporting incidents to DCYF
 - DCYF administrators
 - Children who have experienced restraints or seclusions
 - Disability Rights Center staff
- Research
 - Trauma-informed approaches to treatment for children
 - Evidence-based alternatives to restraint and seclusion
 - Scientific studies regarding the effects of restraint and seclusion on child wellbeing
 - Behavioral health and child psychology research
 - Individual incident reports and videos of restraint and seclusions events
 - Administrative rules mandated by RSA chapter 126-U

III. Next Steps

The OCA System Review will continue the comprehensive survey of the current restraint and seclusion landscape in New Hampshire. There have been significant delays in accessing information from DCYF, including facility certification records and census data. Census data has been provided as of this writing. Certification records, first requested on August 15, 2019, have yet to be available or access to them provided. Additional data collection and analysis includes but is not limited to the following:

- Aggregate restraint and seclusion data by comparison with average census data to identify facility characteristics associated with reported rates of restraint and seclusion
- DCYF expectations and facility-described practices documented in the DCYF certification process
- State contracting arrangements in other states for reflection of expectations of restraint and seclusion use and reporting
- Editing and agency review of final report

IV. Estimated Length of Investigation

It is the goal of the OCA to provide timely system reviews. The length of time for a system review will vary depending upon internal OCA resources, the complexity of the issues and the nature of the review, as well as the length of time needed to obtain accurate and up-to-date reports and relevant information from DCYF and other sources. The OCA will generally work to complete a system review within 60 business days from the date the review is opened. Any delay outside of that timeframe will be documented in the OCA's internal database and approved by the Child Advocate.

The OCA expects to complete the System Review Report for System Review 2019-01 *Restraint & Seclusion: Practices and Reporting* for submission to DCYF, the Oversight Commission on Children's Services and any other related agencies or providers involved in the review no later than October 30, 2019. Should the OCA fail to adhere to this timeline, an updated briefing, which explains the need for additional time, will be posted.

V. Conclusion

This System Review Briefing, and the subsequent System Review Report, will be posted on the OCA's website. The OCA is appreciative of the cooperation and commitment to system improvement of DCYF, agencies, providers, and any other persons involved in this system review.

With Regards,



Moira O'Neill, PhD
Director

This briefing was prepared with assistance by Julie Cotton