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System Review 2020-01 **Review of Complaints about Nashua Children's Home** **December 7, 2021**

FOREWORD

The Division for Children, Youth and Families (DCYF), within the Department of Health and Human Services (DHHS), pursuant to RSA 169-B and C takes children into custody when they are in imminent danger, or when their parents/guardians are unable or unwilling to care for them, or in certain circumstances following adjudication for delinquency. Once custodian, DCYF is obligated to ensure children have access to appropriate, effective, safe care and treatment. At the same time, while DCYF historically held roles as consumer when placing children in residential care, the agency has also been overseer of residential services in certifying beds for reimbursement, overseeing quality of care, and investigating allegations of abuse, neglect, and injuries in restraint at the facilities. In 2019, DHHS transferred residential services to the Bureau of Children's Behavioral Health (BCBH). A common system pressure on casework decision-making described by DCYF staff is the limited number of options for housing a child, sometimes regardless of the child's specific needs. DCYF administrators have expressed frustration with the quality or effectiveness of some residential providers while lamenting the lack of alternatives in a high-pressure situation of a child in need of placement outside their homes.

The Office of the Child Advocate (OCA) acknowledges the complexity of these circumstances. Pursuant to RSA chapter 21-V:2, II (c), the OCA must "[e]nsure that children placed in the care of the state or receiving services under the supervision of an agency in any public or private facility, receive humane and dignified treatment at all times, with full respect for the child's personal dignity, right to privacy, and right to adequate and appropriate healthcare and education in accordance with state and federal law." With sensitivity to the situation, the OCA has undertaken to ground system oversight in Safety Science, an evaluative science of safety-critical industries that emphasizes understanding system influences on decision making, rather than the blame of individuals, or in this case residential providers.

It was in this context that the OCA undertook to review services provided by the Nashua Children's Home (NCH) in response to 17 complaints received and incidents reported. NCH is a DCYF-certified and DHHS-licensed, residential facility in Nashua, New Hampshire. So long as the State of New Hampshire places children in residential facilities, the OCA will endeavor to assure the children benefit. Ultimately, the difficulties in providing appropriate care in institutional settings reveal the problem of congregate care in general, and the need for children to be cared for in normative environments. This is evidenced in empirical research¹ and reflected in the federal [Family First Prevention Services Act of 2018](#) (FFPSA) that aims, in part, to minimize the use of congregate settings. A recent contract signed with NCH by DHHS represents the State's implementation of the federal law and a shift to short-term, trauma-sensitive, evidence-based care. It provides a good framework for NCH internal program improvements as a means of monitoring quality of care and the best interest of children.

¹ Fathallah, Sarah, & Sullivan, Sarah (2021). *Away From Home: Youth Experiences of Institutional Placements in Foster Care*, Think Of Us.

During this review, NCH was in the process of pursuing accreditation to meet criteria for a qualified residential treatment program (QRTP) under the FFPSA. Among other things, qualification for accreditation included staff training in trauma-informed care. To that end, the OCA was told in September 2020 that NCH staff were participating in the first trauma-informed care training in the history of the facility.

Awareness of long-term effects of trauma on child development emerged in the mid-1980s, most notably described in [the Felitti and Anda study \(1995\)](#) on adverse childhood experiences (ACE). This growing body of knowledge firmly rooted trauma sensitivity in therapeutic care of children with histories of abuse and neglect, that typically lead to placement of children at facilities like the NCH. Recognizing this, the State of New Hampshire and other partners were early adopters of trauma-informed care, funding free training for residential program staff for more than a decade. The NCH reportedly did not participate in training offerings. The science that informs the understanding of child development and best practice is evolving rapidly. Providers may be resistant to change due to lack of exposure to the new knowledge, over-reliance on set routine, lack of resources to overhaul ineffective models of care, or delayed demands for change from an overburdened and conflicted consumer/oversight State system.

The State recently shifted from casual vendor relationships to procuring specific residential care creating contracted expectations that did not formerly exist. NCH pursued and was awarded a contract, approved by the Governor and Counsel on July 28, 2021. The new contract requires evidence-based, trauma-informed care. The contract represents a commitment by NCH to provide the best care possible for children. It serves as an opportunity to guide NCH organizational practice and cultural change. It also situates both NCH and DHHS to monitor potential areas of organizational weakness through contract implementation and compliance. This review highlights concerns that underscore areas to watch in contract compliance, reinforcing the opportunity presented by the new contract.

This review took into consideration several sources of information: the complaints and incident reports brought to the OCA, NCH policy and practice, the new contract, and the latest research on child development and trauma-informed care. The OCA makes the following recommendations:

- **NCH** – Update the *NCH Behavioral and Emotional Support Guide* (NCH Guide) to reflect practice and policy consistent with requirements in the contract for evidence-based trauma-informed care
 - Implement documented discharge planning upon admission
 - Upon admission, develop behavioral intervention safety plans for each child consistent with the requirements of RSA 126-U:3 to reduce the incidents of restraint
 - Create and implement a formal reduction plan for restraints with measurable goals
 - Develop a consistent practice and documentation system for medical and mental health management and medication monitoring
 - Consult with DCYF nurses on children’s medical care and medications
 - Staff would benefit from training to include:
 - Residential Counselor Core Training (RCCT) through the Child Welfare Education Partnership
 - [One Trusted Adult](#) training in engaging and working with children
 - [Know and Tell](#) mandated reporter training
 - National Association of State Mental Health Program Directors’ [Six Core Strategies](#)© training
 - Develop flexible and creative accommodation for visiting and caregiver engagement, including during public health crises
 - Pivot to community-based offerings and supportive transitions of resident children
- **DCYF** –Document communications with NCH, including all court orders and plans for children’s care and permanency

- **BCBH** – Monitor compliance with NCH contract requirements. Give specific attention to trauma-informed care, use of restraint, and medical care; and track outcomes for children
 - Track employment of evidence-based, trauma-informed models of care with associated training for all NCH staff
 - Ensure training and implementation of Six Core Strategies[©] and general trauma-informed care²
 - Monitor incidence of restraints and use of Quiet Room for punishment and promote elimination of these practices
 - Inform and monitor compliance with court orders
 - Monitor appropriate employment of clinical professionals and systems for implementing all levels of medical and mental health treatment
 - Monitor discharge planning and associated outcomes
 - Monitor for evidence of a culture and practice that envisions family and community connections in normative living arrangements with expectation of limited short stay in residential care
- **DCYF/BCBH** – Commit to/have confidence in transitioning from congregate care to community-based services. Lessen dependency to place children at NCH.

² Note: NCH is reported to have begun trauma-informed care training in September 2020 and attended introduction to 6-Core Strategies © in October 2021.

Table of Contents

Foreword		1
Table of Contents		4
System Review 2020-01		5
I.	Service Area and Summary of Identified Concern: Safety and quality of care for children in residence at NCH	5
II.	Office of the Child Advocate: Authority and Responsibility	5
III.	Summary of Review Process	6
IV.	Facility Review	8
A.	Nashua Children’s Home Themes of Concern	8
B.	Complaint Findings and Analysis	8
1.	Trauma-informed care	9
	Use of Imposed Separation	10
	Use of Restraints	12
	Reported Restraints	15
	Staff Interactions with Children	16
	<i>Analysis of Trauma-informed Care</i>	17
2.	Orders of authority	18
	<i>Analysis of Orders of Authority</i>	20
3.	Permanency	20
	<i>Analysis of Permanency</i>	21
V.	Conclusion	22
VI.	Recommendations	23
VII.	Agency & Facility Feedback	24
	Appendix A – DHHS Response	25
	Appendix B – NCH Response	26
	Appendix C – OCA Response to NCH Response	32

System Review 2020-01

I. Service Area and Summary of Identified Concern:

Safety and quality of care for children in residence at Nashua Children's Home

The OCA reviewed operations and care of children placed by DCYF at NCH in Nashua, NH. The OCA received 17 complaints about incidents and practices that occurred at NCH over the period from March 2019 to October 2020. The complaints were generated by:

- DCYF field staff, supervisors, and administrators
- Family members
- Former NCH residents
- Former NCH staff
- Foster parents
- Legislators
- NCH residents' attorneys

In addition to citizen complaints, the OCA noted trends in incident reports at the facility warranting attention, specifically incidents involving the use of restraint and isolation.

During the time of this review, DHHS classified NCH as an intensive residential program. It is licensed by the DHHS Child Care Licensing Unit (CCLU) for 55 beds and certified by DCYF for 46 of those beds.

II. Office of the Child Advocate: Authority and Responsibility

The OCA is an independent and impartial state agency statutorily mandated to oversee State-provided and arranged services for children to assure protection of their best interests and to promote effective reforms. RSA chapter 21-V is the OCA's guiding statute. Under RSA 21-V:2, III (a) the OCA shall "[u]pon its own initiative or upon receipt of a complaint, review and if deemed necessary, ... investigate the actions of any agency and make appropriate referrals" RSA 21-V:1, I defines "[a]gency" to mean "any department, institution, bureau, or office of the state, as well as other public and private children and youth service organizations providing services under contract or agreement with an executive agency; provided that 'agency' shall not include the judicial council or any entity for which the council provides services." RSA 21-V:2, III(b) further provides that the OCA shall "[i]nvestigate those complaints in which the child advocate determines that a child or family may be in need of assistance from the office or a systemic issue in the state's provision of services is raised by the complaint." The OCA shall also "[a]dvice the public, governor, commissioners, speaker of the house of representatives, senate president, and oversight commission about how the state may improve its services to and for children and their families." RSA 21-V:2, II(e).

To ensure transparency of government and build trust with citizens, the OCA will periodically conduct system reviews to identify opportunities for system strengthening. At the completion of a system review, the OCA may make recommendations or share any key points for learning to improve policies, practices or procedures or influence broader systemic reform. The OCA strives to provide citizens and stakeholders clear and concise information concerning the system reviews in which the OCA issues recommendations. The OCA will not release the names, addresses or any other identifying information of individuals subject to any confidential proceeding or statutory confidential provision, *see* RSA 21-V:5, V(a), nor shall the OCA release system review findings publicly if there is a pending law enforcement investigation or prosecution, *see* 21-V:5, V(b).

III. Summary of Review Process

The OCA began receiving complaints regarding incidents and quality of care of children placed at NCH in March 2020. Prior to commencing a review, the OCA determines whether DHHS processes are undertaken to completion. This routinely includes:

- DCYF Special Investigations Unit (SIU) investigations of allegations of abuse or neglect in a residential facility,³
- CCLU investigations of violation of laws or administrative rules, and
- General case management by child protection and/or juvenile justice services

These DHHS processes, especially the investigations, take time. During that time, the OCA made inquiries to clarify and/or prompt DHHS actions to address individual complaints. In some instances, the OCA arrived at different conclusions than SIU or CCLU. The SIU and CCLU's authority is prescribed by statute, administrative rules, or policy.⁴

The OCA's oversight of children's services, pursuant to RSA 21-V, is grounded in promoting children's best interest.⁵ While the OCA too seeks to ensure agencies operate in compliance with rules and laws, the expectation of oversight and promoting children's best interest lends a wider lens to the full context of children's care. Arriving at different conclusions from the SIU or CCLU is reflective of that wider lens to go beyond individual incident to examine the context of the event, infrastructure of practice standards, empirically informed approaches to care, and organizational culture as it affects the implementation of practice models, policy, and law of the system at-large. The OCA also shines the wider lens on prior and subsequent actions of the agency or organization to better understand how parties arrived at the complaint-prompting event.

With the goal of promoting internal review and NCH-driven adjustment of practice, the OCA shared a selection and general themes of complaints with the NCH director. The director confirmed that incidents about which the OCA received complaints had occurred. The director did not characterize the incidents as problematic. He cited communications with the SIU and CCLU and their lack of investigation findings as evidence NCH practices were appropriate. The director also provided information about some changes in policy and training, including trauma-informed training and a new policy on staff social media posting, both of which signaled potential for improved care of children at NCH. There was no acknowledgment of the potential negative effect the actions that were the subject of complaints could have on children. The OCA further met with the president of the NCH board of directors (board) and provided a brief summary of the complaints.

After a preliminary meeting with the president of the board, the OCA wrote to the full board to bring concerns to their attention. The OCA listed 13 issues that were subject of complaints, two of which were personnel matters that the OCA explained would not be investigated. There were also three general concerns noted to the board, including

- Over-reliance on physical restraint
- Inadequate response to staff concerns affecting morale
- Delays in staff reporting suspected abuse or neglect

³ To further ensure the safety of NH children, a Special Investigations Unit (SIU) within DCYF investigates all allegations of abuse and neglect in foster homes, institutional settings, and residential, educational, and treatment facilities. <https://www.dhhs.nh.gov/dcyf/cps/index.htm>

⁴ The CCLU's authority stems from RSA chapter 170-E and the applicable New Hampshire Administrative Rules, He-C 4000 et. seq. DCYF SIU's authority stems from RSA 169-C and DCYF Policy 1164, *Intake of Special Investigation Reports*.

⁵ RSA 21-V:2, II(a).

Assessing the complaints and concerns as reflecting cross program aspects and organizational culture, the OCA's summary to the board focused on four cases, outlining case details for the board. Each case included learning points and reflective questions to guide contemplation of the meaning of the actions as they impacted the wellbeing of resident children. The OCA's intention was to prompt the board to examine program practices to identify areas for strengthening and improvement. In an apparent miscommunication, the board interpreted the OCA's list and limited case detail as incomplete investigation to which they were unable to respond. The board also found the complaints "generally outside the scope of the Board's oversight"⁶ Of the cases for which the OCA provided details, the board responded that they were, "not in a position to second-guess [the director's] (and his staff's) clinical judgement on these issues as they pertain to specific cases and/or the response provided by [the director] to you as he is the person with the most direct knowledge to speak to NCH's position relative to the same." In certain areas, the board did note and commit to policy and procedure review and training. The board "committed to ensuring the on-going well-being and care of the children at Nashua Children's Home"

Subsequent to communications with the board, data collection, including interviews, continued. In a snowball effect common with system review, the OCA received additional complaints and/or supportive comments and requests to complete the review. To be clear, this report again represents only synthesized themes to reflect general concerns about organizational culture and practice. Details are limited in accounts of cases to protect involved children's privacy. The findings and recommendations should be viewed as opportunity for program improvement and measuring contract implementation and compliance in the interest of children.

Methods employed in this review included:

- Document review
 - NCH, DCYF and DHHS records including
 - Case notes
 - Individual medical records
 - Treatment plans
 - Communications
 - NCH, DCYF and DHHS policies and procedures
 - Websites and social media
 - NCH, BCBH, & DCYF Personal communications and staff notes
 - Federal and state statutes and rules
- Interviews and electronic communication with
 - Complainants
 - DCYF administrators, supervisors, and field staff
 - DHHS CCLU administrators and staff
 - Court appointed special advocates/Guardian ad Litem (CASA/GAL)
 - NCH director, staff, former staff, and board of directors
 - Former NCH residents
- Observation of facility video and photographs
- Literature review including standards and models of behavioral and physical care, child development, childhood trauma and adverse childhood experiences, and impact of restraint and seclusion on children, including instruction in use of physical restraint
- One of the incidents in a complaint was also the subject of an OCA System Learning Review (SLR). The SLR is a review process, grounded in Safety Science, that facilitates review of systemic impact on decision making by a team of experts in the field.

⁶ Personal communication, (November 2020).

Representatives from NCH and DHHS cooperated with all OCA requests for information and contributed thoughtful analysis of DCYF/DHHS processes. The OCA is grateful for their assistance. The OCA also wishes to acknowledge the important contribution from complainants and children affected by NCH services. They have provided an opportunity to learn and improve conditions for all children served in New Hampshire.

IV. Facility Review

A. Nashua Children's Home Themes of Concern

While it is effective and often necessary to intervene on behalf of a single child, the OCA endeavors to identify system trends that, when addressed, will improve circumstances for all children. In the primary stages of this review, document review, and in some cases complimenting interviews confirmed credibility of complaints. In the cases of three children, the OCA undertook to advocate on their behalf to ensure their immediate needs were met. Two DCYF staff interviewed for this review expressed concerns about their perception of over-use of physical restraints at NCH, unwillingness to accommodate therapeutic needs or therapeutic matching between child and therapist, and lack of support for visits or transitions to foster or adoptive homes. Despite these concerns, the DCYF staff explained a shortage of appropriate foster parents left DCYF in the difficult position of relying upon NCH for a place to put children. Three themes emerged among all complaints and incidents from the beginning of the review and beyond those issues brought to the board. They signaled need for organizational and system examination and improvement. They included:

1. **Trauma-informed care**
2. **Orders of authority**
3. **Permanency**

In addition to complaints about the care and treatment of children, the OCA received several complaints about NCH staff-management relations. The OCA generally does not review personnel complaints. Those concerns are best addressed internally. However, all parties should be aware of potential for staff morale problems impacting the experience of children and their access to appropriate care.

Significantly, this review included referrals for allegations of abuse or neglect at NCH made by NCH staff to DCYF abuse/neglect central Intake more than six months after the alleged incidents occurred. In New Hampshire, all adults are mandated reporters under RSA 169-C:29. Absent a full review to identify influences on NCH staff delays in reporting, training may reinforce knowledge and actions required under the law. Delayed reporting of suspected abuse or neglect of children potentially leaves children in harms way. Delayed reporting also subjects the credibility of reports to question. Staff who delay reporting post-employment may, as happened with NCH former employees, appear to be "disgruntled former employees" risking credible concerns to be dismissed. In response to the OCA's feedback, the NCH board committed to update staff training. A partnership between the Granite State Children's Alliance and DCYF offers free training for mandated reporters through the [Know and Tell](#) initiative.

B. Complaint Findings and Analysis

In this section, individual complaints are synthesized under prevailing themes. Due to the delay in reporting this review, the circumstances of individual children have already been improved and/or they departed from NCH. Resolution of complaints does not always represent learning or system improvement. There is benefit in review and analysis of each situation to determine factors that may provide opportunity for learning and growth, acknowledge system improvement, and serve to inform system-wide strengthening.

As DHHS embarks on a new, procured residential service model, this review serves as a guide in assessment of contract compliance and continuous quality improvement. On July 14, 2021 the Governor & Council approved a 3-year contract with NCH for 46 beds at a total of \$9,804,960.00 (approximately \$71,050 per child per year or \$199.58 per child per day)⁷ ([the contract](#) – see Agenda Item 14). The contract contains a section on Scope of Services (Exhibit B) that outlines expected services and approach to service delivery.

Relevant contractual expectations are listed in each section of identified themes of concern below. Each section includes a brief description of the theme. The new contractual obligations, not in place at the time reported events took place, now serve as a framework for quality improvement and contract compliance towards effective care of children.

1. Trauma-informed care

New Standard of Care Set by Contractual Expectation:

- 1.3.5. The Contractor shall provide residential treatment services with the purpose of:
 - Providing services that are trauma-informed and implementing evidence-based practices to ensure the highest quality of care and the best possible outcomes for the individual
- 1.11.3.4. Staff training that includes but is not limited to the:
 - 1.11.3.4.1. Trauma model and other evidence-based practices utilized in treatment and incorporate applicable concepts and strategies
 - 1.11.3.4.2. Clinical Evidence-Based Practices used to deliver the residential treatment services

The context for trauma-informed care is the circumstances of children placed in residential facilities. Children arrive in those facilities with significant history of adverse childhood experiences (ACEs), placement out of home being one of them. As the OCA has reported previously, children placed in institutional facilities experience trauma or diagnosed post-traumatic stress disorder at a rate more than twice that of combat veterans.⁸ They may suffer from hyperactive, impulse and dysregulation disorders, sensory disorders, depression, anxiety, suicidality, and other psychopathologies, all of which may manifest as disruptive behavior.^{9,10} While the long-term damage of adverse experiences can be debilitating, supportive experiences can rehabilitate and mitigate those effects, allowing for healthy development.¹¹ For traumatized children to heal and grow, they benefit most from nurturing, supportive relationships; feeling safe, stable and protected in a just environment; feeling a sense of social connectedness; and learning social competencies.¹² When placing children in an environment for the express therapeutic

⁷ Shibinette, L (2021). [Personal communication / Requested Action](#) to Governor Christopher T. Sununu and the Honorable Council June 28, 2021. Governor & Executive Council, Agenda Item 14.

⁸ Purvis, KB, Cross, DR, Dansereau, DF & Parris, SR, (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services*, 34(4): 360-386. DOI: 10.1080/0145935X.2013.859906.

⁹ Connor, DF, Doerfler, LA, Toscano Jr., PF, Volungis, AM & Steingard, RJ, (2004). Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies*, 13(4): 497-510. DOI: 10.1023/B:JCFS.0000044730.66750.57

¹⁰ Cohen, JA, Mannarino, AP, Jankowski, K, Rosenberg, S, Kodya, S, & Wolford II, GL, (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential facilities. *Child Maltreatment*, 21(2): 156-167. doi:10.1177/1077559515624775.

¹¹ Sege, RD & Browne, CH, (2017). Responding to ACEs with HOPE: Health outcomes from positive experiences. *Academic Pediatrics*, 17 (7S): S79-S85.

¹² Sege, RD & Browne, CH, (2017).

purpose of healing, it falls upon the residential provider to ensure the milieu includes these healing factors.

In the review of complaints and incident reports the OCA received, several factors emerged that may contribute to, or exacerbate trauma's effects. The OCA noted that in interview, the NCH expressed skepticism of the provision of evidence-based care now included in contract expectations. They questioned the value of evidence-based practices and noted conversations with BCBH staff in which they suggest NCH's "practice-based evidence" informed their own development of a practice model.

The areas of most concern to have traumatic effect included the use of isolation from the resident community and physical restraint. Seclusion and restraint traumatize or re-traumatize subject children and witnessing peers, setting back recovery.¹³ A third factor included staff interactions with children that may have interfered with establishment and maintenance of the trusting, supportive relationships grounded in respect that are necessary for children to feel safe and connected.¹⁴

New Relevant Standard of Care Set by Contractual Expectation:

1.11.3. Staff training and Development

1.11.3.5. De-escalation and restraint model which supports the limited use of restraints or seclusion in accordance with RSA 126-U and aligns with the Six Core Strategies©

1.14 Restraint and Seclusion Practices

1.14.1-3 address training in de-escalation and limiting use of restraints per Six Core Strategies©.

1.14.4. The Contractor shall work with the Department and other partners towards a zero restraint practice.

1.14.5. The Contractor shall develop restraint and seclusion policies and develop a method of review that will support reduction and elimination of restraint and seclusion.

Use of Imposed Separation

NCH utilizes a "Quiet Room"¹⁵ for children who need a calming space, are dysregulated, or who otherwise need to be separated from the NCH community. The NCH states that placement in the Quiet Room is not

¹³ 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.

¹⁴ Raney, B (2019). *One Trusted Adult: How to Build Strong Connections & Healthy Boundaries with Young People*. Circle Talk Publishing.

¹⁵ The Quiet Room consists of a wall of telephone-booth-sized stalls open to the room. Each is fitted with what appear to be two horizontal metal panels, one flush to the back wall at a 90-degree angle and one several inches below and in front of the top one, also at a 90-degree angle making a seat. From appearances, a child may sit on the lower panel facing the wall with a small shelf to lean on or sit facing out with the upper panel sharply supporting the back. In front of the stalls there is a desk facing the stalls and behind the desk on the wall, there appears to be shelving. In one video the OCA viewed, there was also a chair that a staff sat in at the far end of the desk, closest to the door.



seclusion because there is always an NCH staff member present in the room. In an E-mail¹⁶ widely distributed to other providers, DHHS personnel and the Child Advocate, the NCH director took issue with the OCA's [Addendum Report on Restraining and Secluding Children](#) that questioned the intent of RSA 126-U:1 defining seclusion. The noted understanding of the intent of the law was to that the presence of a supervising staff person qualifies "the episode as NOT to be considered seclusion." It was explained that NCH understood the "[d]efinition and inclusion of seclusion, as it were, was informed by situations in which children were placed in sometimes locked, unsupervised rooms by themselves."

There appear to be two defining factors in effecting seclusion: being alone and not being able to leave.

1. A child is alone in a space

New Hampshire RSA 126-U:1, V-a defines "seclusion" as "the involuntary placement of a child alone in a place where no other person is present." At NCH, a staff sits in the Quiet Room across from the stalls where a child would be directed to sit. The presence of the staff would appear to exempt the separation of the child from the rest of the NCH community from the definition of seclusion.

2. A child may not leave the space

RSA 126-U:1, V-a goes on to establish that a secluded child would be "unable to exit, either due to *physical manipulation by a person*, a lock, or other mechanical device or barrier." (Emphasis added.) The statutory definition clarifies that the act of seclusion does "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*." (Emphasis added.) The statute further clarifies that "[s]eclusion does not include circumstances in which ... *the child is physically able to leave the place*." (Emphasis added.)

The separation NCH imposes on children by placing them in the Quiet Room may not meet the statutory definition of seclusion under RSA 126-U. However, the Quiet Room, used dually for punishment and calming space, does isolate children from their peers and community for what NCH staff document as "extended separation."¹⁷ According to the NCH Guide, children may complete extended separation in their rooms, however the Quiet Room, according to the NCH Guide, may be used to prevent disruption of the group and "provide more defined physical boundaries" to mitigate likelihood of placing self or others at risk. Substantial and imminent risk of physical harm to self or others is the criteria required to justify seclusion of a child under RSA 126-U:5-a.

In the NCH Quiet Room, there is a partial barrier between a child and supervising staff by the three walls of an individual stall. Based upon the response of, and feedback from, children subjected to the Quiet Room, the space may have a similar feel and effect of seclusion. Thus, use of the Quiet Room was contemplated in this review based on its potential effects.

The Quiet Room appeared to be a significant factor in physical restraints of children reported by NCH. In a random sample of 54 reports of physical restraint, the OCA noted the Quiet Room was reported to be involved in 45 incidents (83%). A consistent theme emerged of children not wanting to go to the Quiet Room. A majority (37) of restraints in the sample, began as an "escort" to the Quiet Room and escalated.

Nashua Children's Home Quiet Room individual stalls.

¹⁶ Personal communication, (July 2021).

¹⁷ "Extended separation" is described in the NCH *Behavior and Emotional Support Guide* as a serious consequence generally required for children who commit physical assault, destruction of property, and running away. "Utilizing extended separation as a consequence differs from the employment of 'time out,' which permits the child to regain control prior to re-entering the group" (unnumbered page). Duration of separation depends upon the child demonstrating ability to be in the group without serious behavior defined as involving potential harm to self or others.

The reported escalating behaviors of children during escort to, or while in the quiet room included hitting, kicking, pinching, and spitting at staff, running from staff, trying to push past staff to exit, screaming, and banging their heads against the walls and floor. These behaviors triggered more severe restraint in all 37 incidents that began as an “escort” to the Quiet Room. As one former child resident explained,

“Everybody hated that Quiet Room because it was just a white room. There were cubby holes the size of a urinal. There was a metal bench and a metal desk in front of you. And you sat there. It hurt my back. You are supposed to face in but I have anxiety and I couldn’t. They told me to turn around but I couldn’t. ... They knew I had anxiety because they gave me meds and knew what they were for.”¹⁸

The benefit of a quiet place to re-group may be lost on children who are uncomfortable in the space or equate it with punishment and physical altercation in the form of restraint.

Use of Restraints

Evidence of the negative impact of physical restraint is increasingly guiding practice improvements that eliminate their use across health industries. Since 2008 the federal Centers for Medicare and Medicaid Services (CMS) have classified death or serious injury related to physical restraint as a preventable adverse event or error.¹⁹ In this context, the OCA examined complaints received about three individual children who experienced physical restraint at NCH as well as trends observed in restraint reports the OCA received pursuant to RSA 21-V:7.

Dennis.²⁰ 8-year-old Dennis was the subject of at least 27 restraints and removal to the Quiet Room in a 6-month period. The OCA noted a pattern in NCH incident reports of Dennis having trouble at bedtime transition. In an effort to address what staff generally described as “difficulty settling,” or “disruptive” behavior on the unit, NCH staff would warn Dennis he risked removal to the Quiet Room. Complainants noted one incident in which the restraint resulted from Dennis hiding under his bed. He would also hide in his closet. On two other occasions, Dennis’ disruptive behavior followed the removal of an audiobook and from his objecting to other children being read a story at bedtime but not him. Dennis demonstrated consistent resistance towards going to the Quiet Room. That resistance resulted in physical restraint in the process of going there, or once there. Reviewing a collection of incident reports aided in recognizing a pattern that appeared to relate to the insistence on removal to the Quiet Room as an exacerbation of Dennis’ struggle with settling. His behavior, as described, included playing loud music and other disruptions when other resident children were already in bed. Staff reports did not include descriptions of alternative means of comforting or quieting Dennis or references to use of a safety plan. NH RSA 126-U:3 mandates the development of a plan as soon as possible after admission to a facility. The plan must identify a child’s history of trauma and effective responses to potential behavior that will avoid the use of seclusion and restraint. There was no apparent supporting behavioral plan that would proactively settle Dennis for bed. NCH reported that treatment plans would lay out interventions to be used with children, but that the plan would not specify certain responses to a child’s triggered behavior.

Anthony. The OCA noted a similar potential association between physical restraint and removal to the Quiet Room in the experience of another child, 16-year-old “Anthony.” The OCA received complaints about a physical restraint incident involving Anthony for both length (80 minutes) and position (prone or face down). In that case, NCH staff discovered Anthony had contraband empty vape and THC cartridges

¹⁸ Personal communication November 2020.

¹⁹ 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.

²⁰ The OCA uses Pseudonyms to protect the identity, privacy, and safety of children.

in his room. In response, the staff documented he was offered removal to the Quiet Room or the police would be summoned. Anthony resisted the Quiet Room. According to records, he had done so at least once before, when he left the facility after being faced with removal to the Quiet Room. Warning that he would not be able to tolerate the Quiet Room more than a few minutes, he eventually agreed to go. After sitting in a Quiet Room stall briefly, he stood up and attempted to leave the room. Video recording captured the staff standing in his way and closing the door. Anthony is seen attempting to evade the staff, pushing past and towards the door. The staff person stepped in front of him, pushed him against the corner wall. The two struggled and the staff took Anthony to the floor. Two other staff arrived and the three rotated in a struggle to keep Anthony face down on the floor for the next 80 minutes until police arrived, handcuffed him while still face down on the floor, and escorted him from the room under charges by the staff of assault.

The DCYF SIU received a referral for suspected abuse/neglect of Anthony related to this incident. The referral noted that three adult males sat on and straddled him, inhibiting breathing, and caused his pants to drop, exposing his underwear. The SIU reported there was no abuse/neglect²¹ because there was “no injury as a result of the restraint in question and the restraint was being utilized for behavior management purposes.” “Roll back”²² to the CCLU was approved in anticipation of licensing unit reviewing the incident “based on their own policies and procedures.”²³

CCLU staff reported viewing the video tape and all available records. The video tape does not include audio. The CCLU reported to the OCA that they made an initial finding of violation to He-C 4001.22(e), that restraint shall be used in accordance with RSA 126:U, and He-C 4001.22(l)(1), regarding use of physical intervention only after less restrictive behavior management techniques have been tried and found ineffective. NCH disagreed and requested an Informal Dispute Resolution process, as permitted in He-C 4001.08. NCH provided information at dispute resolution, that on the night in question, the weather was projected to be as low as 17 degrees Fahrenheit, and at the time of the incident, it was already below freezing. NCH claimed that if Anthony left the facility, he would not be appropriately clothed. NCH staff told the CCLU at dispute resolution that they restrained him out of concern for his exposure to cold temperature were he to find his way all the way out of the building. With this new explanation, the CCLU deemed the restraint as necessary “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” as required under RSA 126-U:5. The finding of He-C 4001.22(e) was removed. The OCA confirmed the history of weather conditions that night as cold, however, nothing in the NCH or DCYF records addressed concerns about the weather nor was mentioned in OCA’s interviews or during the OCA-facilitated System Learning Review (SLR) of this incident. Without audio on the tape, there is no way of confirming whether the staff also discussed weather conditions with Anthony in attempt to get him to stay in the Quiet Room. Anthony did not disclose any discussion of weather conditions and did not confirm an intention to leave the building entirely.

Because the use of restraint was determined by CCLU to be in accordance with RSA 126-U:5, the violation under He-C 4001.22(l)(1) was also removed. The CCLU’s explanation for the second adjustment to findings was that when the resident attempted to leave, the staff first tried to prevent the restraint by blocking the door and then closing the door. Staff initiated the restraint only after the resident attempted to push past the staff to get to the door. The CCLU apparently viewed blocking exit as exhausting less restrictive behavior management techniques.

²¹ RSA 169-C:3, XVI defines “[i]nstitutional child abuse or neglect” as situations of known or suspected child abuse or neglect wherein the person responsible for the child’s welfare is a foster parent or is an employee of a public or private residential home, institution or agency.

²² “Rolled back the referral” was explained by DCYF personnel as meaning it was referred to the CCLU.

²³ DCYF Bridges Referral Note.

The CCLU did find NCH to be in violation of He-C 4001.14(s)(5), regarding developing and implementing written policies and procedures for, pursuant to RSA 126-U:2, managing the behavior of children, including how and under what circumstances seclusion or restraint is used, which NCH did not dispute. The NCH policy stated that the use of the Quiet Room is considered to be seclusion; however, since a staff is always present with the resident use of the Quiet Room is not seclusion as defined in RSA 126-U I, V-a, so the policy was not pursuant to RSA 126-U:2.

The OCA described Anthony's restraint incident in the [2020 System Learning Review](#) (SLR) Report, as it was the subject of an OCA-facilitated SLR by DCYF and an NCH staff. The SLR team noted Anthony's significant history of ACEs, including chronic abandonment and trauma associated with sexual assault and being trafficked. They noted his coping strategy appeared to be attempting to leave stressful situations, which at NCH, included extended separation and being placed in the Quiet Room. They agreed leaving the building could be unsafe. The SLR team questioned whether NCH employed trauma-informed care to guide interactions with children who have traumatic pasts. The OCA learned in this review that the incident occurred prior to the staff participating in any trauma-informed care training.

The SLR team did not review the video of the incident, however OCA staff did. The OCA observed no visible indication of immediate danger to self or others prior to the restraint. As indicated above, the OCA found no evidence the weather outside was a concern. The OCA also noted the staff made no observable attempt to calmly engage the child or accommodate the child's discomfort in the confining space with alternative means prior to his attempt to leave. This practice was in accordance with the NCH Guide that discourages staff from talking with the children in the Quiet Room.

The NCH Guide, authored by the NCH director, described resident children as typically having experience with abuse and neglect. It did not cite evidence-based practices for handling trauma, or explanations of trauma, its manifestations or factors that may exacerbate trauma effects. Instead, guidance emphasized providing external control for children, anticipating that without external control, children's behavior will escalate. It also anticipated that some interventions will enrage children. In such cases, the guide described as an "imperative" that the child be physically restrained (unnumbered page).

Jake. The OCA received a complaint about 16-year-old Jake being restrained in prone position and sat upon by a staff person he did not know. The NCH incident report described Jake as restrained for being loud and disruptive on the unit after bedtime. Jake's mother had visited earlier in the day and left a collection of DVDs for him. In the evening when he was readying to view the videos, the staff discovered they were R-rated and thus prohibited. Jake refused to give staff the DVDs. The staff responded by confiscating his video player. Jake was described as loudly demanding his property returned for a considerable length of time, disrupting the unit beyond bedtime. Upon investigation, the DCYF SIU learned the child was sitting in the doorway of his room yelling throughout the incident. Three staff proceeded to physically restrain him in prone position for 15 minutes. As with the previous incident involving Anthony, the police were called, however he was not removed from the facility immediately.

The following day, Jake's juvenile probation and parole officer (JPPO) received a series of E-mail communications from the NCH director, including: "*[JPPO]...I want this kid OUT on Monday...send him back to SYSC...convince a judge to make it happen. You know our reluctance in taking him. Especially during this time, can't have this kid endangering my staff like this.*" The director noted the child's mother was the "catalyst with this." However, there was no evidence the staff contacted the mother to manage the disruptive situation. There was also no review of whether a child making loud noise while sitting on the floor as reported, represented "substantial and imminent risk of serious bodily harm" to self or others, the threshold for justifying physical restraint pursuant to RSA 126-U:5. The child's behavior may have caused distress for other residents attempting to sleep. The SLR team examining the previously described restraint of Anthony discussed the possibility that in difficult situations, staff may resort to physical

restraint for immediate mitigation of problem behavior, rather than investing in more complex engagement to promote the child's internal controls.

NOTE on the use of law enforcement:

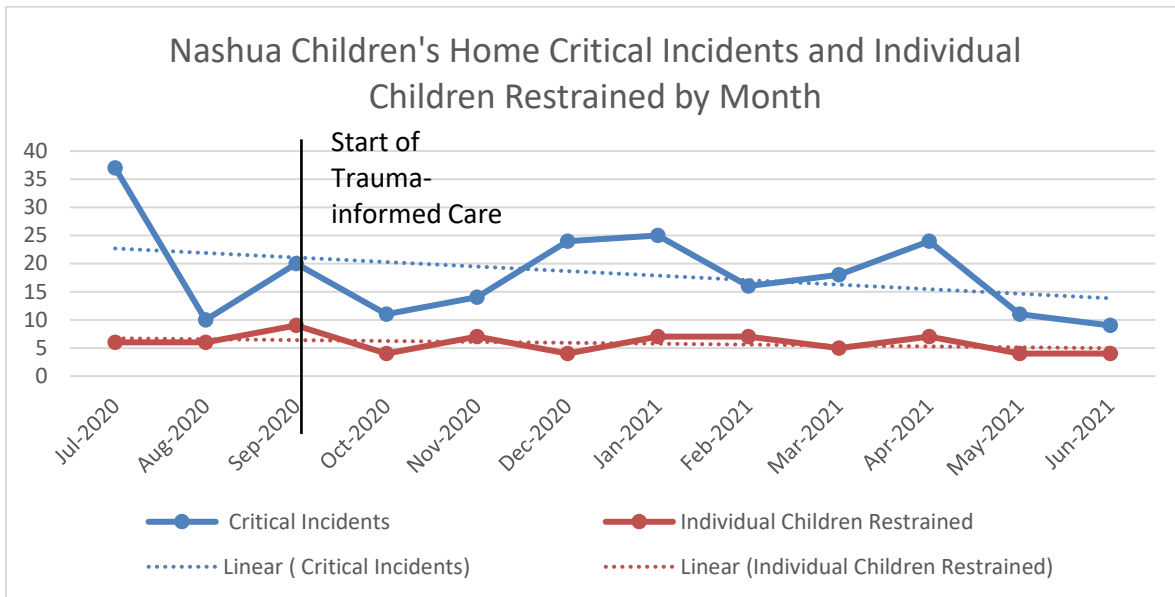
The use of law enforcement, as employed in both Jake's and Anthony's cases, risks the perception of a tenuous therapeutic commitment to children. In the processing of the SLR of Anthony's experience, the SLR team discovered the child had been placed at NCH with "dual orders" from the District Court. As the OCA has described elsewhere,²⁴ 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 DCYF staff 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 trusting relationship. Trust 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 DCYF staff team member described the dual order as an "escape valve" to commitment.

Reported Restraints

RSA 21-V:7 Incident Reports. In addition to the complaints brought to the OCA on behalf of the three specific incidents of restraint, the OCA also noted trends in restraint use among critical incident reports received routinely under RSA 21-V:7. Specifically, the OCA noted a high incidence of the use of physical restraints, as previously mentioned, the majority of which occurred on the way to or in the Quiet Room. In reference to one child's experience, a DCYF professional stated, "*In 15 years I don't think I've read about physical restraints as much as in this case at NCH.*" The diagram below demonstrates trends in use of restraints on child residents over the period of the last fiscal year, July 2020 to June 2021. The diagram also includes a point of reference at September 25, 2020, the approximate time OCA reviewers were told that staff commenced trauma-informed care training. That was reportedly the first time in the history of the organization staff were trained on trauma-informed care. It is a requirement of accreditation for eligibility to participate in DHHS' new contract.

There were a total of 219 critical incidents at NCH reported to the OCA during the time period of July 2020 through June 2021, which is an average of approximately 18 per month. Restraints accounted for 98% of the critical incidents (215 of 219) reported to the OCA. July 2020 contained the highest number of critical incidents (37) and June 2021 contained the fewest (9). Restraints involved an average of 6 individual children each month. September 2020 contained the highest number of individual children restrained (9) and December 2020, May 2021, and June 2021 contained the fewest (4).

²⁴ Office of the Child Advocate, (2021). [Summary of 2020 System Learning Reviews](#): Opportunities to Improve and Build on Strengths of the Child Welfare System Through Examination of Critical Incidents, State of New Hampshire.



Regression analysis shows a slightly negative trend line in critical incidents and individual children restrained by month over the reference period with R^2 values of .1231 and .1227 respectively. These low R^2 values show that time had a very weak effect on incidents of restraint over the period. P-Values for critical incidents and individual children restrained by month are .2634 and .2644 respectively. P-Values show the likelihood that trends are due by chance, and p-values greater than .05 are generally not regarded as statistically significant. Due to low R^2 values and high p-values we cannot determine a meaningful decreasing trend in critical incidents following the reference period. Trauma-informed care training may lead to a decrease in incidents over time, however it has had no demonstrated effect yet. The data should continue to be monitored for future trends.

Staff Interactions with Children

Rose. The OCA received a complaint about social media exposure of 8-year-old Rose that was also the subject of a referral to the DCYF abuse/neglect central intake line. At least one posting of which the OCA received a copy depicted Rose in an apparent state of distress with an adult appearing to chastise her about a personal hygiene matter. The image was accompanied by a statement potentially referencing the child's medical condition that could be interpreted as demeaning. Other NCH staff reportedly "liked" the posting.

In response to staff complaints about the posting, NCH established a social media policy where there had been none. The board noted the importance of effective policy governing social media exposure and committed to reviewing and revising it as necessary. They also committed to annual policy and procedure review with all employees. The response appeared to demonstrate appreciation of the obligation of confidentiality under several federal and state laws governing the care of children in the custody of the Division for Children, Youth and Families (DCYF), specifically:

- Child Abuse Prevention and Treatment Act, 42 U.S.C.A. § 5106a(b)(2)(B)(vii)
- Health Insurance Portability and Accountability Act 45 CFR § 164.502
- RSA 169-C:25, III
- RSA 170-G:8-a, II
- RSA 170-G:8-a, V

The board reported no further such problematic posts. The OCA has received no further reports of such postings. Thus, the practice appears to have been resolved with the advent of policy and training. Concerns remain, however, in the way the practice and explanation of the postings may be reflective of

an organizational culture that had not yet embraced sensitivity to trauma and adverse childhood experiences. NCH disagreed that the posting was demeaning of the child. The board described it as bad judgement on the part of the employee who posted, however they noted it was “made in lighthearted spirit and with no malicious intent...”

This lighthearted spirit may also have been behind the experience of another former child resident who reported having the feeling that the staff made a game of the children. His recollection was of a more direct negative culture, quite possibly unintentional, but nevertheless, with profound effect on him. He recalled a staff person admonishing him saying, “You are just a kid in placement. No one is listening to you so you may as well listen to me.”²⁵

Analysis of Trauma-informed Care at NCH

Malicious intent is rare among staff in child serving programs. More often experiences like those reported above are reflective of staff knowledge deficit about basic child development, the effect of trauma and the content of the law. However, the impact of belittling, humiliating in public, singling out, and ridiculing, even when intended as lighthearted, may have similar effect on a child’s emotional wellbeing as intentional malice. These are all characteristics of psychological maltreatment according to the American Academy of Pediatrics.²⁶ Children, especially those with traumatic pasts, may not have capacity to tolerate this type of interaction. They may also not see it as intended as lighthearted. This type of knowledge can be gleaned in staff training and education on child development and trauma, and supervision and guidance. Similarly, examining the emotional impact of community separation by placing children in the Quiet Room may be a useful exercise for NCH in determining effects of interventions.

In the use of physical restraint, understanding the law and its application is foundational to providing safe care to children. It is also only a minimum standard of care. In 2019, with the passage of Senate Bill 14, New Hampshire codified a mandate for children’s behavioral health care to be trauma-informed and evidence-based.²⁷ The new contract DHHS has undertaken with NCH reflects the new law and acknowledges the broad and negative effects of trauma-insensitivity, seclusion or separation, and restraint. It requires trauma-informed evidence-based practice and training as well as training in the National Association of State Mental Health Program Directors’ Six Core Strategies© program. Negative effects from the use of restraint go beyond physical injury or death, which is the common yet incomplete measure of harm. Deaths related to these practices are significant but rare. The impact on social and emotional wellbeing of children who are restrained or witnesses to restraint can result in chronic social and emotional morbidity. For example, Fox (2004) noted an exacerbation of post-trauma responses in children who are restrained or witness the restraint of other children.²⁸

Careful and comprehensive training can therefore remediate these problems and equip staff to develop the trust and supportive relationships grounded in respect necessary for children to develop a sense of connection to fuel resilience. Section 1.11. Staffing, Training and Development of the contract scope of service demands comprehensive and ongoing training for all program staff, whether providing direct care to children or not. DHHS’s invocation of the benefits of the Six Core Strategies © program, by requiring employment of the program at NCH in the new contract, sets a higher standard of care. Six Core

²⁵ Personal communication November, 2020.

²⁶ Hibbard, R, Barlow, J, MacMillan, H, & the Committee on Child Abuse and Neglect and AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, Child Maltreatment and Violence Committee, (2021). [Clinical Report: Psychological maltreatment](#). *Pediatrics* 0031-4005.

²⁷ RSA 135-F:3, III(e).

²⁸ Fox, LE, (2004). [The impact of restraint on sexually abused children and youth](#). *Residential Group Care Quarterly Newsletter*, 4(3). Child Welfare League of America.

Strategies© has proven effective in reducing the use of seclusion and restraint, thereby preventing aversive and traumatizing experiences for children, and creating a healing milieu.²⁹

Incident data analyzed by the OCA is limited in its reliance upon provider reporting to DHHS and its consistency. The analysis does suggest some important themes however, that can be useful in adjusting care for individual children and therapeutic milieu for all children placed. Tracking incidence of restraints after the first trauma-informed care training the staff received is a limited indicator of staff and administration buy-in to the philosophy of being trauma-sensitive to children in institutional care. However, if contract compliance for implementing evidence-based care that is trauma-informed, such as the Six Core Strategies ©, is achieved, measures of success such as reduction of restraint use, should be reported positively. Success of implementation will be reliant upon buy-in from all of NCH, including most importantly, its leadership, defining and expressing a vision, values and philosophy that expects elimination of the use of physical restraint and a supportive, therapeutic milieu.

2. Orders of authority

New Relevant Standard of Care Set by Contractual Expectation:

1.3.8. Cultivating strong community networks around the individual to support long-term thriving in community settings after discharge

1.15.1.2.1.4. Having an environment that is welcoming, and has space for families that is natural, inviting, and comforting

1.15.1.2.2.2. Welcoming natural support networks and professionals as a support to the family and youth

1.15.1.2.2.3. Having flexible visitation policies that promote face-to-face contact, supported visitation as well as technology that prioritizes the individual's connections

Two sets of complaints addressed the experience of two children for whom either the Court or a medical provider ordered specific actions or care that the NCH did not follow.

Aimee. The OCA received a complaint regarding 16 year-old Aimee who had an alternative planned permanent living arrangement (APPLA) for whom a primary caring adult (PCA)³⁰ was identified and approved by the Court. Children for whom reunification with parents or adoption is unlikely may have an APPLA with a PCA who is a guiding and supportive adult without custodial responsibility for the child. The complaint was that Aimee's court-approved PCA, a former NCH employee, was banned from NCH property and could not visit Aimee. E-mail communications between NCH and DCYF indicated NCH believed the PCA, with whom the child had a positive established relationship, would interfere with the work of the then current NCH therapist. Instead, NCH wrote that the current NCH therapist would be a default PCA with the child's assumed long-term placement at the NCH. There was no explanation in the record of any concerns about the court-appointed PCA that would have warranted the restrictions.

²⁹ Azeem, MW, Aujla, A, Rammerth, M, Binsfield, G, & Jones, RB, (2001). [Effectiveness of Six Core Strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital.](#) *Journal of Child and Adolescent Psychiatric Nursing*, 24: 11-15. doi: 10.1111/j.1744-6171.2010.00262.x

³⁰ APPLA is type of permanency plan for older youth involved with DCYF who are not reunifying with their parents or are not adopted or under guardianship with another adult. APPLA requires: a child who is at least 16 years of age and a court approved Primary Caring Adult (PCA). A PCA is defined as someone the youth wants to be his/her/their PCA who is fit to serve as the PCA and makes a lifelong commitment to be the youth's primary source of guidance and encouragement. The PCA must also understand the youth's current and future needs and be an adult other than the youth's parents. It is the intent that every youth with an APPLA permanency plan have a PCA. <https://www.courts.state.nh.us/fdpp/Protocols-Relative-to-RSA-169-C.pdf>

Upon interview with the OCA, NCH disclosed not knowing a PCA is approved by Court order after significant vetting of the potential in the relationship pursuant to RSA 169-C:24-c, II. NCH claimed DCYF never told NCH the PCA was court-ordered and cited E-mails and conversations with a BCBH staff that supported the NCH position. The BCBH staff did not document the conversations and there was no record of a response to the director's E-mails. DCYF Central Office staff reported the field team made every effort to work around NCH's objections with phone visits and meetings off site, however those measures were met with objections as well. DCYF acknowledged that NCH had no authority to decide the child could not interact with a court-approved PCA. The Court subsequently ordered the child leave NCH.

New Relevant Standard of Care Set by Contractual Expectation:

1.22.2. The Contractor shall employ clinical professionals that ensure effective treatment outcomes.

1.22.3. The Contractor shall provide clinical treatment services in a frequency to quickly stabilize the individual's symptoms and to meet each individual's clinical needs.

1.22.6. The Contractor shall assure that treatment is clear across the program and clear to the multidisciplinary team.

1.24.1. The Contractor shall implement medication procedures in accordance with applicable federal laws, and rules

Rose. A second complaint received that indicated NCH acted outside orders involved the manner in which NCH staff treated 8-year-old Rose, a child with a medical condition.

A reporter who received a complaint from one of Rose's peers at NCH forwarded it to DCYF Central Intake as suspected abuse or neglect. The reporter claimed the peer had described a hygiene program in which NCH staff required Rose report gastroenterological information to a male staff. The peer reported feeling uncomfortable because sometimes Rose would cry, and staff would withhold snacks until she made her report. DCYF accepted a referral as "added information" to Rose's open family services case and rolled it back to CCLU.

There is no evidence Rose's CPSW on the open family case was aware of or followed up with the referral. Later when the OCA inquired to DCYF about Rose's medical treatment, case documentation indicates the CPSW forwarded the OCA inquiry to NCH staff.

Upon receiving the complaint, the OCA requested Rose's medical records, which the NCH provided. Rose's medical records indicated that a specialist physician prescribed medication and a specific behavior routine to address a gastroenterological condition. The emphasis of the behavior part of the intervention was to create a positive, comfortable environment for Rose and *not* (emphasis added) to address any outcome of the intervention. The OCA found no incorporation of the physician's explicit guidance in NCH medical or other treatment documentation. One prescribed medication and its administration was not documented on medication sheets leaving no indication whether it was ever administered. On two occasions, Rose was administered medication with effects that could be socially embarrassing prior to community outings, situating her for social discomfort. Despite the instructions to create a positive, comfortable environment for Rose and not to discuss outcomes of the intervention, NCH staff required Rose report the outcome of the intervention to staff, which appears to have included male staff from another unit. Notes from therapeutic sessions indicated that Rose felt she was the subject of a "joke." It is documented that she reported the staff would not believe her if she disclosed her discomfort because she had not disclosed sooner and had been called a liar before.

Upon interview, NCH confirmed the staff subjected the child to the reporting routine despite the medical orders and that she did not make any complaints. NCH explained the lack of documentation of the medical

regimen and reporting procedure was reflective of the facility not employing medical staff and their intentional home-like atmosphere avoiding an overly medical model program. They explained that medically prescribed regimens were discussed at staff shift change when they had shift change meetings.

The CCLU found no violations based on interviews with Rose and NCH staff. The CLLU reported to the OCA that Rose told the CCLU investigator that she felt safe at the program and could choose to whom she reported the outcome of her regimen. The CCLU reported to the OCA they did not receive the detailed information the OCA discovered upon reviewing medical records.

Analysis of Orders of Authority

The rigor of the Court process approving PCA assignment reflects the nature and significance of the PCA. The Court assures a high level of commitment that is essential to a child's identity and resilience. Refusing to honor and facilitate the PCA relationship with a child interferes with a Court order, and demonstrates a lack of recognition of the value of personal and significant relationships and their effect on resilience and child wellbeing. That NCH claimed not to know PCAs were a product of court decisions suggests an opportunity for DCYF to improve communication with NCH. The Court itself was reportedly perplexed by the child's lack of access to her PCA. If DCYF were unable to engage NCH to accommodate the relationship with clear communication and education, the Court might have considered seeking explanation from NCH directly. As with all care of a child in custody, documentation of communications about issues that arise is not only essential to case management, but also to learning. Had BCBH staff documented interchanges with NCH, knowledge and understanding of the situation could be measured and where deficits existed, addressed. For example, credible objections to the individual appointed as PCA would have been useful to inform the court for the best decision.

Medical orders such as those for Rose are generally impactful of children's health, the disregard for which could have serious negative outcomes. Even in a home setting, a parent or other caregiver monitors a child's medical regimen for adherence, side-effects and outcome. The absence of a medication monitoring system and adherence to prescribed orders is neither homelike nor safe. As noted above, the new contract mandates clinical professionals and medication procedures that ensure effective treatment and compliance with laws, rules, and standards of care. This expectation is an opportunity for improvement to ensuring appropriate oversight of resident children's prescribed medical care. Since the time of Rose's stay at NCH, DCYF has been allocated funds to hire district office nurses. As those positions are filled, field staff will have access to professional expertise to monitor medical conditions and appropriateness of care.

3. Permanency

Relevant New Standard of Care Set by Contractual Expectation:

1.3.1. Prioritizing short-term treatment with the goal of rapidly reunifying children with their families and/or community support networks

1.3.4. Prioritizing family engagement and providing caregiver education and engagement in the individual's care and recognizing that families and caregivers are an integral part of the Treatment Team Meetings/Child and Family Team

1.3.10. Supporting and improving the transition of the individual from residential treatment into their home community, by utilizing oversight and supportive transitional services through the CME

1.13.6.3. In order to provide individuals with successful and supported transitions, the Contractor shall work with the individual's family, caregivers, community behavioral health providers, DCYF, CME, peer support providers, school district and the next treatment providers as follows but is not limited to:

1.13.6.3.3. Sharing and transferring pertinent information prior to discharge about progress and improvements made by the individual to ensure continuity of treatment in the community

1.13.7. The Contractor shall complete comprehensive discharge and transition plan, which includes a strong focus on family and caregiver education and involvement in the individual's aftercare in order to prioritize episodic lengths of stay and for the purpose of the individual's successful transition from residential treatment to home, school, and community as soon as possible.

The focus of a set of complaints about one resident child was NCH's lack of support for a child to transition out of the facility. The theme of delaying permanency in a least restrictive, normative setting were also present in other cases. For example, in Aimee's case of not having access to her PCA, NCH suggested relationships with NCH staff would be primary due to the assumption the child would remain in NCH programs up to and possibly beyond age 18. The coronavirus pandemic complicated matters for visitations and building relationships with new families. The board noted in their November 2020 letter of response to the OCA that there had been no COVID infections among child residents to date, a remarkable accomplishment. Since then, eight children have reportedly tested positive. However, complainants still expressed the perception that NCH contributed to delays in children's permanency with family by not supporting transition with shared information or supporting opportunities for bonding to new families.

Dennis. In addition to experiencing frequent physical restraint, 8-year-old Dennis was not able to establish a productive relationship with a therapist. COVID-19-related restrictions complicated engagement with prospective foster parents. Dennis' DCYF team described NCH as not willing to facilitate creative solutions to visits within restrictive protocols, such as outside visits. As restraint incidents increased, both DCYF and the CASA/GAL determined it would be best to move Dennis to a foster home even without a purposeful transition period. NCH registered complaints about the decision to move the child in several E-mails. Once the decision was made, rather than work with the child's team and foster parents to introduce the child and provide therapeutic guidance to meet those needs, NCH staff communicated a strictly negative description of the child directly to the foster parent. Complainants described the NCH communication as painting an "ugly picture" of a "scary" child who was only controllable in a congregate setting where many staff were available to intervene. The child subsequently had difficulties but remains in a foster home readying to be introduced to a pre-adoptive family.

Oliver. After a considerable length of stay at NCH, 7-year-old Oliver had the opportunity for moving to a foster home. NCH provided very little information about the child to the new caregiver. As a result, the foster parent did not anticipate a need to keep the child safe from certain known triggers. Although the triggers were identified at admission to NCH, DCYF staff reported there was no record of treatment for the problem or exposure to the trigger for the purpose of testing or desensitizing. When the foster placement failed, the NCH argued the child was better off at NCH in a long-term placement. With information from this OCA review, DCYF determined not to return the child to NCH and an alternative placement was sought. The failed attempt at a normative home has further complicated the permanency for that child.

DCYF Responsibilities. In both Dennis' and Oliver's cases, information sharing and preparation for receiving foster parents was ultimately the responsibility of DCYF as the custodial parent. The direct and negative communication to Dennis' foster parent by NCH staff was reportedly made without DCYF knowledge. However comprehensive review, team meetings, and extensive history from records, builds out a complete picture of a child, his strengths, and his needs. In cases like Oliver's, scrutiny of the child's needs and strengths throughout the stay in a facility equips DCYF to best inform and prepare a receiving foster parent, as well as make the right match of child to foster parent. Rose's experience with the altered medical care and postings about her on social media also represented another opportunity for supervision and guidance. Even with subsequent referrals to DCYF abuse/neglect central intake, there was no documentation demonstrating awareness of her treatment or use of that information to track progress or benefit of the program.

Analysis of Permanency

In the experience of Aimee for whom NCH objected to the relationship with her PCA, NCH also suggested that, rather than the court-appointed PCA, her PCA would be a current NCH therapist who would be with her up to and beyond the age of 18. That suggestion reflected the assumption of long and indefinite residential care, contrary to the current expectation of the contract. The federal FFPSA is predicated on

minimizing children's separation from home or community. The new contracts reflect that new standard of care and expectation.

The new contracts also set expectations for explicit and comprehensive preparation of receiving caregivers when children leave a residential program. Success of transition is wholly dependent upon preparation through information sharing. Dennis and Oliver's experiences demonstrated the hazards of transition without advance knowledge and understanding of the complexity of needs with which institutionalized and traumatized children present.

The key takeaway is that institutional placements should be short in length of stay with discharge planning commencing at admission. The children's experience underscores the shared responsibility of residential provider, DCYF, and BCBH to ensure transitions home or to new homes are fully informed and supported. The cultural shift the contract demands of NCH and DCYF is the nurturing of a vision for children to have homes and connections in communities where they may thrive.

V. Conclusion

There is no doubt that there are children who have been placed at the NCH who have thrived. This review is an account of concerns raised for children who had a different experience. Even with document review and first-hand accounts, an assessment such as this may appear subjective or unfair because it does not take into account the many successes achieved by the program. However, the number of complaints and incidents require attention under the OCA's RSA 21-V mandate to review. The delay in NCH pursuing training and incorporating sensitivity of trauma into programming may have delayed integration of advances in the science of child development and effective care. Moreover, the known negative impact of ineffective care on witness children warrants consideration for program assessment.

Of those complaints that were also referred to DHHS for investigation, the limited scope of abuse/neglect and licensing purview resulted in nothing that rose to a licensure violation or an abuse/neglect finding. However, with broader narrative examination there was evidence of factors that, when addressed, will promote an effective therapeutic milieu, grounded in a philosophical embrace of evidence-based, trauma-informed care and permanency for children in their community.

NCH is valued by the community for its charitable care of children with complex needs. DCYF and other entities continue to use it as a placement for children. Yet the community knows little about what happens at NCH or what should happen. DCYF's reliance on the facility also sends a very different message than what some DCYF staff and administrators expressed about the quality of care at NCH. Despite these contradictions, NCH has demonstrated capacity for change and there is now a strong infrastructure in a legal and binding contract that establishes obligation for quality, effective, safe, evidence-based, and trauma-informed short episodes of care. To ensure success, the DCYF and BCBH will have to support and guide NCH as well as all other residential programs to make the changes, comply with contracts, and pivot to community-based offerings in the best interest of children.

VI. Recommendations

- **NCH** – Update the *NCH Behavioral and Emotional Support Guide* (NCH Guide) to reflect practice and policy consistent with requirements in the contract for evidence-based trauma-informed care
 - Implement documented discharge planning upon admission
 - Upon admission, develop behavioral intervention safety plans for each child consistent with the requirements of RSA 126-U:3 to reduce the incidents of restraint
 - Create and implement a formal reduction plan for restraints with measurable goals
 - Develop a consistent practice and documentation system for medical and mental health management and medication monitoring
 - Consult with DCYF nurses on children’s medical care and medications
 - Staff would benefit from training to include:
 - Residential Counselor Core Training (RCCT) through the Child Welfare Education Partnership
 - [One Trusted Adult](#) training in engaging and working with children
 - [Know and Tell](#) mandated reporter training
 - National Association of State Mental Health Program Directors’ [Six Core Strategies](#)© training
 - Develop flexible and creative accommodation for visiting and caregiver engagement, including during public health crises
 - Pivot to community-based offerings and supportive transitions of resident children
- **DCYF** – Document communications with NCH, including all court orders and plans for children’s care and permanency
- **BCBH** – Monitor compliance with NCH contract requirements. Give specific attention to trauma-informed care, use of restraint, and medical care; and track outcomes for children
 - Track employment of evidence-based, trauma-informed models of care with associated training for all NCH staff
 - Ensure training and implementation of Six Core Strategies© and general trauma-informed care³¹
 - Monitor incidence of restraints and use of Quiet Room for punishment and promote elimination of these practices
 - Inform and monitor compliance with court orders
 - Monitor appropriate employment of clinical professionals and systems for implementing all levels of medical and mental health treatment
 - Monitor discharge planning and associated outcomes
 - Monitor for evidence of a culture and practice that envisions family and community connections in normative living arrangements with expectation of limited short stay in residential care
- **DCYF/BCBH** – Commit to/have confidence in transitioning from congregate care to community-based services. Lessen dependency to place children at NCH.

³¹ Note: NCH is reported to have begun trauma-informed care training in September 2020 and attended introduction to 6-Core Strategies © in October 2021.

VIII. AGENCY & FACILITY FEEDBACK

On December 7, 2021, the OCA completed this review and provided advanced copies of the report to the director of NCH, the president of the NCH board of directors, and the DHHS Directors of the Divisions for Children, Youth and Families, and of Behavioral Health. We requested feedback on the report by December 14, 2021. Responses are included below in Appendix A for DHHS and Appendix B for NCH. Appendix C includes the OCA's response to the NCH response.

Appendix A – DHHS Response

The DHHS did not respond to or provide feedback on the report. Informally we learned that although there was no response, the recommendations of the report aligned with DHHS initiatives under way.

Appendix B – NCH Response

(Please Note: The statement of response and accompanying photos submitted by the NCH follow as submitted. The OCA edited the NCH statement to correct the alias of a child that was incorrectly listed in the review report. Both have been corrected.)

The following is the response of Nashua Children’s Home (NCH) to the System Review conducted by the Office of Child Advocate (OCA). It should be noted, however, per the OCA website, that this report was due on October 15, 2020, with the website indicating that any delay in the release of the report past that date would be posted on the website. No such notation was ever made. Also notable is while the final report is dated October 13, 2021, it was not provided to Nashua Children’s Home for review until December 7, 2021. Further, NCH has been accorded the opportunity to respond, but must do so by December 14, 2021. At issue is a question of basic fairness, with a report provided 14 months past its published due date, with the respondent (Nashua Children’s Home), having only seven days to generate a response to a 24-page document.

The OCA report contains a number of inaccuracies, and less charitably, falsehoods. There are also a number of identified complaints of which NCH had no knowledge, and is in a compromised position to respond absent additional detail. Lastly, we believe that the findings of the OCA belie a general lack of understanding of residential group care, with an absence of appreciation for the challenges of caring for groups of children, not solely individuals. The challenge for Nashua Children’s Home, of which we are cognizant, is to continue with individualized programming, to the extent possible, given staffing resources.

The falsehoods referenced apply to the situations involving specific children, whom the OCA identified with aliases, and also to programmatic descriptions of NCH insofar as support for transition planning and reporting of abuse or neglect. Two cases in particular, “Oliver” and “Dennis” contained false information. The situations with other children will be discussed further on in this response:

***Oliver: Oliver’s transition was buoyed by conferences between the Supervisor of his unit, his NCH therapist, other senior NCH Residential Program staff, the foster/pre-adoptive parents, the CPSW and the CASA. That “NCH provided very little information to the new caregiver” is preposterous on its face. NCH shared abundant information. That the placement failed three weeks later was in no way due to insufficient information sharing. That then eight-year old Oliver and his then nine-year old sister, also in placement at NCH (parental rights had been terminated, biological father was deceased, there were no other siblings) were then placed in separate residential facilities rather than returned to NCH, which had been their home for two years, remains one of the most compelling travesties in our ongoing relationship with DCYF and associated advocacy groups. Per phone calls from the now 10-year-old sister, who continues to call NCH with some regularity, there has been no face-to-face contact between the two siblings since their removal from the prospective foster/pre-adoptive home nearly 14 months ago**

***Dennis: The Supervisor of Dennis’ unit was asked expressly by Dennis’ CPSW from DCYF to communicate directly with the foster parent about Dennis. This communication was shared with DCYF. The CPSW’s supervisor conveyed her thanks to NCH for having shared the information. It was never communicated to NCH that the communication was an “ugly picture of a scary child.” We were asked to offer our experience with Dennis’ behavior and effective de-escalation techniques. We shared our experience with Dennis, honestly and openly.**

***The OCA report, in Section IV-A cites “...unwillingness to accommodate therapeutic needs or therapeutic matching between child and therapist, and lack of support for visits or transitions to foster**

or adoptive homes.” NCH was provided no context for this statement, no examples of these dynamics, save for these specific cases cited. This section also noted “referrals for allegations of abuse or neglect at NCH made by NCH staff to DCYF abuse/neglect central Intake more than six months after the alleged incidents occurred.” NCH is aware of no such occurrences, and neither DCYF Special Investigations nor CCLU has indicated any instance of delayed reporting by NCH staff. We are aware of one instance, cited later re: a medical practice, whereby notification was made to CCLU by an external clinical supervisor of a former NCH staff member, which was some months delayed.

NCH recently achieved accreditation through CARF International. Accreditation is for a three-year period, the maximum time period allowable by CARF. Noteworthy is that none of the CARF recommendations for NCH going forward align with those of the OCA, and the CARF report specifically cites the “camaraderie” among staff, and “a palpable sense of staff unity and response,” a far cry from “morale” issues noted by the OCA, absent any context whatsoever. The CARF Surveyor conveyed to NCH that the ongoing challenge for us will be to maintain conformance with over 1,300 CARF standards, while continuing to embrace the culture of who we are, our child-centeredness, our prioritization of the needs of children and families. The Accreditation Report issued by CARF reads in part, “Community partners report that NCH enjoys an excellent reputation in the community. This is its first CARF survey, and the organization, with the assistance of a consultant, prepared well for the accreditation process. In addition to its many strengths, the organization has some areas for improvement that are noted in the recommendations of this report, including in the areas of health and safety and workforce development. The organization is aware of the areas that should be addressed and has the commitment and willing staff to do so. The positive attitude demonstrated to the recommendations and consultation offered instills confidence that the organization will use the results of this survey to further improve organizational and service quality. Nashua Children’s Home appears likely to maintain and/or improve its current method of operation and demonstrates a commitment to ongoing quality improvement. Nashua Children’s Home is required to submit a post-survey Quality Improvement Plan (QIP) to CARF that address all recommendations identified in this report.” The “Areas of Strength” identified by CARF, some in stark contrast, to the allegations of the OCA are:

-The leadership of NCH is competent, hardworking, and knowledgeable. The leadership team members are experienced and dedicated to ensuring that the needs of the persons served are addressed. The work and service delivery culture that leadership fosters is characterized by camaraderie, a palpable sense of staff unity and response, and appreciation for each other and the persons served.

-The organization’s leadership is supported by a cadre of energetic, creative staff members who work with a team spirit and are appropriately involved in accountability for the organization’s operation and strategic planning. Staff members are invested in their work, as evidenced by their positive, respectful, proactive, and enthusiastic attitudes and their thoughtfulness and creativity. They are dedicated to the highest level of care.

-The organization’s leadership and staff members are congratulated and recognized for the quality of services they have continued to provide during the COVID-19 pandemic.

-The organization has in place a strong framework of business function policies, written procedures, and plans. This is evidenced by its continued growth over the years. The leadership continually looks for areas in which to increase services and to have different locations to provide much-needed services.

-NCH has an open-door policy for family visitation in a non-pandemic timeframe. Each youth has a visiting plan that is developed by the youth’s team and is unique to family needs.

-Youth that have been served at NCH stay in touch with the staff. They send cards, staff members attend their weddings, and they report their success stories back "to their families," as they consider the staff members at NCH an essential part of their extended families.

-NCH is located on a large campus with many buildings, plus an additional campus that is located in another area of the community. The grounds and buildings utilized in the provision of services were clean; well maintained; and, at the time of this survey, completely decorated for Halloween as each unit was involved in a decorating contest.

-An active, committed board governs NCH. Progressive, supported board members willingly contribute their time and talent to ensure that the organization's mission is fulfilled.

-Effective communications are valued at NCH. Referral sources, staff members at all levels, and board members are encouraged to provide input and feedback to the organization.

-NCH's board of directors invites a staff members from each level of the organization to board meetings as a guest to introduce themselves to the board and share their role in the organization. This allows the governing board to know staff members at every level and to ensure that staff members at every level of the organization understand how important they are to the success of the organization.

Notably, CARF issued no recommendations for quality improvement in the area of Individualized Planning, Transition/Discharge, Medication Use or Promoting Nonviolent Practices. The full Accreditation Report is attached.

Other areas:

*There was perhaps a misunderstanding around the history of NCH insofar as participation in trauma-informed training. The clinicians of NCH, several years ago, did participate in Trauma-Focused Cognitive Behavioral Therapy (TFCBT), offered at Dartmouth. Beginning in March, 2020, ALL Residential Program staff commenced training in ARC (Attachment, Regulation, Competency) sponsored by the Justice Resource Institute (JRI). This training was interrupted due to COVID, but in March 2021, all staff did complete the training. Our affiliation with the trainer assigned by JRI continues on a monthly basis. All Nashua Children's Home Residential Program staff recently attended a day-long training, on-site, on "Fostering Identity Development & Resiliency in Youth," presented by Dr. Tana Bridge of Eastern Michigan University.

*NCH does not disdain evidence-based practices but continues to believe that there's a place for "practice-based evidence," meaning the value of tried and true practices with children which have been "evidenced" to be effective over time. <https://onlinelibrary.wiley.com/doi/abs/10.1002/cpp.379>

*Regardless of the explanations offered re: Quiet Room and Seclusion, the use of our Quiet Room by children does not equate to Seclusion as defined by RSA: 126-U, as the space is continually staffed when children are present. The Quiet Room is sometimes requested by children of their own volition, knowing that is it a neutral, low-stimulation area. Children needing space from their respective milieu often have the opportunity to settle elsewhere as well, in various staff offices, in the "rec room," or in the newly opened "Sensory Room" (photos attached).

*Nashua Children's Home typically does not utilize law enforcement to manage behavior within our programs. There are times, however, where physical safety is paramount, and the situation can be most effectively resolved with the assistance of law enforcement. Unfortunately, this will be increasingly true with the growing hesitancy to utilize physical restraint when necessary. This is one of those "both way" situations where A (child's behavior being extremely disruptive)-B (our being encouraged to refrain from

physical intervention) =C (involvement of law enforcement), but NCH has been encouraged not to utilize C either. For the record, over the course of years, Nashua Children's Home has maintained a mutually beneficial, and optimally cooperative relationship with the Nashua Police Department, including their response to a tragedy 20 years ago wherein a Nashua Children's Home staff member was murdered. We utilize law enforcement judiciously, and we believe prudently, only when necessary.

Other children:

*Aimee: In this instance, it was absolutely the case that NCH had no prior knowledge that a PCA had been assigned, and was not furnished the court order stating such. The concern with the former therapist serving as PCA was initiated by the current therapist and then reinforced, as a general concern, by the Community Program Specialist of BCBH, our primary liaison with that state agency. The child subsequently leaving NCH had nothing to do, as far as we know, with the PCA issue. We were informed on a July Thursday that she was to be discharged to her family on Friday. This resulted in a beach activity for her unit returning early, the girl herself being upset. The plan, prior to this, endorsed by both the girl, her family, DCYF and her GAL, was for her to remain at NCH through her high school graduation, and then to seek tenancy in the NCH Transitional Living Program (TLP), which remains in the lives of youth far past the closure of their case by DCYF and/or CASA/GAL. The TLP as a program was to be the default PCA, NOT the then NCH therapist. Instead, she returned home and reportedly experienced some of the negative outcomes affecting youth her age (i.e., pregnancy, dropping out of school) who leave the child-protective or juvenile justice system.

*Anthony: As noted by the OCA, there was not a finding that the physical intervention with Anthony violated RS 126:U. Another area in which the challenges of residential group with at-risk youth is not fully appreciated by monitoring and regulatory agencies is in the need for staff to exercise split-second decision-making. This was an instance where a boy with a history of being sexually trafficked was threatening to leave the facility, and moved to do so. Supervising staff needed to decide whether to allow this boy access to Nashua city streets, where the episode of being sexually trafficked could easily reoccur, or to prevent him from doing so. Staff chose the latter route, doing so with the belief that those responsible for his court-ordered placement through the juvenile justice system would expect us to prevent the boy from absconding if we were able to do so. We later learned that the position of DCYF in these situations did not support our doing so, thus staff have now been instructed to not interfere with older adolescents who are attempting to abscond from the facility.

*Rose: In this case, the attending physician most certainly did instruct staff to have her engage in a "sitting" toileting program, with these documents furnished to the OCA. He also asked whether this program was "productive." The only way for staff to ascertain the productivity of this program was to ask Rose, and Rose was offered the choice of staff member to whom to communicate the productivity. Snack was never withheld as a component of the program, though she was told, as a "first things first" matter upon returning from school, that she had to sit for the prescribed number of minutes prior to having snack. Rose feeling "safe" in the program and being able to report to the staff member of her choice was corroborated by Rose in her interview with CCLU.

*Dennis: There have been ongoing efforts to program for "Dennis" at bedtime, per his needs. These include the assignment of a 1:1 counselor for him at times, the use of various music devices, many of which have been successful. The majority of physical interventions with Dennis range from 1 to 4 minutes. Given the focus on Dennis, it would have been instructive for the OCA to contact his Guardian-ad-Litem for her opinion on the effectiveness of his NCH programming. If this has not occurred, perhaps her opinion could be solicited going forward.

*Jake: The 16-year-old, placed within a peer group of nine other adolescent boys was disrupting the milieu after bedtime. Had Jake not been placed with a peer group, but alone, perhaps staff could have invested more time in the resolution of this situation prior to putting hands on Jake in an attempt to move him away from the peer group.

In closing, Nashua Children's Home has reviewed the finding of the OCA, in a report that was due nearly 14 months ago, with no intervening explanation for its delay. We have responded with thoughtfulness and transparency, within the limits of the 7-day time frame that we were accorded. We believe some of the accounts relayed by the OCA to be simply false, and others with the level of information made available to NCH so scant as to make an informed response nearly impossible. Lastly, we compared the report of the OCA to the Accreditation Report of CARF International, an internationally-recognized accrediting body. The CARF report represented a two year process that was inclusive, transparent, thorough, and on time. The reader, we believe, can plainly see that the two reports reached vastly different conclusion on the services to children and families provided by Nashua Children's Home.

Respectfully Submitted,

David Villiotti

Executive Director

NCH New Sensory Room



NCH New Sensory Room



Sensory Room Items

- Sensory Swing
- Crash Pad
- Sensory Bubble Tube and Vibration Bench
- Yoga Ball
- Sensory Trampoline
- Sound Machine
- Star Projector
- Bluetooth Speaker to play music
- Portable DVD Player with Yoga/Meditation/Breathing exercise DVDs for younger and teen age groups
- Fidget Toys
- Zen Garden
- Sensory Body Sock
- Sensory Weighted Vest
- Various Sensory blankets and pillows
- Stuffed animal that does guided breathing exercises to calm

Appendix C – OCA Response to NCH Response



Moira O'Neill
Child Advocate

State of New Hampshire

Office of the Child Advocate



December 17, 2021

David Villiotti, Director
Nashua Children's Home
125 Amherst Street
Nashua, NH 03064

Dear Mr. Villiotti,

Thank you for your recent response to the Office of the Child Advocate's *System Review 2020-01 Review of Complaints about Nashua Children's Home (NCH)*. Per your request, we will include your statement and attached photographs with the original review report. With apologies, we edited your statement for the use of a child's alias that was used incorrectly in our report, which we repaired there.

Thank you for your feedback on the delay of the report, the lack of updates on our website and the misleading date on the report. We agree our communication about reviews and reports could be improved. We are in the process of hiring more staff and hope to be better situated to keep the website current. The date of the report was an editing error. It was only completed on December 7, 2021, when we sent an advance copy to you, your board president, and to the Department of Health and Human Services (DHHS). We regret any inconvenience the incorrect date caused. We do note, however, that although you found our request for response within one week unfair, you did not request an extension of time, which we would have gladly allotted.

As explained in Section IV-B., page 8, complaints received by the Office of the Child Advocate (OCA) were synthesized under prevailing themes. We felt limiting details would protect children's privacy while alerting the NCH to areas for potential improvements. As we explained in the methods section of the report, we used a wide array of sources of information to review circumstances associated with complaints we received. We stand by the integrity of the data. Twice in your response you promoted lengthy stays at NCH for children, which belies an understanding of the federal Family First Prevention Services Act of 2018 (FFPSA) that is reflected in the service contract NCH recently signed with DHHS. The law and the contract aim to limit the time children spend in residential facilities. This is based in empirical evidence confirming children do better in homes.

We applaud the development of the new sensory room. It should improve children's experiences when they need space. We congratulate you on achieving accreditation under CARF International, as noted in the report. Accreditation is required under the FFPSA to qualify for reimbursement with federal dollars. The positive reviews of staff relationships assessed by the accreditor is a strength of the program. The OCA only warned of potential for staff morale problems and the effect on children, were complaints about staff-management relations credible. That we left to your internal review. We cannot account for the accreditor's lack of recommendations for improvements such as the OCA recommended. We were only able to report on the incidents and practices brought to our attention and investigated. We welcome the opportunity to discuss any further concerns or review our recommendations

Yours truly,

Moira O'Neill, PhD