State of New Hampshire

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JEFFREY A. MEYERS
COMMISSIONER

January 14, 2019

Ms. Moira K. O'Neill
Director
Office of the Child Advocate
121 South Fruit Street
Concord, NH 03301

RE: New Hampshire DHHS response to the Office of the Child Advocate Annual Report

Dear Ms. O'Neill:

Over the last year, the Department has strived to work collaboratively with members of the Office of the Child Advocate (OCA), understanding that although the roles of the OCA and the Department are different, both are committed to ensuring the safety of New Hampshire's children through substantive and continuous systems improvement.

With this in mind, the Department agrees with the report's general themes that focus on children's interests, system capacity, and early action. Additionally, most recommendations for action are aligned with either immediate priorities the Department is currently working on, planning on working towards, or actions we would like to be able to take as additional resources become available.

We particularly appreciate the OCA's recognition that child well-being is a collective responsibility and that our shared goal of safe children, strong families and supportive communities requires the commitment of many. However, the report at times obscures the OCA's recognition that DCYF is part of a system of child well-being that includes law enforcement, the courts, educators, advocates, families and communities, among others. This ambiguity, which is present throughout the report, will create confusion among readers that DCYF, and DCYF alone, is responsible for ensuring the well-being of New Hampshire's children. This confusion threatens to jeopardizes the progress stakeholders have made to transform how this system ensures our children are safe, our families are strong, and our communities work to support these goals.

Additionally, some of the recommendations in the report cite data or entities that are incorrect or need additional clarification.

For example, the report's reference to the number of overdue assessments is an inaccurate portrayal of the potential risks involved in an open assessment, why these reports remain open, and where responsibility resides to determine when a case can be closed. While closing cases on time is important, an open case does not mean, as the report suggests, that families are not being seen. An overdue assessment is one in which the assessment has not been closed within 60 days.

These assessments may not be completed within 60 days for a host of reasons, including: pending litigation; ongoing Law Enforcement investigations that must be resolved before DCYF is able to

conclude an assessment; complex assessments reliant upon expert review and information; DCYF staff keeping an assessment open when there is sufficient information to make a finding so they can continue to work with a family to attempt to mitigate risk (as often happens in matters involving substance use); and DCYF staff not having the time to complete all of the activities and documentation needed to close an assessments. In additional, the number of overdue assessments is not an unduplicated count – families may have multiple concurrent assessments. The report's lack of context in this area is troubling.

Nevertheless, the Department acknowledges that the number of overdue assessments continues to be a challenge and has put in place a comprehensive plan to continue to manage and address the level of risk to children in open assessments and to close cases within specified timeframes which relies upon the use of overtime and some assistance from a third party provider. The report states that referrals to this provider to assist with case closures have ceased "without explanation." This is inaccurate. Initially, many of the overdue cases were significantly overdue and required only some minor additional support in order to be closed. However, the referrals for case closure assistance have slowed over time as the nature of overdue cases has changed. The assessments currently overdue are more recent, more complex and require more than simply confirming information and updating documentation. The increasing complexity of overdue assessments has necessitated a change in DCYF's contract with the vendor. To successfully assist with closing these complex cases, the vendor's staff assisting need to embed in the district offices to work more directly and collaboratively with staff and supervisors. The vendor has not been able to embed in district offices without an amended contract. A contract finalizing this changed model is scheduled to come before the Executive Council for its consideration later this month.

Ultimately, however, overdue assessments are a symptom of incoming assessment volume outpacing the supply of assessment staff. While overall, the number of assessments per year seems to have plateaued after years of steady increases, it still outpaces system capacity: October, November and December of 2018 brought historic peaks in the number of new assessments in each of those months. Until the volume of new assessments declines or additional staffing and resources are available to keep pace with the volume of referrals, it is unlikely that this number will further decrease significantly.

Regarding staffing and resource needs, the report incorrectly cites the number of positions identified in DCYF's prioritized budget needs. The correct number is 114 – 57 CPSWs, 22 supervisors, 14 case aides, and 21 administrative support staff. While we welcome the OCA's support for additional staffing, in this time of looking at needs across systems and operating within existing resources, accuracy is critical when discussing adding resources.

There is some confusion throughout the report about what "entity" is being referenced in a specific section, e.g., DCYF, DHHS, Courts, Office of the Chief Medical Examiner (OCME) – and whether it is a single entity or the larger "system" that needs to change. While there is a well-intentioned attempt to identify issues and recommend specific changes, those recommendations do not always clearly identify which entity needs to change. This will confuse readers and lead them to assume

the responsible agency is always DCYF. The risk of this lack of clarity is that the true root cause of the problem will be missed.

Thus, we believe the focus must be on our collective responsibility for child safety and community-based prevention programs focused on enhancing parents' ability to prevent abuse and neglect – specifically fatalities – from ever occurring. DCYF is, at its core, a crisis response system, and the ability to strengthen families and keep children safe stems from supportive communities strengthening families before DCYF is ever involved.

The report references the deaths of two children following "enhanced assessments." Pursuant to policy, these enhanced assessments, which include additional visitation and oversight, are required for assessments when children are born substance exposed. The reference to these tragedies suggests that these children died as a result of child abuse and neglect while DCYF was involved. However, the OCA makes clear elsewhere in the report that these children appear to have died as a result of a sudden unexplained infant death (SUID) and natural causes. The report's inconsistency potentially threatens to erode public trust in the State's child protection system and should be clarified by the OCA.

The report discusses the role and recent closures of supervised visitation centers, but fails to make clear that these centers primarily serve families with domestic violence, marital, or other custody disputes. Historically, these are not families that are involved with DCYF. Rather, DCYF supervised visitation is typically supervised by staff, family, or providers.

The report references pressure placed on residential providers to admit children and refers to this as the "no eject/no reject policy," which refers to a common practice nationally in which providers are contracted to serve children and youth with defined clinical needs, and they are expected to serve and ultimately meet the therapeutic goals of those children. New Hampshire does not currently have a "no eject/no reject" policy.

The report addresses the costs of the Sununu Youth Services Center (SYSC) as compared to the costs of the balance of Juvenile Justice (JJ) system. The figures cited in the report only compare the cost of JJ system staffing to the cost of SYSC, but excludes the JJ system costs of residential services, in-home services, and courts. The Department and DCYF integrate programs and budgets because it is a more effective way to provide services to our residents and a more efficient use of our resources. DCYF has detailed budget information on its programs and would have provided those details for the OCA report. However, the OCA never requested it.

Further, some of the information regarding SYSC is dated and does not include some of the progress made in recent months. Training has been completed facility-wide on Trust Based Relational Intervention, a trauma-informed model of care. Additionally, the reduction in the census has made it possible for staff to accompany and otherwise support youth in additional programing and activities. While the report identifies considerable needs that remain at SYSC, youth in recent

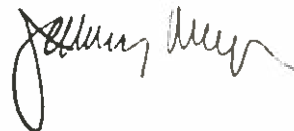
months have had more access to activities, including some the report identifies as no longer available.

The report asserts that DCYF stopped internal reviews of child fatalities. In fact, DCYF has a long history of conducting critical incident reviews, including fatalities, and holding on a monthly basis meetings of Division staff to review the results. However, in the summer of 2018, the OCA advised DCYF that it wanted to participate in these meetings. DCYF was advised by the Attorney General's Office that the OCA was entitled to attend, but that the related policy had to be revised to explicitly include the Office of the Child Advocate's inclusion in order to comply with statuary provisions regarding Quality Assurance Reviews. While DCYF continued its practice of conducting critical incident reviews, DCYF thereafter advised the Child Advocate accordingly and placed the monthly review meetings on hold while the policy was rewritten and provided to the Attorney General's Office for review and approval. Approval has been received and the policy was finalized in December 2018. As a result, the meetings are resuming this month, with the OCA's participation.

The information regarding the Child Fatality Reviews is also incomplete and suggests that the Child Fatality Review Committee (CFRC) is neglecting its responsibilities. This lacks context and is inaccurate. A legal issue has precluded many of the reviews historically conducted by the CFRC. The CFRC is not a statutorily authorized entity, and the confidentiality statutes do not authorize DCYF or other entities to share otherwise confidential information and do not protect the information shared with the CFRC from further disclosure. The Attorney General's Office advised DCYF that it could only share information with the CFRC in very limited circumstances unless and until the statute was amended to explicitly allow information sharing and preventing further disclosure. As a result, the CFRC has halted reviews, awaiting a legislative solution to this problem.

We thank the OCA for its diligence over the past year and its efforts in documenting its learnings in a comprehensive document. While we do not agree with every aspect of the report, we recognize that it is largely informed by the lived experiences of individuals who have experienced different aspects of the system and that those experiences are important. We look forward to the opportunity to review and discuss the information and recommendations presented with the OCA, as well as the opportunity to work toward our shared goals.

Sincerely,



Jeffrey A. Meyers
Commissioner