



**DISABILITIES RIGHTS CENTER, Inc.**

**INVESTIGATION REPORT, FINDINGS &  
RECOMMENDATIONS**

The Use of Force and Restraint and  
Adequacy of Mental Health Care at the  
John H. Sununu Youth Services Center

**Prepared by the Disabilities Rights Center**

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**The Disabilities Rights Center is the designated federal protection and  
advocacy system for New Hampshire and is a member of the National  
Disability Rights Network**

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## **I. EXECUTIVE SUMMARY**

Prompted by information the Disabilities Rights Center (“DRC”) obtained from a prior investigation, DRC initiated a broad investigation<sup>1</sup> as to whether practices, including the use of force and restraints at the John H. Sununu Youth Services Center in Manchester, New Hampshire (“SYSC”) placed youth at risk of harm.

DRC is New Hampshire's designated Protection and Advocacy (“P&A”) agency and is authorized by federal statute "to pursue legal, administrative and other appropriate remedies" on behalf of individuals with disabilities and to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.” *See* 42 U.S.C. § 10805(a)(1)(A).

This systemic investigation found improvements in services and treatment of the youth confined at SYSC including a reduction in restraint use. However, the investigation also revealed troubling practices which adversely affect the treatment and welfare of the youth. Reflective of this mixed picture is the status of the thirteen recommendations DRC made in its first investigation.<sup>2</sup> Two have been fully implemented, six have been partially implemented, two have been subject to internal policy changes, and three have not been implemented at all.

In this investigation, DRC conducted a detailed analysis of 139 incidents involving some form of restraint against 109 children and conducted a detailed analysis of each incident. Looking to professional standards as a framework for reviewing each restraint incident, the investigation revealed a pervasive pattern of inappropriate restraints and excessive use of force by facility staff during the time period reviewed. This pattern is particularly troubling considering the dangers associated with restraints and the nature of the children at SYSC, many of whom have been exposed to high levels of trauma and have at least one diagnosable mental health disorder.

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<sup>1</sup> This systemic investigation was conducted by Rebecca G. Whitley, Esq. staff attorney with the Disabilities Rights Center who conducted the first investigation at SYSC and was supervised by Richard Cohen, Esq., DRC’s executive director and former member of the Eric L. Oversight Panel which monitored DCYF’s compliance with the Eric L. Settlement Agreement, former director of the Division of Investigations of the Mass. Department of Mental Retardation, and author of “Best Practices in Abuse and Neglect Reporting and Investigation,” a chapter in Bradley, V.J. & Kimmich, M.H. (2003) *Quality Enhancement in Developmental Disabilities*. Baltimore: Brookes Publishing. DRC also retained the expert consultant services of Christina Crowe, MSW. Her biography is attached as Appendix A.

<sup>2</sup> DRC made 17 recommendations in total in the first report. Four of the recommendations applied to the individual case of abuse and neglect leaving 13 which applied to the facility and the juvenile justice system.

**DRC found:**

- 42% of youth reviewed were subject to restraint during their stay at SYSC.
- Staff used excessive force in 53% of the incidents reviewed.
- Youth were injured in at least 39% of the incidents reviewed.
- 45% of the incidents reviewed involved use of force or restraint that was not justified by the situation.
- Staff regularly used dangerous restraint techniques to control youth's behavior. 19% of the restraints involved a take-down restraint and 20% of the restraints involved a floor or bed restraint. It is also likely that over half of restraint incidents at SYSC involved a prone restraint, a dangerous practice that exposes youth to an unreasonable risk of death or injury.

DRC also reviewed complaints made by SYSC residents to the SYSC Ombudsman; conducted interviews of the New Hampshire Division for Juvenile Justice Services' Director, William W. Fenniman Jr.; researched historical issues of abuse and neglect at New Hampshire's sole juvenile justice facility; and reviewed DJJS's response to DRC's first investigation at SYSC.

DRC's investigation exposed differences between policy and practice at the facility and a deep-seated and pervasive culture of the use of force to control residents. Although the physical conditions at SYSC have dramatically improved since the new facility opened in 2006, little has changed in terms of culture. DRC also found widespread disrespectful behavior by staff towards youth at the facility. DRC's review of complaints made to the Ombudsman by SYSC residents showed that SYSC staff engage in verbal harassment of SYSC residents. Close to 19% of resident complaints reported on name calling and swearing at residents and other harassing behavior by staff.

DRC also worked with an expert on children's services and the mental health care of abused, neglected and adjudicated children, Christina Crowe, MSW. Ms. Crowe's review included a review of restraint data supplied by SYSC from January 2009 through April 2010 and her own comprehensive review of 8 children's cases. Ms. Crowe concluded in her report that while there has been some progress in reducing the number of restraint incidents at SYSC, her review showed that there remains a problem regarding the appropriateness of restraint use at the facility. She noted that except in rare instances, the incidents of restraint of the 8 residents she reviewed did not seem justified.

In her examination of the adequacy of mental health screening and treatment at SYSC Ms. Crowe found obvious improvements over the past several years. She also had significant concerns. In summary, Ms. Crowe found:

- Policies have been developed that promote adequate and useful assessments of youth.
- However, assessments still lack well formulated vocational and career components as well as in-depth explorations of family strengths and interests.
- Psychiatric assessments generally support the medication decisions that are made, but are not integrated into the overall clinical assessment.
- SYSC has well developed protocols and templates for treatment planning with emphasis on actively engaging the youth in the development of their own goals, however records of weekly team meetings fail to document progress or lack of progress.
- Treatment plans and reviews do not change based on progress or lack of progress. They also fail to address efficacy and changes in medication; family involvement; and vocational plans and activities.
- SYSC offers a broad range of group supports however it is difficult to determine how effective this approach has been because outcome data is lacking.
- Plans to introduce trauma-focused treatment are promising.
- SYSC's Psychiatrist has extensive experience and is well versed in emerging trends in evidence-based treatment; however psychiatry services are isolated from overall treatment planning and review.

In general, Ms. Crowe found that the facility's clinical program is moving in the right direction. However Ms. Crowe found that it was difficult to draw definitive conclusions about the effectiveness of SYSC's approach to treatment due to the "constraints of the model relative to the [Sununu] Center's mission and... the lack of objective outcome data" regarding residents progress.

Ms. Crowe also observed that many children with mental and emotional disorders placed at SYSC are likely being unnecessarily and inappropriately institutionalized. She cited research showing that treatment in community-based settings is more effective than placement in an institution and that it is far more efficacious for children to learn and apply life skills in a

community setting rather than in an institution. Ms. Crowe also cited research showing that institutionalizing youth does not further public safety and that incarcerating youth has been shown to have detrimental effects on them, including their mental and physical well-being, education, employment and ability to reintegrate into their communities.

Other findings in the report suggest that prevention programs and community-based alternatives to incarceration are also more cost effective than incarcerating children in large institutions and are proven to improve public safety by reducing recidivism rates and overall juvenile crime.

### **RECOMMENDATIONS**

#### **➤ To the John H. Sununu Youth Services Center<sup>3</sup>**

- 1) Integrate family and vocational assessments into assessment and treatment planning to improve overall effectiveness and to better prepare residents for return to the community;
- 2) Implement a process to collect outcome data resulting from group and individual treatment interventions and services;
- 3) Incorporate psychiatry and medication monitoring into regular team processes;
- 4) Establish an independent review of all youth on two or more psychoactive medications;
- 5) Implement an on-line clinical record that is shared among those involved with treatment and programming of youth;
- 6) Ensure that youth are not subjected to excessive, unjustified or unnecessary restraints in compliance with RSA 126-U (SB 396-FN);
- 7) Provide regular reports on the use of restraint so that progress towards reducing its use can be monitored;
- 8) Discontinue the use of prone restraint.
- 9) Prohibit staff from threatening restraint as a way to gain compliance;
- 10) Improve staff training to prevent power struggles with youth which often leads to the use of unnecessary force and physical restraint; and
- 11) Provide adequate staff training on treating residents with respect including elimination of verbal harassment.

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<sup>3</sup> DRC's recommendations incorporate recommendations made by Ms. Crowe.

➤ **To the New Hampshire Division for Juvenile Justice Services and Department of Health and Human Services:**<sup>4</sup>

1) Regularly post the reports and plans created from the Performance-based Standards (“PbS”) system on DJJS’s website and forward them to relevant senior DHHS officials and legislative policy makers;

2) Promulgate rules under RSA 541-A that clearly establish procedures for the investigation of suspected abuse and neglect of children in institutional settings, pursuant to RSA 169-C:37 and RSA 169-C:3-a(III). This recommendation was made in DRC’s January 2009 report;

3) Create a unit, independent of DJJS, to investigate complaints and allegations of abusive use-of-force and restraints made by SYSC residents. The unit should have the authority to conduct interviews with the alleged victim and potential witnesses; use the standard set out in RSA 126-U (SB 396-FN); and immediately refer incidents to DCYF that may rise to the level of abuse;

4) Reduce the length of stay for both committed and detained youth by increasing the use of appropriate home and community-based interventions and investing substantially in alternatives to secure confinement;

5) Improve and increase the use of diversion program(s) so that youth can successfully remain in their communities and avoid institutionalization;

6) Increase the use of community-based supports to avoid return to SYSC following release;

7) The Legislature and DHHS should consider adopting a comprehensive statutory and regulatory scheme establishing a statewide system of care.

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<sup>4</sup> *Id.*

## **II. INTRODUCTION**

Prompted by information the Disabilities Rights Center (“DRC”) obtained from a prior investigation, DRC initiated a broad investigation into whether practices, including the use of force and restraints at the John H. Sununu Youth Services Center in Manchester, New Hampshire (“SYSC”) placed youth at risk of harm. Issues were also raised regarding SYSC’s and other state entities’ capacity to address allegations of staff abuse and neglect. Lastly, DRC examined issues concerning the adequacy of mental health screening and treatment received by children detained and committed at SYSC.

In the course of this investigation, DRC reviewed every incident report in the files of 109 children.<sup>5</sup> A detailed analysis was conducted of all incident reports in which one or more restraints were involved. DRC also reviewed complaints made by SYSC residents to the SYSC Ombudsman; conducted interviews of the New Hampshire Division for Juvenile Justice Services’ (“DJJS”) Director, William W. Fenniman, Jr.; researched the history of abuse and neglect at the facility; and reviewed DJJS’s response to DRC’s first investigation at SYSC.

DRC also worked with an expert on children’s services and mental health care of abused, neglected and adjudicated children, Christina Crowe, MSW. Ms. Crowe conducted an extensive file review of 8 youth at SYSC and conducted a series of interviews at the facility. Ms. Crowe’s biography is attached as Appendix A and the results of her review are attached as Appendix B.

All of DRC’s findings are contained in Section VI and VII. Section VIII details DRC’s recommendations regarding all findings and conclusions in this report.

## **III. BACKGROUND**

### **a. Disabilities Rights Center**

DRC is New Hampshire's designated Protection and Advocacy (“P&A”) agency and is authorized by federal statute "to pursue legal, administrative and other appropriate remedies" on behalf of individuals with disabilities. DRC is a statewide organization that is independent from state government or service providers. As New Hampshire's P&A, DRC carries out the Protection and Advocacy for Individuals with Mental Illness (“PAIMI”) Program. The Protection and Advocacy for Mentally Ill Individuals Act of 1986 provides for the PAIMI program which is funded and overseen by The Center for Mental Health Services within the U.S. Department of Health and Human Services. *See* 42 U.S.C. § 10801 et seq. Under the PAIMI

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<sup>5</sup> *See* Section V.a. for an comprehensive description of the sample.



Program, DRC is authorized to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.” *See* 42 U.S.C. § 10805(a)(1)(A).

**b. New Hampshire Division for Juvenile Justice Services**

The Division for Juvenile Justice Services (“DJJS”), part of the New Hampshire Department of Health and Human Services (“DHHS”), is responsible for providing services to youth adjudicated under state law as delinquent or as Children In Need of Services (CHINS). DJJS conducts court-ordered investigations; utilizes community-based services, placements, and programs; and supervises juveniles on probation and parole.

DJJS also provides institutional services at its combined pre-trial detention center and commitment facility, the SYSC. SYSC is New Hampshire's sole architecturally secure facility for juveniles. SYSC has a 144-bed capacity, with 120 beds dedicated to youth committed to the facility following adjudication and 24 beds dedicated to youth detained at the facility prior to adjudication. The average census of the facility over the past several years has been approximately 60 youth.

The Youth Detention Services Unit (“YDSU”) is part of SYSC. As part of the Juvenile Detention Alternative Initiative (“JDAI”) funded by the Annie E. Casey Foundation, any time police or other authorities are seeking a secure out-of-home placement for a juvenile prior to adjudication, they are required to complete a detention risk assessment screening instrument (Risk Assessment Instrument or “RAI”) to ensure that only appropriate youth are detained.<sup>6</sup> New Hampshire also has identified beds in group homes in the state available for youth as an alternative to detention at YDSU.<sup>7</sup>

Committed delinquents sent to SYSC are assigned to a particular program and curriculum after an initial classification assessment. Judges and Juvenile Probation and Parole Officers (“JPPOs”) use formal guidelines to determine whether an adjudicated delinquent meets objective criteria for commitment to state custody. Committed delinquents may also be administratively

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<sup>6</sup> The Detention Assessment Screening Instrument and Instructions for Law Enforcement Personnel for Completing Detention Assessment Screen Instrument (available from the State of New Hampshire Judicial Branch: <http://www.courts.state.nh.us>).

<sup>7</sup> New Hampshire: State Juvenile Justice Profiles (National Center for Juvenile Justice) (2006).

released to a residential facility, including DHHS-certified group homes and institutions. JPPOs provide case management for all youth on their caseloads.<sup>8</sup>

**c. DRC's Previous Abuse & Neglect Investigation at SYSC**

In June 2008, DRC received a report of an alleged incident of abuse against a youth at SYSC. The report alleged that on June 9, 2008, two employees of SYSC used excessive force while restraining a youth, who had significant emotional disabilities.

Pursuant to DRC's federal authority, DRC conducted an extensive investigation of the alleged incident of abuse. In an investigation report issued in January 2009, DRC found that two residential youth counselors at SYSC used unnecessary and excessive force against the fourteen-year old boy committed to the facility. The staff employed a take-down restraint in an extremely small space; dragged the youth face-down across the floor by his feet; and held him in a prone floor restraint for an unknown amount of time before applying handcuffs and removing him from his room. DRC found that staff placed pressure on the boy's back and shoulders during the prone restraint, thus exacerbating the risks associated with this dangerous practice. DRC also found that the youth's behavior did not warrant the restraint and that the youth counselor's actions were unnecessary, excessive, and carried out in an abusive and dangerous manner.

As a result of the incident, the boy's face and back were scratched and bruised, leaving blood on the floor, desk and wall of his room. This was not the first time this boy was injured as a result of a restraint at SYSC. The previous year, staff restrained him face down on his bed and twisted his right arm so far up his back that it reached his neck and fractured his elbow.

In the course of this first investigation, DRC also reviewed SYSC's response and its reporting and investigation of the allegation of abuse. DRC found a number of failings, most of which appeared to be systemic in nature. DRC's findings regarding the incident raised issues about SYSC's systems of abuse prevention, reporting, investigation, correction and accountability, as well as the facility's treatment of children with mental illness.

The first investigation also raised issues regarding other state entities' capacity to address allegations of institutional staff abuse and neglect, such as the New Hampshire Division for Children, Youth and Families ("DCYF") and the Office of the Attorney General. Following the June 2008 incident, staff members at SYSC failed to report the incident to DCYF, even though the boy reported the abuse to a number of staff members. The incident clearly warranted

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<sup>8</sup> *Id.*

reporting by SYSC staff, and at least 8 staff members were aware of the alleged abuse. Staff failure to report the alleged abuse violated RSA 169-C:29, which lists the individuals required to report alleged abuse. The incident was eventually reported to DCYF by the boy's Guardian ad Litem and was investigated by the Office of the Attorney General. The incident was also internally investigated by the SYSC Bureau Chief of Residential Services and a Senior House Leader. Despite what had occurred to the youth, both investigations concluded that no abuse had occurred and that the actions taken by residential staff members were appropriate.

The discrepancy between DRC's findings and those of the Attorney General's Office and SYSC arose in part from differing investigation methodologies and from different positions about the standard for abuse and neglect, particularly as to how the standard applies to restraint. DRC's position, and that of federal regulations promulgated by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), is that excessive or unnecessary restraint constitutes abuse and neglect. In meeting with representatives from the Attorney General's Office and DHHS, DRC raised the issue of whether the current standard for abuse and neglect in New Hampshire (as written or as interpreted) reflects best professional or federal standards. DRC also raised the question of how this standard is applied to institutional settings like SYSC and how the standard particularly applies to restraint and seclusion. DRC suggested the possibility of a more rigorous and detailed standard that the state could implement through 1) policy development at the facility; 2) rule promulgation to govern the administration and oversight of entire facility; 3) rule promulgation under RSA 169-C:37; or 4) statutory change. None of these suggestions appear to have been adopted.

#### **d. Children with Disabilities in New Hampshire's Juvenile Justice System**

While it is difficult to get a definitive number, a 2006 research review estimated a national rate of between 30% - 60% of youth in the juvenile justice system that have been diagnosed with a disability.<sup>9</sup> Other estimates show that as many as 70% of youth in juvenile justice facilities have one or more disabilities.<sup>10</sup> These numbers are significantly higher than the average incidence of disability in the general school-age population.<sup>11</sup>

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<sup>9</sup> Morris, K., and Morris, R., *Disability and Juvenile Delinquency: Issues and Trends*, 615 and 617 (*Disability & Society*, 21(6), 613-627) (2006).

<sup>10</sup> Skibbie, M., *Children with Disabilities in the New Hampshire Juvenile Justice System*, 4 (University of New Hampshire's Justiceworks Program in cooperation with The Institute on Disability) (April, 2004), *citing*

Estimates of how many youth in the juvenile justice system have significant mental health needs also vary some what, however the numbers are extremely high. According to Dr. Eric Vance, DJJS's medical director, 68% – 80% of children in the juvenile justice system have a mental illness. He also estimates that 60% – 70% of the boys and 70% – 90% of the girls at SYSC have been physically and/or sexually abused and are dealing with Post-Traumatic Stress Disorder (“PTSD”).<sup>12</sup>

Others have estimated that between 65% and 70% of youth in residential juvenile justice facilities have mental health disorders, while 50% of youth in the juvenile justice system in non-residential settings have mental health disorders.<sup>13</sup> A recent study, conducted by the National Center for Mental Health and Juvenile Justice (“NCMHJJ”) funded by the U.S. Office of Juvenile Justice and Delinquency Prevention, confirmed these high rates, finding that the vast majority of youth in the juvenile justice system have at least one diagnosable mental health disorder.<sup>14</sup> The NCMHJJ study also found that over 60% of youth in the juvenile justices system met criteria for three or more diagnoses and that youth experience high rates of disorder across the various types of mental health disorders. NCMHJJ also confirmed that substance abuse continues to affect this population as well, concluding that 60.8% of youth in the juvenile justice system with a mental health diagnosis also meet criteria for a substance use disorder.

A study completed by the University of New Hampshire's Justiceworks program, in cooperation with the University's Institute on Disability looked at the impact of New Hampshire's juvenile justice system on children with disabilities. Among other initiatives, the study examined the population at the Youth Development Center (“YDC”), SYSC's predecessor, and found that the population at YDC had a markedly higher incidence of disability than the rest

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Leone, P.E., Zaremba, B.A., Chapin, M.S., and Iseli, C., Understanding the Overrepresentation of Youths with Disabilities in Juvenile Detention, 389-401 (District of Columbia Law Review 3, Fall) (1995).

<sup>11</sup> Morris & Morris, *supra* note 6; and Skibbie, *supra* note 7.

<sup>12</sup> Minutes from June 23, 2008 meeting of the “Commission to Develop a Comprehensive State Mental Health Plan Corrections Committee.”

<sup>13</sup> Shufelt, Jennie L., and Coccozza, Joseph J., Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study National Center for Mental Health and Juvenile Justice (Available at [www.ncmhjj.com](http://www.ncmhjj.com)) (2006).

<sup>14</sup> *Id.*

of the New Hampshire adolescent population.<sup>15</sup> The study also found that 80% of the YDC population showed a history of substance use or abuse.<sup>16</sup> Finally, the study concluded that a child committed to YDC who does not have a history of disability is more likely to be released on parole or administrative release than those with a history of disability.<sup>17</sup>

#### **IV. HISTORICAL REVIEW OF SYSC**

Troubling conditions of confinement and cultural problems at New Hampshire's juvenile justice facility have existed for some time. On November 21, 2000, the New Hampshire Union Leader reported that the State was investigating numerous incidents of alleged staff abuse of juveniles at YDC, SYSC's predecessor, and indicated that DHHS would present the findings of its investigation to the State Attorney General's office with recommendations for action. The article quoted State Representative L. Randy Lyman, then vice chairman of the House Committee on Children and Family Law, who said that the complaints she had received alleged "an extensive pattern of abuse, physical and mental." Based on those complaints, Representative Lyman reported that she filed a bill establishing a study committee on whether YDC should become a separate unit under DHHS.<sup>18</sup> In the article, Representative Lyman expressed concerns about the "lack of adequate state facilities for youth with psychological problems."

DHHS later issued a press release, dated April 19, 2001, reporting on the findings of a 7-month investigation of 25 reports of child abuse and neglect alleged to have occurred at YDC between June 1, 2000 and December 31, 2000, that had been discussed in the November 21 Union Leader article. Then Director of DCYF, Nancy Rollins, stated in the press release that the investigation had resulted in a judgment of no abuse and neglect in 20 of the 25 reports. She reported that the Department's Special Investigations Unit did however, find "patterns of conduct among some YDC staff that, while not constituting abuse or neglect, are troublesome

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<sup>15</sup> The study found that 73% of the population at YDC had a disability compared to 9.62% of the New Hampshire adolescent population. Skibbie, *supra* note 7. These results remain consistent with other national studies. See Shufelt & Coccozza, *supra* note 10.

<sup>16</sup> Skibbie, *supra* note 7.

<sup>17</sup> *Id.*

<sup>18</sup> The legislature later passed HB 743 which created the Division for Juvenile Justice Services (DJJS) as part of the New Hampshire Department of Health and Human Services (DHHS). This bill gave DJJS the responsibility for the delivery of services to all juveniles adjudicated delinquent under RSA 169-B and all children adjudicated as in need of services under RSA 169-D. The bill also gave DJJS the responsibility for running the Youth Development Center and the Youth Services Center.

and warrant being assessed and addressed by YDC administration. This included numerous incidents of the use of improper restraints, belittling residents through name-calling and the use of foul language.” (Emphasis added.) Acting YDC Director Joseph Diament promised to “address all issues raised in the investigation.” The press release contained a series of recommendations made by DHHS, DCYF and YDC to enhance YDC services and protect the rights of residents and employees.

The Union Leader ran a follow-up story on April 20, 2001. The article quoted a representative from the New Hampshire Attorney General’s office who characterized the situation as “a very small group of problem employees.” In the article, then Director of DCYF, Nancy Rollins said that “the investigation did find that five residents at YDC had been abused by staff, principally due to the excessive use of force during physical restraint.” Acting YDC Director Joseph Diament promised that these problems would not be “brushed under the rug.”

Senate Bill 55 (“SB 55”), a bill creating a commission to study the youth development center was introduced and referred to the Senate Committee on Public Institutions/Health and Human Services on January 4, 2001. At the Committee hearing on February 6, 2001, Senator Beverly A. Hollingsworth testified that she was very concerned about YDC and the purpose of SB 55 was to “look at the whole problem” at YDC. She testified that “maybe we needed to look at smaller places instead of this large facility” and that “the state needs to be sure that the places that we send our juveniles to is a place that helps them to be a better citizen and isn’t so abusive that it’s the last place you want to send someone.”

Cynthia Herman, from Child & Family Services of New Hampshire (“CFS”) testified that CFS and the Family Empowerment Council, a group of concerned parents of children who have been at YDC or are currently at YDC, were interested in seeing the bill move forward. She testified that “deep-seated cultural changes” needed to take place at the institution, as well as “upgrading the policy for how we treat children in more of a rehabilitative arena than in a punitive (one).”

Denis Parker, from the State Employees’ Association testified at the January 4, 2001 SB 55 hearing and was particularly concerned about the “inflammatory articles in *The Union Leader*.” Mr. Parker felt that things often got embellished and that it hurts the employees at YDC. He requested that an employee of YDC be on the committee and reminded the Senators that children are at YDC because they have committed crimes.

James Kennedy, a student from the Franklin Pierce Law Center with experience in juvenile corrections, said that “it’s not just the structure or grounds of the school” that he thought needed “resurrecting here in New Hampshire.” He testified that “you’re not going to change people by imprisoning them – separating them completely from society without an ethic of care.” He said the he “would support the idea of localizing and making it smaller instead of having this huge conglomerate of putting our kids into.” Lastly, Peter R. Favreau, then Commissioner of Youth Development Services testified that “we are not a prison, we are a treatment facility.” He also testified that the “physical facilities” at YDC were “deplorable.”

Senator Hollingsworth later introduced SB 55 to the House Committee on Children and Family Law on April 24, 2001, creating a commission “to study the need for and location of architecturally secure facilities and community shelter care facilities to service juveniles.” This was an amended title from the original introduction of the bill. Under SB 55, the duties of the commission were to study the current operation and administration of the youth development center and make recommendations (the “SB 55 Commission”).

In a public hearing of the Senate House Committee on Children and Family Law on May 9, 2001, then Director of YDC Joe Diament expressed support for SB 55, saying that the conditions at the center were in “very bad shape and changes must and will be made.” He indicated that changes needed to be made to the physical plant. When asked about juveniles with mental illness, Mr. Diament said that this problem would be handled in the best way possible and that the incidence of juveniles with mental illness was increasing, largely because of the lack of services.

The bill was passed by both the Senate and the House and signed by the Governor on June 21, 2001. The SB 55 Commission later issued an Interim Report dated January 14, 2002. The report presented the SB 55 Commission’s review of five years of caseload/population and the length of stay data for juveniles. The report also detailed the SB 55 Commission’s review of the existing architecturally secure facilities and recommended, *inter alia*, construction of a new consolidated facility with 48 detention beds and housing for 108 committed youth.

Noting that the SB 55 Commission had spent considerable time and effort regarding reviewing the existing facility, the SB 55 Commission reported in their January 14, 2002 report that they had not yet addressed the issue of “a review of and planning related to the rehabilitative, educational and other programs to be provided at both the architecturally secure

and shelter care facilities.” The SB 55 Commission expressed their desire to continue working on all duties, including the review of and planning related to the rehabilitative, educational and other services provided at the architecturally secure and shelter care facilities and a review of the services they provide.

The SB 55 Commission issued another report dated November 1, 2002, which focused primarily on the logistics of building the new facility. The SB 55 Commission recommended, among other things, that a new 144 bed, architecturally secure facility housing “committed” and “detained” youth should be built on the Youth Development Campus in Manchester. The new facility added 33 beds to the existing total of architecturally secure beds available within DJJS. The SB 55 Commission indicated that “this size is deemed fully able to meet current demands and allow for modest growth without encouraging over-use of this very expensive end of the juvenile justice service continuum.” The SB 55 Commission estimated that the total dollar amount for the building would be \$33 million. The November 1, 2002 report contained no mention of any current or proposed reviews of the programs and services offered by the facility.<sup>19</sup>

The new John H. Sununu Youth Services Center (“SYSC”), a detention and training school facility, opened for admissions on the grounds of the Youth Development Center (“YDC”) in Manchester in late summer 2006. Since that time, the facility has seen a decline in census. DHHS Commissioner Nick Toumpas recently acknowledged that SYSC is “drastically underused, given that it can hold nearly 140 teenagers but typically has 60.”<sup>20</sup> In fact, last year Director Fenniman closed down one wing of the facility as a cost-saving measure.

The future of SYSC recently became the subject of budget reduction discussions. In early April 2010, Governor John Lynch proposed a plan that included \$85 million in general fund spending cuts to close New Hampshire’s budget deficit. The proposal included a DHHS plan to use extra space at SYSC to house youth currently in community shelters operated around the state. The proposal would have closed three state-contracted community shelters for children in Bradford, Jefferson and Antrim. Instead of remaining in their communities, the proposed

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<sup>19</sup> Passage of new legislation (SB 193) extended the SB 55 Commission’s work until November 1, 2004. The Commission never filed another report and met for the last time in August 2003.

<sup>20</sup> Timmins, Annmarie, House panel eyes prisons, Women, juveniles would relocate (Concord Monitor) (May 6, 2010).



change would send children to SYSC, where they would be housed in a wing separate from the current detained and committed juvenile population. According to the proposed plan, juveniles who were committed and detained would be moved to two units and a third unit, with 36 beds, would be turned into transitional housing. A fourth unit, with 45 beds, would house the shelter.

Moving children from community shelters and residential placements to SYSC was expected to save the State \$4.1 million in fiscal year 2011. There was strong opposition to this proposal. Opponents argued that it was inappropriate to place youth who require shelter or transition services in an institutional setting. Opponents also argued that it was more costly to place youth at SYSC than in community-based settings. The proposal eventually failed in the Legislature.

The House Finance Committee later proposed a plan that would close the women's prison in Goffstown, move the female inmates to SYSC, and relocate juveniles to the former prison in Laconia. This plan did not prevail either. In the end, the three community shelters remained open and a study committee was established to study and make recommendations regarding the transfer of populations of the youth development center and the state prison for women. Other recent changes at the facility included a series of staff layoffs in October, 2009 and June 2010.

## **V. SUMMARY OF DRC'S SYSTEMIC INVESTIGATION**

### **a. Background and Methodology**

DRC's statutory mandate under PAIMI provides DRC with broad authority of unaccompanied access to SYSC, its grounds and buildings, its residents, and facility records for the purpose of monitoring facility conditions and treatment of residents, investigating complaints of abuse and neglect, and providing protection and advocacy to residents with mental illness. In order to carry out P&A statutory objectives, PAIMI provides DRC with the authority to have access to records of individuals under certain circumstances. A P&A is entitled to be provided reasonably prompt access to the records of any resident who has a parent or guardian with respect to whom a complaint has been received by the P&A or with respect to whom there is probable cause to believe the health or safety of the resident is in serious and immediate jeopardy.<sup>21</sup> See 42 USC 10805(a)(4)(C)(iii), 42 C.F.R. 51.41(b)(3).

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<sup>21</sup> Under this provision, a P&A is entitled to the records of an individual who has a parent or guardian after they have 1) made a good faith effort to contact the parent or guardian; 2) made a good faith effort to offer assistance to the parent or guardian to resolve the situation; and 3) the parent or guardian has failed or refused to act on behalf of the resident 42 USC 10805(a)(4)(C)(iii), 42 C.F.R. 51.41(b)(3).

Following DRC's first incident investigation at SYSC, DRC concluded that it had probable cause to believe that system-wide abuse and neglect may be occurring at SYSC and therefore affecting any child residing there. DRC thus began this investigation by requesting to review a sample of all incident reports from SYSC for the last two years. DRC was instead granted access to the files of all youth currently committed or detained to SYSC as of August 10 and 11, 2009, respectively, whether they were physically at the facility or on administrative release. DRC reviewed every incident report of these children, plus an additional 20 children for whom DRC had obtained parental releases, for a total of 109 children. The average census at the SYSC for the past several years has been about 60 youth. Of the 109 files, 42% of the children had incident reports showing that they had been restrained.

DRC conducted a detailed analysis of all incident reports in which one or more restraints were involved. Because many of the children had been either committed to the facility for a long period of time and others had been released and re-admitted on one or more occasions, the incident reports ranged from April 8, 2005 to May 31, 2009. From the 109 files, DRC reviewed 139 incidents involving some form of restraint. Many children were restrained multiple times while at the facility. Most incidents involved multiple restraints.

DRC also reviewed approximately 170 complaints made to the DHHS Office of the Ombudsman. DRC did not review every complaint made to the Ombudsman but did review 100% of the complaints made by the specific group of youth DRC to which was granted access. The oldest complaint reviewed was opened on May 12, 2004 and the most recent complaint reviewed was opened on July 19, 2009.

#### **b. Legal and Policy Framework**

In reviewing the 139 incidents where staff used force or employed a restraint, DRC looked to a) the definition of abuse and neglect contained in regulations promulgated under the federal PAIMI statute and b) best professional standards as a framework for reviewing each restraint incident.<sup>22</sup>

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<sup>22</sup> At the time of this incident review, New Hampshire law did not directly address use of restraint or force at SYSC or when the use of restraint rises to the level of abuse or neglect. A discussion of New Hampshire law is contained in Appendix C. Youth in juvenile justice facilities also have constitutional and federal statutory rights. A summary of these rights is contained in Appendix D.

## **1. Definitions of Abuse & Neglect under PAIMI**

Regulations promulgated under the PAIMI Act by SAMHSA, define “abuse” as “any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.”<sup>23</sup>

The SAMHSA regulations also define “neglect” as “a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes, but is not limited to, acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff.”<sup>24</sup>

## **2. Professional Standards and Use-of-Force**

There is a clear consensus in the literature that the use of force and restraints are merely safety procedures and should not be used as behavioral interventions. Use of force and restraints should only be used in emergency situations, where it is necessary for the immediate safety of the child or others and only after all less restrictive interventions have been attempted. A complete discussion of the literature is included in Appendix E.

In its review, DRC used the standards contained in the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative (“JDAI”) conditions assessment instrument.<sup>25</sup> The instrument contains best professional standards used to train assessment teams in over 80 JDAI

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<sup>23</sup> See 42 C.F.R. § 51.51.2.

<sup>24</sup> *Id.*

<sup>25</sup> A discussion of other applicable standards is included in Appendix G.

sites around the country.<sup>26</sup> The JDAI standards are applicable to all secure facilities that house youth. The JDAI standards are unique in that they provide very detailed requirements that incorporate both legal and accepted professional standards (including standards for medical and mental health) to protect the health, safety, and legal rights of youth in secure facilities.<sup>27</sup>

JDAI standards instruct that staff at juvenile justice facilities should only use force and mechanical restraints when a youth's behavior threatens imminent harm to the youth or others. If the use of force, restraints or isolation is necessary, the standards provide that they should be preceded by less restrictive techniques, including talking with youth to de-escalate the situation and bringing in other staff, mental health professionals, or other youth. JDAI standards encourage a graduated set of interventions that avoid the use of physical force or mechanical restraints; employs a range of interventions or actions before using force or restraints; and permits only that amount of force needed to ensure the safety of the minor and others.

The JDAI standards also prohibit restraining youth in a prone position and putting pressure on the youth's back.<sup>28</sup> Finally, the standards prohibit the use of pain compliance techniques at facilities.

### **3. SYSC Policy**

SYSC's policy on the use of force has recently undergone a number of significant revisions. The improved SYSC policies:

- Included details regarding less restrictive methods for dealing with behavior;
- Removed reference to the use of pain compliance techniques – techniques previously permitted at the facility;
- Removed certain dangerous justifications for the use of force, such as to prevent resident disturbances and to maintain order within SYSC;

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<sup>26</sup> JDAI created a conditions assessment instrument that contains standards for juvenile justice facilities based on constitutional and statutory law, case law, and professional standards. These standards are widely recognized and are available at <http://www.jdaihelpdesk.org/conditions/Pages/SelfAssessmentToolsandGuidelines.aspx>.

<sup>27</sup> For medical and mental health issues, the JDAI assessment tool incorporated the National Commission on Correctional Health Care ("NCCHC") Standards for Health Services in Juvenile Confinement Facilities (see more information regarding these standards below). The assessment tool also included guidance from the ACA Standards for Juvenile Detention Facilities and Standards for Juvenile Correctional Facilities; The Institute of Judicial Administration and American Bar Association ("IJA/ABA") Juvenile Justices Standards (1980); and The National Advisory Committee for Juvenile Justice and Delinquency Prevention ("NAC") Standards for the Administration of Juvenile Justice (1980).

<sup>28</sup> The dangers associated with prone restraint are discussed in Appendix F.

- Added a stated goal of zero use of force and/or restraints – an important step towards changing a culture of restraint;
- Discouraged the use of prone restraint techniques making a specific reference to the dangers associated with this practice;<sup>29</sup>
- Added specific references to staff’s obligation to report abuse and neglect pursuant to New Hampshire’s Children Protection Act;
- Added detailed reporting and internal oversight procedures;
- Prohibits the use of force for punitive reasons;
- Prohibited confronting residents in their room (unless there are exigent circumstances) because it only serves to escalate resident behavior;
- Prohibited the use of fixed restraints – i.e. cuffing children to railings or furniture;
- Prohibited four/five point restraints; and
- Added a Use of Force/Restraint/Critical Incident Review Panel.

SYSC’s policy does not clearly limit the use of restraints to emergency situations, where it is necessary for the immediate safety of the child or others. It permits the use of restraints to protect property. Permitting use of force to protect property is contrary to the literature and the clear consensus among treatment providers across all settings, as described above, and does not take into account the historical misuse and abuse of restraints on this vulnerable population.

It also permits physical restraint to “de-escalate exigent circumstances.” This is also contrary to the literature which shows that restraints tend to escalate both the youth and the situation.

### **c. Results of Incident Review**

#### ***Prevalence of restraint***

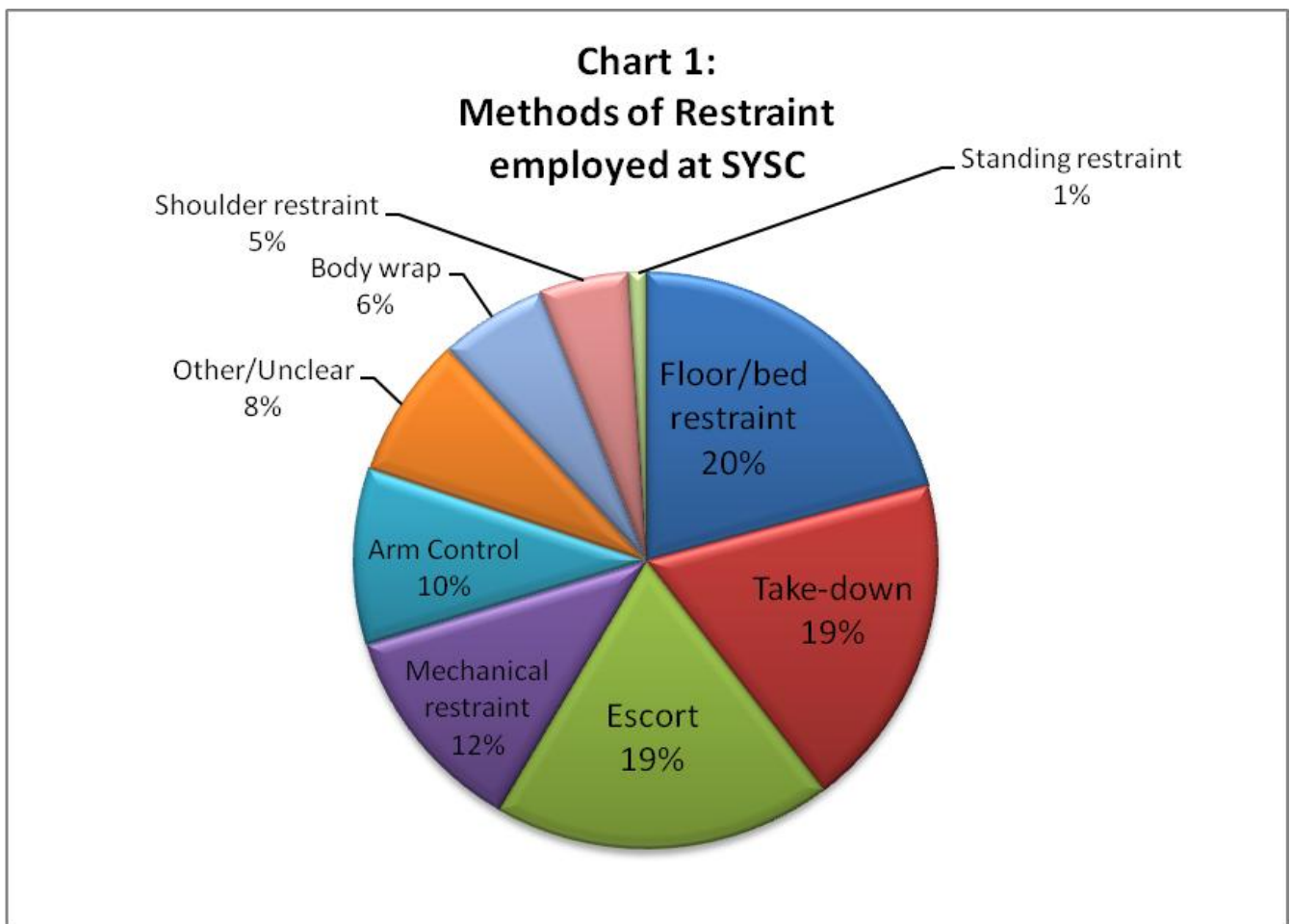
DRC reviewed every incident report in the files of 109 children. Of the 109 children, 42% had been subject to some form of restraint during their stay at SYSC. Using best professional standards as a framework, a detailed analysis was conducted of all incident reports where one or more restraints were involved. From the 109 files, 139 different incidents were reviewed where staff either used force or employed one or more restraints.

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<sup>29</sup> In DRC’s prior SYSC investigation report, we recommended that the facility immediately discontinue the use of prone restraint.

### ***Types of Restraints Employed***

Of the 139 incidents reviewed, there were a total of 371 total different restraints. An incident describes the entire event, including what may have preceded the restraint(s) and what occurred after the restraint(s). Most incidents involved multiple restraints. Chart 1 below illustrates the range of methods of restraint employed at SYSC and the frequency with which each method was used in the incidents reviewed.<sup>30</sup> The most common incident reviewed involved staff using a 1 or 2-arm “takedown” to put a child into a prone floor or bed restraint, ending with the placement of the child in handcuffs and removal from the unit. This is very similar to the incident DRC reported on in January 2009.



As shown in Chart 1, 19% of the 371 restraints reviewed involved a take-down restraint. This method involves a staff member forcibly taking down a resident to either the floor or a bed

<sup>30</sup> SYSC incident reports reference that staff use Mechanical Advantage Control Holds (“MACH”), which are techniques taught in the “Controlled F.O.R.C.E.” training system, a physical intervention program used by law enforcement.

to control the child's movement. This is a dangerous restraint technique even when staff are trained. In addition to issues of control when taking-down a child, many of the take-down restraints occurred in a child's room on the unit. The rooms on the unit are very small and the likelihood that a child's head would come into contact with a piece of furniture is very high.

Of the 371 restraints reviewed, 20% involved a floor or bed restraint. This type of restraint involves a child being held down either on the floor or a bed by a SYSC staff member, typically following a take-down. The child is then held in either the prone (face-down) or supine (face-up) position during the floor or bed restraint.

Despite the known risk of prone (face-down) restraints,<sup>31</sup> SYSC staff consistently used prone restraints to control youth and subsequently place the youth in handcuffs. Of the 139 restraint incidents DRC reviewed, at least 39% of the incident reports documented the use of the prone position during a floor or bed restraint. An additional 15% of the incidents likely involved an undocumented prone restraint because the incident involved a "take-down" restraint (as described above) for the purpose of controlling a child and/or placing a child in handcuffs. Therefore it appears that over half of restraint incidents at SYSC involved a prone restraint, an extremely dangerous practice that exposes youth to an unreasonable amount of risk.

As detailed in the chart above, 12% of the restraints used at SYSC were mechanical restraints, or handcuffs. Of the 371 restraints reviewed, 6% were body wraps, a method where a staff member "wraps" or pulls his/her arms around a child's chest while the child is in a seated or upright position. The incident reports reviewed did not indicate whether the child was seated or upright during each body wrap.<sup>32</sup>

Lastly, 19% of the restraints were escorts, 10% of the restraints were arm controls, and 5% were shoulder restraints, all lesser restrictive methods to restrict a child's movement or lead a child away from a situation. It was unclear or otherwise undocumented what method staff used in 8% of the restraints reviewed.

For each use of force and restraint incident reviewed, DRC conducted a multi-point analysis based on three (3) considerations. DRC first reviewed whether the use of force was justified by the situation. Placing limits upon and ultimately eliminating unnecessary or unjustified restraints is critical because restraining a child is inherently dangerous and has no

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<sup>31</sup> The risks associated with prone restraint are discussed in Appendix F.

<sup>32</sup> A seated body wrap can be more dangerous than a sitting one because it can restrict breathing.

therapeutic value.<sup>33</sup> DRC then reviewed whether staff used excessive force during the incident and whether there were documented injuries as a result of the incident.

### *Necessity of Restraints Employed*

DRC used the JDAI standard described above to evaluate whether each use of force or restraint was justified. For each incident, DRC reviewed whether the youth's behavior threatened imminent harm to the youth or others. If so, the restraint was justified. If the youth's behavior did not present the threat of imminent harm to the youth or others, the restraint was considered unjustified.

DRC's incident review found that 45% of the incidents clearly involved use of force or restraint that was not justified by the situation and therefore unnecessary. Where the documentation was unclear, DRC erred on the side of concluding the restraint was justified. A large number of restraints resulted from resident noncompliance rather than safety issues. Many incidents occurred in the residents' rooms. According to DRC's expert, "[t]his means that there is no place where the resident is 'in charge' or has control over his own environment." Ms. Crowe sees this as a problem because "these youth have come from difficult circumstances, are adolescents, and have lost their community" and concluded that "it would seem crucial to provide them (the residents) with opportunities to earn status, personal space, and control over their environment, rather than always taking away that which is essential to their fragile identity."

The most common justifications for restraint were for "disruptive behavior" and "failure or refusal to follow a staff directive." A common pattern that emerged from the restraint incidents reviewed was control. The incidents often began as a power struggle between the resident and staff. This often escalated the incident to the point where the use of force may have seemed necessary to control the situation and force the resident to comply. The use of force in these incidents likely could have been avoided if staff did not engage in a power struggle and instead de-escalated the situation.

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<sup>33</sup> See Achieving better outcomes for children and families, reducing restraint and seclusion, (Child Welfare League of America) (2004); Mohr, Wanda K, Restraints and the code of ethics: An uneasy fit, (Archives of Psychiatric Nursing, Vol 24, No. 1 (February)) (2010); and Position Statement 24: The Use of Restraining Techniques and Seclusion (Mental Health America - formerly known as the National Mental Health Association), [hereinafter MHA Position Statement 24] which states that "seclusion and restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and even death". Mental Health America therefore "urges abolition of the use of seclusion and restraints to control symptoms of mental illnesses."



### *Use of Excessive Force*

To determine if staff used excessive force, DRC reviewed each incident to determine 1) whether staff failed to use the least restrictive approach to manage the youth's behavior during the incident; 2) whether staff failed to use the least restrictive method to manage the incident; 3) whether staff failed to properly execute the restraint method; 4) whether staff executed the restraint in a manner that harmed the youth or exposed the youth to the risk of harm; and 5) whether staff used greater force than appropriate and necessary. Excessive force was determined if any of these 5 questions were answered in the affirmative.

Based on this analysis, it was determined that staff used excessive force in 53% of the incidents reviewed. SYSC consistently used a high degree of force to gain control in many different situations. Anything from "disruptive behavior" to "threatening to fight another resident" to "failure to follow a staff directive" resulted in a full prone restraint with handcuffs. Staff also frequently threatened restraint as a way to gain compliance.

While it is difficult to conclusively determine from written incident reports whether each situation was preventable, it appeared from many incidents reviewed that staff could have used less restrictive behavioral interventions to control the situation and address and de-escalate a youth's behavior. Resorting to the same failed method in confronting behaviors resulted in many youth who were restrained multiple times in a short time period. Power struggles between staff and residents tended to escalate problems into serious incidents rather than de-escalate the situation.

### *Manner of Execution and Injuries*

Many restraints at SYSC were also improperly executed and exposed youth to the risk of serious injury or death. For example, as stated above, many of the take-down restraints DRC reviewed occurred in a child's room on the unit. The unit rooms are very small and the likelihood that a child's head could come into contact with a piece of furniture is very high. Youth were injured in at least 39% of the incidents DRC reviewed.<sup>34</sup> There were a wide variety of injuries, including injuries to fingers, hands, wrists, elbows, arms, knees, ankles, shoulders, heads, noses, and jaws.

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<sup>34</sup> It may be that some injuries were not documented on the incident reports because they were either latent and/or appeared after staff wrote the report.

### ***SYSC's Internal Review of Restraint Use***

To SYSC's credit, they have increased the use of administrative reviews of each incident since DRC's prior investigation at the facility. Approximately 62% of incidents reviewed by DRC went through some form of administrative review. While administrative reviews were not common in 2006 – 2008, they have clearly increased in the last couple years.

However, the analysis of SYSC's administrative review process raised questions about whether it is effective or meaningful. Of the incidents that went through an administrative review and were later examined by DRC, not one was found to have violated a substantive provision of SYSC policy. The incidents that were found out of compliance with SYSC policy were for documentation deficiencies, such as failing to include the nurse's report or failing to include a witness statement.

It does not appear from the new administrative process described by SYSC administration or the restraint data obtained from the facility that the administration is doing a detailed evaluation to determine whether each restraint is actually justified or whether the incident could have been avoided. DRC's expert concluded that while there has been some progress in reducing the number of restraint incidents at SYSC, the incidents of restraint of the 8 residents reviewed revealed that there remains a problem regarding the appropriateness of the use of restraint at the facility.

#### **d. Results of Ombudsman Complaints Review**

DRC reviewed approximately 170 complaints made to the DHHS Office of the Ombudsman. As stated above, DRC did not review every complaint made to the Ombudsman, rather DRC reviewed 100% of the complaints made by the specific group of youth DRC was granted access to.

A pervasive complaint throughout the reports is the inappropriate use of language by staff and repeated issues of disrespectful treatment of residents. Close to 19% of resident complaints regarding staff centered on name calling and swearing at residents and otherwise harassing behavior by staff. While the Ombudsman did not make specific determinations about each complaint, the large number of and similarity between complaints raises considerable concern about the staff culture at SYSC. Considering that "belittling residents through name-calling and the use of foul language" was identified as a major issue in the 2000 investigation at YDC, it appears that there is long-standing acceptance of inappropriate staff behavior at the facility.

Other troubling complaints about SYSC staff included: 1) refusing to allow a resident to go to the bathroom; 2) sexual harassment; 3) threatening comments made to residents, such as *I'm going to come in your room and knock you out; You wanna' f--- with me?*; and *Give me a reason to restrain you*; 3) forcing a resident to clean the bathroom with a toothbrush and when the resident refused he was not allowed to call his family; 4) preventing residents from getting a grievance form; and 5) punishing youth for refusing a meal or medications.

There were also numerous complaints regarding inappropriate use of force. One resident reported that a staff member threw a chair at him and punched him in the head. Another resident reported that staff pushed another resident down the stairs and used force on the resident just to provoke a response. Yet another resident reported that staff punched another resident. Multiple residents reported that they were restrained too roughly. Other restraint-related complaints included: 1) staff restrained a resident for ringing his buzzer two times; 2) staff came into a resident's room and provoked her and when the resident tried to get away staff pushed and held her down, causing her to hit her head; and 3) staff restrained and dragged a resident to his room after they saw him put a grievance form in the box.

DRC was also concerned with the adequacy of the Ombudsman's responses. The Ombudsman often did little investigation of his own, and often took staff's word for truth over a resident's report of an incident. The Ombudsman typically spoke with the resident however conducted little follow-up, such as interviewing other witnesses who could potentially corroborate the resident's complaint. Most often the follow-up, investigation and resolution were left to SYSC administration or a House Leader.

## **VI. FINDINGS FROM DRC'S SYSTEMIC INVESTIGATION**

### **a. Incident and Ombudsman Complaint Review**

Based on the abuse standard set out in regulations promulgated by SAMHSA, DRC finds that a pattern of abusive use of force and restraint exists at SYSC, as elaborated below. *See* 42 C.F.R. § 51.51.2. In the definition of "abuse", the PAIMI regulations include: "the use of excessive force when placing an individual with mental illness in bodily restraint" and "verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue. *See* 42 C.F.R. § 51.51.2.

Based on the neglect standard set out in regulations promulgated by SAMHSA, DRC finds that SYSC “failed to provide a safe environment” to children detained or committed to the facility, as elaborated below. *See* 42 C.F.R. § 51.51.2. This is based on the pattern of abusive use of force and restraint, the verbal harassment of children by SYSC staff, and the inadequate internal review process by the administration and the DHHS Ombudsman.

DRC’s incident review revealed that there remains a dangerous combination of high rates of prone restraints at SYSC, staff who are quick to resort to restraint, as well as a standard for initiating a restraint that does not comport with best professional standards. While SYSC produced data showing a decrease in the use of restraint<sup>35</sup>, essentially for the months following DRC’s review, this investigation did not include an examination of the accuracy of SYSC data or the appropriateness of the data after August, 2009.

Ms. Crowe noted in her report that “[w]hile there has been some progress in reducing the number of restraint incidents at SYSC, the incidents of restraint of the 8 residents reviewed revealed that there remains a problem regarding the appropriateness of restraint use at the facility. She added further that:

“Except in rare instances, the incidents of restraint of the 8 residents reviewed did not seem justified. In fact, most appeared to be situations where staff wanted to take control. Some residents may present as more challenging to staff than others, by the attitude and stances they assume. In those cases every effort should be made to reduce conflict between and among the staff and resident. It would be very detrimental for staff to assume they need to be harsh in order to set an example.”

As previously noted, 42% of DRC’s sample was subject to some form of restraint during their stay at SYSC. DRC also found that staff used excessive force in 53% of the incidents reviewed. As stated above, SYSC consistently used a high degree of force to gain control in many different situations, restraining children for anything from “disruptive behavior” to “threatening to fight another resident” to “failure to follow a staff directive.” Many use-of-force restraints at SYSC were also improperly executed and in a manner that exposed youth to the risk of serious injury or death. Youth were injured in at least 39% of the incidents DRC reviewed.

Second, DRC’s investigation also revealed that staff regularly used unjustified and unnecessary restraints, in violation of professional and legal standards. DRC found that 45% of

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<sup>35</sup> *See* Appendix B, p. x.

the incidents clearly involved use of force or restraint that was not justified by the situation and therefore unnecessary. An unreasonably large number of restraints resulted from issues of resident noncompliance rather than for safety issues. This, as noted above, was corroborated by Ms. Crowe's review.

It is also concerning that SYSC staff are trained in law enforcement physical intervention techniques. This clearly does not comport with the administration's stated goal of moving away from a correctional-minded facility towards a treatment-minded facility.

Third, DRC's investigation found that staff regularly used dangerous restraint techniques to control youth's behavior. As stated above, the most common incident reviewed involved staff using a 1 or 2-arm "takedown" to put a child into a prone floor or bed restraint, ending with placing the child in handcuffs and removing the child from the unit. DRC found that 19% of the restraints reviewed involved a take-down restraint and 20% of the restraints involved a floor or bed restraint. Despite the known risk of prone restraints, SYSC staff consistently used such methods to control youth and place them in handcuffs. It is likely that over half of restraint incidents at SYSC involved a prone restraint, an extremely dangerous practice that exposes youth to unreasonable risk.<sup>36</sup>

Last, DRC's investigation revealed that staff continue to engage in verbal harassment of SYSC residents. DRC's review of complaints made to the DHHS Ombudsman raised considerable concerns over the staff culture at SYSC. Close to 19% of resident complaints DRC reviewed centered on name calling and swearing at residents and otherwise harassing behavior by staff.

The culture at New Hampshire's juvenile justice facility is a historical concern in the state. Even though the physical conditions improved when the new SYSC opened in 2006, it appears that little has changed in terms of culture. Although SYSC's review of incidents and policies on the use of force are moving in the right direction, DRC's analysis shows that there remains a difference between policy and practice at the facility. In addition, it appears that a deep-seated and pervasive culture of using force and verbal harassment to control residents remains.

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<sup>36</sup> The risks associated with prone restraint are discussed in Appendix F.

## **b. Mental Health Treatment at SYSC**

DRC's prior investigation at SYSC raised concerns regarding the adequacy of mental health treatment at the facility. As a result, DRC worked with Christina Crowe, MSW, an expert in children's services and mental health care, who provided an independent and expert perspective on the clinical competence and services provided at the facility.<sup>37</sup> Ms. Crowe conducted an extensive file review of 8 youth at SYSC, interviewed a number of staff at the facility, and made a series of findings based on the following questions:

1. Is the SYSC properly screening, evaluating and diagnosing mental health problems?
2. Are they providing adequate mental health care and treatment?
3. Do they have adequate treatment planning?
4. Are they providing adequate, humane and safe behavioral management for children with disabilities, including the use and review of restraint use.
5. Do they have appropriate medication practices?
6. Do they have adequate programming to address youth's substance abuse issues?
7. Are any of their policies and practices contraindicated given the needs of the children, particularly those with diagnoses of mental illness?

Regarding screening, evaluating and diagnosis of mental health problems at SYSC, Ms. Crowe found that assessments completed at the facility before 2007 were "barely adequate." She noted that, beginning at some point in 2007 assessments become more structured, focused, and better supported medication decisions. She found that psychiatric assessments are only completed on youth who exhibit symptomatic behavior however are not integrated into the overall clinical assessment.

In her review, Ms. Crowe noted two major omissions in the youth's assessments. The first was the existence of "well formulated vocational and career assessments that explore a youth's potential and interest in post-secondary education, vocational and professional opportunities." Ms. Crowe asserted that this was a striking omission given the "age and histories of these youth, and the express mission of DJJS." She specified that tying educational, vocational, and professional interests into overall assessments emphasizes the importance of preparing youth for their futures and becoming productive members of their communities.

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<sup>37</sup> Ms. Crowe's complete report is attached in Appendix B.

The second omission Ms. Crowe identified was the lack of in-depth exploration of family strengths and interests. Discussing why family is an important “protective factor” for a youth at SYSC, Ms. Crowe confirmed that a “better assessment of the barriers faced by the families could help identify strategies that could support their engagement with the Center’s efforts.”

Ms. Crowe noted that despite a history of inadequate assessments, SYSC has recently made efforts and developed policies that promote adequate and in some cases quite useful assessments. She found that assessments at the facility could be improved by integrating the findings from both psychiatric assessments and vocational and family assessments. She also concluded that “integrated service delivery is critical to adequately address the needs of youth with disabilities at the Center.”

Regarding treatment planning, Ms. Crowe concluded that “there are well developed protocols and templates for treatment planning (at SYSC) with emphasis on actively engaging the youth in the development of their own goals.” However, after noting that weekly team meetings are held to discuss the progress of each resident as well as to identify progress or lack thereof, Ms. Crowe concluded that “in most reviews, it was not easy to find any record of progress or lack of progress, except notations of compliance, i.e. getting along with peers and staff.”

In her review of the treatment plans at the facility, Ms. Crowe found three major deficiencies. The first was the failure to include documentation of the efficacy of medication and changes in treatment plans. Ms. Crowe noted that this is “critical given the amount and types of medications prescribed at the Center” and that many of the youth whose records she reviewed were receiving multiple psychoactive medications.

The second deficiency was the failure to address family involvement in the treatment plans. Ms. Crowe discussed the importance of family involvement for juveniles and cited the fact that this information is not integrated in the assessment phases and consequently is not integrated into the treatment plans or the reviews.

In her analysis of treatment reviews at the facility, Ms. Crowe observed that “[w]hile there are mandatory 90-day reviews, there was no evidence of changes to the overall treatment plans based on progress or lack of progress.” She found that while there “is quite an extensive and broad range of groups offered” at the facility, “it is difficult to ascertain how effective the treatment is without outcome data.”

The third omission in the treatment plans and review process at SYSC was the lack of “review of vocational plans and activities to develop work skills and interests.” Ms. Crowe remarked, “given the stated mission of ensuring success in the community, this seems a glaring and ultimately unfortunate omission.”

Lastly, Ms. Crowe mentioned that there are plans to introduce trauma-focused treatment at the facility in collaboration with a federally funded network. She confirmed that “[g]iven the histories of abuse and neglect that the residents have, this potentially could be a very useful and potentially effective treatment if implemented with fidelity.”

Regarding medication practice, Ms. Crowe found that a “major limitation of the way psychiatry services are provided at SYSC is their isolation from the teams and...overall treatment planning and review.” She concluded that “[i]deally, the Psychiatrist (at the facility) would benefit from the information shared at team meetings as well as being able to recommend appropriate individual and group interventions for any particular youth.”

Ms. Crowe concluded her review with an analysis of whether the facility achieves DJJS’s intended purpose and therefore the necessity of the facility as a whole. Part of DJJS’s mission is “to promote community safety and positive youth development.” DJJS’s mission statement also provides that:

*“DJJS will document that youth are measurably better when they leave the supervision and care of the juvenile justice system than when they enter. DJJS will achieve positive results through the use of evidence-based practices by assuring offender accountability through restoration of individuals and communities harmed by misconduct and by treating youth as assets to be developed within families and communities.”<sup>38</sup>*

Ms. Crowe found that “given recent improvements and ongoing plans to import evidence-based treatment into the clinical program it would appear the Center is moving in the right direction.” However, she also found that “given the constraints of the model relative to the Center’s mission and...the lack of objective outcome data, it is difficult to draw definitive conclusions about the effectiveness of the Center’s treatment and approach.”

Ms. Crowe also observed, based on discussions with DJJS staff and her record review, that options in the community are “sparse or insufficient to provide effective care and treatment

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<sup>38</sup> Fenniman Jr., William W., Director, Division for Juvenile Justice Services, Budget Overview Presentation by to House Finance Division III, Slide 3 (March 5, 2009).



to this population.” She concluded that as a result, “many children with mental and emotional disorders placed at SYSC are likely being unnecessarily and inappropriately institutionalized.” Based on this information and similar national trends, Ms. Crowe opined that it is likely that many youth at SYSC should have been directed to community mental health services as an alternative to incarceration if those services had been available.

A shortage of community-based alternatives to incarceration can often lead to longer detention and commitments.<sup>39</sup> A greater focus on this issue is necessary to ensure that the lack of appropriate and available treatment services in the community does not create an overreliance on secure confinement and the unnecessarily long detention and commitments for youth in New Hampshire.

In discussing the fact that many youth could be returned to the community if adequate community based treatment were available, Ms. Crowe observed that “treatment would be more effective if it could take place in community based settings” and that “there is no evidence to support that skills learned in an institutional setting can be transferred to the community, thwarting the stated mission of DJJS.” Ms. Crowe cited current research showing that institutionalizing youth does not further public safety, is not effective as community-based prevention interventions and programs, and that short stays in institutional care can actually increase criminal behavior.<sup>40</sup>

Lastly, Ms. Crowe indicated that “[i]ncarcerating youth has been shown to have detrimental effects on youth, including their mental and physical well-being, education, employment and ability to reintegrate into their communities” and that there “is clear evidence that incarcerating children can actually increase the risk of future delinquency while community-based interventions have been proven to reduce recidivism rates and actually work to reduce juvenile crime.”

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<sup>39</sup> Data from 2001 indicated that the time to release from commitment to YDC, SYSC’s predecessor, was longer than the national average. See Skibbie, *supra* note 7. The data also showed that the population at YDC was made up of a lower proportion of serious and violent offenders than nationally. Recent data provided by SYSC staff the average length of stay for committed youth at SYSC is 9 months and the average length of stay for detained youth at SYSC is 32 days. DJJS’s website indicates that the average length of stay prior to initial release from the Youth Services Center is 8-12 months.

<sup>40</sup> Ms. Crowe cited “Pathways to Desistance”. Available at <http://www.modelsforchange.net>.

Research has shown that prevention programs and community-based alternatives to incarceration are more cost effective. There is ample evidence that placing youth in institutions is more expensive than community-based prevention programs and interventions.<sup>41</sup>

States can realize significant cost savings in the short term by operating evidence-based community-based programs.<sup>42</sup> The average national cost for holding a youth in a juvenile justice facility is \$240.99 per day per youth.<sup>43</sup> According to DJJS Director, William W. Fenniman Jr., the rates for fiscal year 2010 were \$451 per day for each committed youth and \$375 per day for each detained youth. States can also realize significant cost savings in the long term by investing in community-based programs that are proven to be more effective in reducing recidivism and better preparing children to reintegrate into their communities.

## **VII. FINDINGS REGARDING IMPLEMENTATION OF RECOMMENDATIONS FROM DRC'S FIRST INVESTIGATION AT SYSC AND RECENT INITIATIVES AT SYSC**

### **a. Generally**

DRC made 17 recommendations in its January, 2009 report. Chart 2 below lists each recommendation and provides the status of implementation efforts by New Hampshire official or agencies. As set out below, only 2 of DRC's 17 recommendations have been fully or substantially implemented. Of the 13 recommendations that apply to SYSC, DJJS and DHHS, 2 have been fully implemented; 6 have been partially implemented; 2 have been subject to internal policy changes; and 3 have not been implemented at all.

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<sup>41</sup> See The Costs of Confinement: Why Good Juvenile Justice Policies Make Good Fiscal Sense (Justice Policy Institute) (May 2009) [hereinafter Cost of Confinement]; OJJDP Model Programs Guide (available at <http://www.ojjdp.ncjrs.gov/>); and Holman, Barry and Jason Ziedenberg, The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities (Justice Policy Institute Report).

<sup>42</sup> See Cost of Confinement, *supra* note 35; Fact Sheet: Community-Based and Home-Based Alternatives to Incarceration (Center for Children's Law and Policy) (available at <http://www.cclp.org/>); Evidence-Based Juvenile Offender Programs: Program Description, Quality Assurance, and Cost (Washington State Institute for Public Policy Institute) (June 2007); and Best Practices in Juvenile Justice Reform (The Future of Children – Princeton/Brookings) (available at <http://futureofchildren.org/>).

<sup>43</sup> Cost of Confinement, *supra* note 35, citing the American Correctional Association, 2008 Directory: Adult and Juvenile Correctional Departments, Institutions, Agencies, and Probation and Parole Authorities.

**Chart 2: Status of State’s Implementation of  
DRC’s Recommendations from January, 2009 Investigation Report**

<b>Recommendation</b>	<b>Implemented?</b>	<b>Comments</b>
<b>Recommendations to DJJS &amp; SYSC regarding the individual abuse &amp; neglect case</b>		
1) Develop appropriate concrete, specific, informed and behaviorally positive strategies, to therapeutically respond to youth’s behavior challenges.	No	Youth did not have a specific behavior plan other than the standard “intensive level” treatment plan.
2) Utilize an independent, qualified psychologist or other behavioral specialist to help develop and oversee the plan and approach.	No	SYSC did not have an independent psychologist or behavior specialist look at developing an individualized program for youth.
3) Provide the youth a written apology for the harm he suffered while at SYSC.	No	
4) Take the appropriate disciplinary action against the employees involved.	Unknown	
<b>General Recommendations to DJJS &amp; SYSC</b>		
5) DJJS should conduct a rigorous analysis of their current behavior management system to ensure it is in line with professional standards. This should be overseen by an independent organization such as <b>JDAI</b> . At a minimum DJJS should review their current behavior management system, however we also strongly suggest that an organization such as JDAI review all of DJJS’s policies and procedures as related to SYSC.	Partially	SYSC underwent a major policy review as part of the accreditation process through the American Correctional Association (“ACA”) and recently received accreditation from the ACA, which provides accreditation to correctional agencies.  SYSC also implemented the Performance-Based Standards for Youth Correction and Detention Facilities (“PbS”), a management system designed to provide improvement and accountability through data collection system and analysis, directed by the Council of Juvenile Correctional Administrators (“CJCA”).
6) SYSC should immediately discontinue the use of prone restraint.	No	SYSC “discouraged” the use of prone restraint techniques through an internal policy amendment.  As of September 1, 2010, pursuant to SB 396-FN, SYSC was required to discontinue use of any physical restraint or containment technique that “obstructs a child’s

		respiratory airway or impairs the child’s breathing or respiratory capacity or restricts the movement required for normal breathing” or “places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child.”
7) SYSC should immediately discontinue the use of pain compliance techniques.	By policy	SYSC removed the allowance of joint manipulation and pressure point techniques from their internal policy. DRC has not verified whether the techniques have been eliminated in practice.
8) Establish and implement specific procedures to ensure staff report abuse and neglect pursuant RSA 169-C:37 and provide training to staff on how to report institutional abuse and neglect.	By policy	SYSC revised their policy to ensure compliance with RSA 169-C:37 and provided additional training to staff on the revised policy. DRC has not verified whether staff now appropriately report alleged abuse and neglect.
9) Establish and implement specific procedures to advise residents that they may report abuse and neglect pursuant RSA 169-C:37 and how to report institutional abuse and neglect.	Partially	Advised by SYSC administration that this was part of youth’s orientation and included in rights brochure.
10) Initiate and continue training of all staff on their mandatory abuse and neglect responsibilities.	Fully	Advised by SYSC administration of additional staff training on this issue.
11) Ensure that all staff receive training on appropriate management of the behavior of children with mental illness.	Partially	Added trauma-focused and crisis intervention to staff training curriculum. However, the facility continues to train staff using the “Controlled F.O.R.C.E. Training System, a physical intervention program used by law enforcement.
12) Ensure that counselors are available at all times.	Fully	Advised by SYSC administration that trained clinical staff are on call 24 hours a day, 7 days a week.
13) Expand data collection on behavioral incidents to better track the occurrence of behavioral incidents.	Partially	SYSC revised incident reporting system and increased data collection through the implementation of PbS. The PbS data is not yet available online. According to DJJS data, the number of restraints at the facility has decreased.
14) Institute a more extensive monitoring process of incidents of restraint and isolation, including regular restraint reviews involving an appropriately qualified consulting psychiatrist or psychologist who can review incident reports as a way to improve staff intervention in behavioral incidents.	Partially	Implemented a Use of Force Review Panel as a quality assurance measure chaired by facility psychiatrist - policy compliance incident reviews are still reviewed by administration; Rearranged staffing schedules; Revised Use of Force policy; Increased data collection; Developed new

		incident reporting system.  Unclear if Panel reviews whether or not each incident of restraint was necessary or appropriate and what standard Panel uses to review incidents.
15) Provide DRC a written plan with timelines implementing recommendations.	Partially	DHHS provided a written response to DRC's January, 2009 report on March 6, 2009 and again on April 23, 2009 following a meeting with representatives from DHHS and the Attorney General's office.
<b>Recommendations to DHHS</b>		
16) Promulgate rules using professional standards to govern the administration and oversight of SYSC.	No	
17) Promulgate rules consistent with DHHS's authority to investigate reports of institutional abuse and neglect and to take the appropriate action for the protection of children pursuant to RSA 169-C:37 and RSA 169-C:3-a(III). <sup>44</sup>	No	DRC also suggested the possibility of a more rigorous or detailed standard for institutional abuse and neglect that the state could implement through 1) policy development at the facility; 2) rule promulgation to govern the administration and oversight of entire facility; 3) rule promulgation under RSA 169-C:37; or 4) statutory change. None of these suggestions were adopted either.

The following are some additional observations and findings related to several of the recommendations.

**b. External and Independent Oversight**

Recommendations 5 and 16 were particularly important because at the time of DRC's prior investigation, with the exception of the educational program, none of the facilities or programs at SYSC were licensed, certified, regulated, monitored or accredited by external agencies to ensure conditions, services and programs at SYSC met safety, treatment, health and welfare standards. SYSC operated under its own internal policies and procedures that were not readily available to the public and did not go through the public rule-making process.

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<sup>44</sup> Rule-making pursuant to this section is permitted under RSA 169-C:37 and required under RSA 169-C:3-a(III). RSA 169-C:37 provides that "[e]ither the department of justice or the commissioner of the department or both may adopt rules consistent with this authority to investigate such reports and take appropriate action for the protection of children." (Emphasis added). RSA 169-C:3-a(III) provides that "[t]he commissioner of the department of health and human services shall adopt rules under RSA 541-A relative to...[t]he authority to investigate reports of institutional abuse or neglect under RSA 169-C:37." (Emphasis added).

Additionally, the two oversight and advisory groups established under New Hampshire law were largely inactive. This is still the case.<sup>45</sup>

The lack of external and independent oversight coupled with DRC's other findings concerning the behavioral management system at SYSC prompted DRC to recommend that DJJS conduct a rigorous analysis of their current behavior management system to ensure the entire facility was in line with professional standards. DRC recommended that this should be overseen by an independent organization such as Annie E. Casey Foundation's Juvenile Detention Alternative Initiative ("JDAI"). While DRC recommended that at a minimum DJJS should review their current behavior management system, DRC also strongly suggested that an organization such as JDAI review all of DJJS's policies and procedures as related to SYSC.

Some form of external licensing, certification, regulation, monitoring, accreditation or oversight of SYSC was especially important because SYSC houses individuals with disabilities, particularly children with mental illness who require treatment and are susceptible to further harm from suboptimal environmental conditions or conduct. Subsequent to the release of the first investigation, DRC learned that Director Fenniman was implementing two initiatives: 1) accreditation through the American Correctional Association ("ACA") and 2) implementation of Performance-Based Standards for Youth Correction and Detention Facilities ("PbS"), a management system designed to provide improvement and accountability through data collection and analysis, directed by the Council of Juvenile Correctional Administrators ("CJCA"). Both Director Fenniman and Commissioner Toumpas have expressed a commitment to changing the culture at SYSC from a correctional-minded facility to a treatment-oriented facility.

As detailed in Ms. Crow's report, SYSC has engaged in other initiatives aimed at addressing the use of restraint at the facility, including implementing a Use of Force Review

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<sup>45</sup> RSA 169-H established the "Commission on Juvenile Justice" in 1995 "to receive certain reports from the department of health and human services." The Commission as also empowered "to conduct hearings and to call witnesses and receive testimony regarding reports received from the department." Although still required by law, the Commission has not met since 1998 and has never filed a report. The commission was recently repealed by HB 1690, effective December 31, 2010.

The Juvenile Justice and Delinquency Prevention Act (JJDPA) requires each state to assemble a State Advisory Group to administer JJDPA funds and provide compliance reports to the federal government. In September, 2001, RSA 621-A:9 established the "Juvenile Justice Advisory Board." This statute required the Board to "act in an advisory capacity and make recommendations to the commissioner relative to programs and services provided to children at the youth development center and the youth services center." This law is still in effect, however the Board has not met since 2004. The advisory board has not filed a report. A report is due December 10, 2010 and biennially thereafter.

Panel, rearranging staffing schedules, revising the facility's Use of Force policy and incident reporting system, and adding crisis intervention and trauma-focused training to staff training curriculums. Other positive changes include Director Fenniman's implementation of a "zero tolerance" policy for staff violations of SYSC's use of force policy and revised room confinement procedures so that youth can no longer be locked in their room for multiple days at a time.

Although the above initiatives provide for more external oversight, it remains to be seen whether they are sufficient to significantly address the troubling cultural issues at SYSC, and the move towards a more treatment, rehabilitative approach. For example, SYSC recently received full accreditation from the ACA, which provides accreditation to correctional agencies. While this is a positive development, accreditation does not necessarily ensure quality treatment or even reduction of punitive practices. This is because ACA accreditation is focused on compliance with certain prescribed policies rather than implementation.

Additionally, the ACA standards do not reflect legal and accepted professional standards or standards for medical and mental health treatment. For example, the ACA standards allow for the use of restraints in non-emergency situations and permit the use of restraints to protect a jurisdiction's property.

More promising is the PbS initiative described above. However, this initiative alone is not sufficient. Similar to the ACA standards, the CJCA's position does not clearly limit the use of restraints to emergency situations and permits the use of restraints to protect property.

Accordingly, DRC reiterates the recommendation that DJJS and SYSC implement the standards contained in the JDAI conditions assessment instrument. The instrument contains standards that are applicable to all secure facilities that house youth. The JDAI standards are unique in that they provide very detailed requirements that incorporate both legal and accepted professional standards (including standards for medical and mental health) to protect the health, safety, and legal rights of youth in secure facilities.<sup>46</sup>

### **c. Mental Health Treatment**

The administration has made several recent improvements to the mental health treatment provided at the facility. According to DJJS, all clinical staff are trained and supervised by Dr. Eric Vance, DJJS's psychiatrist. SYSC currently has seven clinicians, one clinical manager, a

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<sup>46</sup> See note 22.

full time psychiatrist, a full time psychologist, and two guidance counselors. Other recent additions to the program include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Resiliency/Strength-Based Treatment Planning, Individual and Family Therapy with Master Level Clinicians, Trauma-Focused Cognitive Behavioral Therapy, Abuse-Focused Cognitive Behavioral Therapy, and revised Substance Abuse Treatment programming. DRC has not obtained or reviewed any outcome data from these programs. DJJS also added abuse and neglect reporting training to all staff and revised their reporting policy guidelines under RSA 169-C.

Other positive changes include Director Fenniman's strengthening of the job qualifications for Youth Counselor positions; the elimination of the arbitrary "point system" at the facility; the espoused "zero tolerance" for staff violations of SYSC's use of force policy; and the increased breadth of programming at the facility.

#### **d. DCYF Investigation of Incidents of Abuse and Neglect at SYSC**

Based on its first investigation, DRC recommended that DHHS promulgate rules governing the investigation of abuse and neglect at SYSC and to take appropriate action for the protection of children. DHHS has been under an obligation to promulgate these rules since November 1, 1995, pursuant to RSA 169-C:3-(a)III.

The basis for DRC's recommendation included:

- the lack of procedures at SYSC which instructed staff of their mandatory reporting obligations;
- the fact that the incident which was the subject of DRC's first investigation was not reported by SYSC staff to DCYF, as well as other evidence that staff non-reporting was common;
- the fact that the RSA 169-C:3-(a)III rules had not been developed; and
- concerns regarding DCYF's capacity to perform institutional/paid caretaker abuse and neglect investigations.

This final concern stemmed from DCYF-reported data showing only a 4% "founded" rate of investigations of institutional/paid caretaker abuse and neglect state-wide as well as, to some extent, evidence DRC has gathered or observed in other investigations and cases with which it has been involved.<sup>47</sup>

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<sup>47</sup> The Special Investigations Unit (SIU) of DCYF handles reports of abuse and neglect from SYSC and other state or state-funded residential arrangements, e.g. group homes, foster care, etc. Data reported by DCYF under post [Eric](#)



To obtain a complete picture of how well the State completes their child protection and investigation responsibilities in this area, and before making definitive findings, DRC as part of this, its second investigation, and pursuant to its federal authority requested (a) a complete list of allegations of abuse and neglect at SYSC made to DCYF within a certain timeframe and (b) copies of the investigations of the reports.

However, contrary to DRC's federal access authority,<sup>48</sup> DHHS and the Attorney General's Office did not promptly provide DRC with the information. In fact, it was only recently (on September 3, 2010, almost 14 months after the original request) after repeated requests, that the Attorney General's office confirmed that they had provided the complete version of the requested list. DRC will continue to pursue and obtain the remaining information in order to ascertain the thoroughness and quality of the external investigation process.

## **VIII. RECOMMENDATIONS**

### **a. To the John H. Sununu Youth Services Center<sup>49</sup>**

- 1) Integrate family and vocational assessments into assessment and treatment planning to improve overall effectiveness and to better prepare residents for return to the community;
- 2) Implement a process to collect outcome data resulting from group and individual treatment interventions and services;
- 3) Incorporate psychiatry and medication monitoring into regular team processes;
- 4) Establish an independent review of all youth on two or more psychoactive medications;
- 5) Implement an on-line clinical record that is shared among those involved with treatment and programming of youth;
- 6) Ensure that youth are not subjected to excessive, unjustified or unnecessary restraints in compliance with RSA 126-U (SB 396-FN);<sup>50</sup>

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L protocols shows what appears to be a low substantiation rate of these types of reports done by the SIU. The most recent data available to DRC from December 2008 to November 2009 shows that of the 46 cases investigated, only 2 (4%) were founded, 40 (87%) unfounded and 4 (8%) were closed as incomplete.

<sup>48</sup> 42 USC 10805(a)(4)(C)(iii), 42 C.F.R. 51.41(b)(3).

<sup>49</sup> DRC's recommendations incorporate recommendations made by Ms. Crowe.

7) Provide regular reports on the use of restraint so that progress towards reducing its use can be monitored;

8) Discontinue the use of prone restraint. This recommendation was also made in DRC's January 2009 report. SYSC must ensure compliance with RSA 126-U (SB 396-FN) which prohibits the use of any physical restraint or containment technique that "obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing" or "places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child." Dr. Thomas Andrew, New Hampshire's Chief Medical Examiner, has stated that placing a child in a face-down or prone position carries extreme risks even if the chest is not compressed.

9) Prohibit staff from threatening restraint as a way to gain compliance;

10) Improve staff training to prevent power struggles with youth which often leads to the use of unnecessary force and physical restraint; and

11) Provide adequate staff training on treating residents with respect including elimination of verbal harassment.

**b. To the New Hampshire Division for Juvenile Justice Services and Department of Health and Human Services<sup>51</sup>**

1) Regularly post the reports and plans created from the Performance-based Standards ("PbS") system on DJJS's website and forward them to relevant senior DHHS officials and legislative policy makers;

2) Promulgate rules under RSA 541-A that clearly establish procedures for the investigation of suspected abuse and neglect of children in institutional settings, pursuant to RSA 169-C:37 and RSA 169-C:3-a(III). This recommendation was made in DRC's January 2009 report;

3) Create a unit, independent of DJJS, to investigate complaints and allegations of abusive use-of-force and restraints made by SYSC residents. The unit should have the authority to conduct interviews with the alleged victim and potential witnesses; use the standard set out in

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<sup>50</sup> The majority of SB 396-FN became effective on September 1, 2010. SB 396-FN states that "[r]estraint shall only be used...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... when all other interventions have failed or have been deemed inappropriate." It also states that "[r]estraint shall never be used explicitly or implicitly as punishment for the behavior of a child."

<sup>51</sup> DRC's recommendations incorporate recommendations made by Ms. Crowe.

RSA 126-U (SB 396-FN); and immediately refer incidents to DCYF that may rise to the level of abuse;

4) Reduce the length of stay for both committed and detained youth by increasing the use of appropriate home and community-based interventions and investing substantially in alternatives to secure confinement;

5) Improve and increase the use of diversion program(s) so that youth can successfully remain in their communities and avoid institutionalization;

6) Increase the use of community-based supports to avoid return to SYSC following release;

7) The Legislature and DHHS should consider adopting a comprehensive statutory and regulatory scheme establishing a statewide system of care. This would ensure that recommendations 3-6 are developed and sustained systemically and cost effectively, while also balancing the rights of youth and safety concerns of the public. It would also ensure appropriate administration and oversight of SYSC and the juvenile justice system.

# **APPENDICES**

**Appendix A: Expert Biography**

**Appendix B: Expert Report**

**Appendix C: New Hampshire Law & Use of Force**

**Appendix D: Federal Law & Use of Force**

**Appendix E: Literature & Restraints**

**Appendix F: Prone (Face-Down) Restraints**

**Appendix G: Standards & Use of Force**

## **Appendix A**

### **EXPERT BIOGRAPHY**

Christina Crowe, MSW, is currently an Instructor in Psychiatry for Harvard Medical School. For more than twenty years (1982-2002) she was the Director of Clinical and Community Programs at the Judge Baker Children's Center in Boston, Massachusetts. During that period she established and/or directed programs such as the federally funded National Technical Assistance Center for the Evaluation of Children's Mental Health Systems, the Manville School, the Massachusetts Child at Risk Hotline and a variety of clinical programs providing assessment and treatment to children and youth who had experienced trauma.

In addition to her current academic appointment, Christina has taught at Simmons College School of Social Work and the Boston University Graduate School of Social Work. From 2002 to 2006 she was the Mental Health Consultant on the Emily J. Consent decree in the State of Connecticut. Prior work in New Hampshire was as a Panel member overseeing the Eric L. Settlement in New Hampshire.

Current systems reforms she consults on include the implementation of the remedies on the 1) Rosie D. settlement in Massachusetts (mandating a system of care for children with emotional and behavioral disorders); 2) Community Practice Review in the Jackson v. Richardson settlement in New Mexico; and 3) Rolland v. Patrick in Massachusetts, ensuring community placement for adults with Developmental Disabilities. Christina is a graduate of Boston College Graduate School of Social Work (1972) and Regis College (1963).

**Appendix B**  
**EXPERT REPORT**

**REPORT, FINDINGS & RECOMMENDATIONS**  
Reporting on the Adequacy of Mental Health Care at SYSC  
**Prepared by Christina Crowe, MSW**

Christina Crowe, MSW  
345 Brookline St  
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## **I. Introduction to Expert's Review**

***Mission Statement:** The mission of the Division for Juvenile Justice Services (DJJS) and the John H. Sununu Services Center (SYSC) is to promote and balance community safety and positive youth development through the utilization of evidence based practices. DJJS will document that residents are measurably better when they leave the care of the juvenile justice system than when they enter. DJJS will achieve positive results by assuring offender accountability through restoration of individuals and communities harmed by misconduct and by treating its residents as assets to be developed within families and communities. SYSC will provide security, supervision and appropriate programs that will ensure that committed residents have a greater chance of being successful in the community when they leave SYSC than when they enter it.<sup>52</sup>*

As a result of a review of several serious incidents and a review of restraint practices at the Sununu Youth Services Center (SYSC), DRC developed considerable concern about the care that is provided to the youth who are committed to SYSC and who may have serious emotional disturbances or significant mental health issues. As a result, DRC requested an independent review by someone with experience in evaluating the clinical care of children and youth in public programs.

The purpose of this review was to provide DRC with an independent perspective on the clinical competence and services provided at the Center. This review addressed the following questions:

1. Is the SYSC properly, screening, evaluating and diagnosing mental health problems?
2. Are they providing adequate mental health care and treatment?
3. Do they have adequate treatment planning?
4. Are they providing adequate, humane and safe behavioral management for children with disabilities? Including the use and review of restraint use.
5. Do they have appropriate medication practices?
6. Do they have adequate programming to address youth's substance abuse issues?
7. Are any of their policies and practices contra indicated given the needs of the children, particularly with diagnoses of mental illness.

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<sup>52</sup> SYSC parent and resident handbook 2010.

## **II. Summary of Expert’s Review and Methodology**

This review was conducted through the following:

- A. Review of a complete set of records for 8 residents, 5 targeted, 3 chosen randomly representing a cross section of detained and committed youth.
  - i. Review of all available written documentation from the Medical, Educational, General and Detention files at the Center, including Psychiatric information, available assessments, progress reports, and pertinent communication.
  - ii. Reviewed incident reports involving restraint for the 8 residents.
- B. Follow up interviews with clinical staff
  - i. Eric Vance, MD Psychiatrist
  - ii. Penny Sampson, M.S., LCMHC Manager of Clinical Services
  - iii. Brian Bedard, LCMHC, Treatment Coordinator.
- C. Tour of facility done in December 2010, with 2 additional visits in May 2010.
- D. Policy review.

## **III. Results of Expert’s Review and Findings**

### **a. Screening, Evaluating and Diagnosing Mental Health Problems**

*SYSC Policy states: Residents will receive a comprehensive psychosocial assessment within 15 days of commitment to SYSC.*

The records reviewed were for time periods from 2005 to current period. Assessments completed before 2007 could be deemed “barely adequate”. Sometime in 2007, completed assessments found in the records appear better structured and more focused. The improved assessments include documentation of both Risk and Protective factors and are intended to drive specific treatment plans.

For example, an assessment completed in April, 2009 documents the following:

- the placement history;
- mental illness and clinical treatment history;
- substance use and abuse;
- family history (including mental illness and substance abuse history);
- significant developmental history;
- medical history;



- educational history;
- work history;
- spiritual history;
- symptomology;
- diagnostic impressions;
- risk and protective factors; and
- treatment recommendations.

Psychiatric assessments are only completed on youth who exhibit symptomatic behavior. While they are kept in a medical record and are available to all clinical staff, the psychiatric assessments are not integrated into the overall clinical assessment. They usually support the medication decisions that are made.

Also missing from most assessments are well formulated vocational and career assessments that explore a youth's potential and interest in post-secondary education, vocational and professional opportunities. Though some assessments recommend that such vocational assessments be completed, they were notably absent from the records reviewed. Given the age and histories of these youth, and the express mission of DJJS, this seems like a striking omission. The Center has culinary arts, automotive and woodworking programs that are important resources for this population. Tying educational, vocational, and professional interests into overall assessments could emphasize the importance of assisting the youth to plan for their futures, thereby becoming productive members of their communities.

Family is a key resource and the primary for support for all youth. Especially in these hard economic times, the absence of family support is a major risk factor. Working with the families would be a crucial strategy to alleviate "lack of family" as a risk factor and promote "available family" as a protective factor. Family therapy and intervention is also critical for these youth who are separated from their communities and families and who will eventually return to those settings. According to one source, "[m]ost studies confirm that maintaining family ties while youth are incarcerated and establishing or preserving positive family relationships correlate with a successful transition back into the community, and ultimately, with

reduced recidivism.”<sup>53</sup> It can also support positive, long term outcomes for youth and family in the juvenile justice system.<sup>54</sup>

A major omission in the assessments viewed is any in-depth exploration of the family strengths and interests. According to staff, some families do engage in the family therapy programs that are available. However a significant number of families do not participate. A better assessment of the barriers faced by the families could help identify strategies that could support their engagement with the Center’s efforts. Some barriers clearly may be the families’ own mental health or substance abuse issues, but there could also be transportation or lack of resources to support their inclusion.

In general, there is clear evidence that despite a history of inadequate assessments, efforts and policies have been developed that promote adequate and in some cases quite useful assessments. These assessments could be improved by integrating the findings from vocational and family assessments as well as the psychiatric assessments. Integrated service delivery is critical to adequately address the needs of youth with disabilities at the Center. Similar to serving youth with disabilities in the community, “when services are fragmented or disconnected, they are less likely to result in significant improvements to youth.”<sup>55</sup> Integrated services delivery as well as a comprehensive set of assessments that addresses the full range of each youth's needs would assist the Center and DJJS to carry out its stated mission of ensuring the residents have a greater chance of being successful in the community when they leave the Center.

#### **b. Treatment Planning**

There are well developed protocols and templates for treatment planning with emphasis on actively engaging the youth in the development of their own goals. The goals are the key component and will allow staff as well as the youth and family to track progress or lack of progress. The higher level clinical staff interviewed are quite articulate that their overall clinical framework has them focused on reducing risk factors identified in the initial assessment and

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<sup>53</sup> “Unique Challenges, Hopeful Responses: A Handbook for Professionals Working with Youth with Disabilities in the Juvenile Justice System” (PACER Center, Inc. 2nd Ed. 1999), pg. 52, citing (Dague & Tolin, 1996).

<sup>54</sup> *Id.*

<sup>55</sup> “Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence Based Research” (National Council on Disabilities, 2003), Section 8.2.

increasing the protective factors. Earlier plans focused on fitting the youth into available programs: groups, individual counseling, and family therapy. According to the newer planning process, the work in those venues is designed to focus on the “goals in the Plan, not attendance at the activity”.

Weekly team meetings are held to discuss the progress of each resident as well as to identify progress or lack of it. However, in *most* reviews, it was not easy to find any record of progress or lack of progress, except notations of compliance, i.e. getting along with peers and staff. Quarterly reviews of treatment plans are required at the Center and staff are expected to adjust or amend plans according to what is learned in the quarterly reviews.

Significant areas of omission in these reviews are the inclusion of medication efficacy and changes, or family involvement. This information is not integrated in the assessment and consequently not integrated into the treatment plans or the reviews. While these domains of care may be the responsibility of other staff, they should be integrated into the overall plan. Time availability prohibits the Center’s psychiatrist from being an active team member, but the treatment information, including medication, needs to be integrated with the rest of the significant information about the youth. The effect of the medication can only be legitimately assessed in the context of the overall gains and accomplishments or difficulties experienced by the youth. That context is best described by the multidisciplinary team that sees the resident on a daily basis. The Center’s psychiatrist needs the regular, rather than episodic, feedback from the team to gauge how well the medication regime is managing the targeted symptoms. This is critical given the amount and types of medications prescribed at the Center. Many of the youth whose records were reviewed were receiving multiple psychoactive medications.

The other crucial omission (area that is omitted) in the documentation available was any review of vocational plans and activities to develop work skills and interests. Again, given the stated mission of ensuring success in the community, this seems a glaring and ultimately unfortunate omission. Here is a major opportunity to promote skill development and potentially improve self esteem for the youth.

The process of treatment planning and review is built into the timeframe of the residents’ arrival and stay. While there are mandatory 90-day reviews, there was no evidence of changes to the overall treatment plan based on progress or lack of progress. While it may exist, it would be crucial for staff to know that a resident is or is not progressing based on actual goals, rather than

merely “getting along” on their unit or in their classroom. Amended or revised treatment plans would occur based on progress rather than according to a calendar date.

The types of group and individual treatment described are based on knowledge of what works with this population. Cognitive Behavioral Treatment is evidence-based, though best provided by highly trained clinicians. There is quite an extensive and broad range of groups offered and it is difficult to ascertain how effective the treatment is without outcome data.

There are plans to introduce trauma-focused treatment in collaboration with a federally funded network. Given the histories of abuse and neglect that the residents have, this potentially could be a very useful and potentially effective treatment if implemented with fidelity.

### **c. Use of Force & Restraints**

As a result of public concern about the use of restraint and administration’s desire to ensure residents are safe, the Center established a “Use of Force Review Panel in July, 2009. Every incident of restraint is reviewed and analyzed by this panel that meets twice a month. The Panel recognized that some of the incidents were based on conflict between a resident and a staff member. To diffuse that specific tension and give fresh perspective to the evolving situation, response teams were designed. The response teams are composed of different staff that step in and try to calm the situation and mediate the original conflict. Clinical leadership reports that this has been very effective in reducing the use of restraint and other incidents.

In addition, analysis of incidents involving restraints and seclusion identified the time periods where such were most prevalent. Staffing schedules were rearranged so that some clinical staff would be working during those times when such incidents were prevalent, thereby increasing the opportunity for staff support and intervention.

A review of the actual data does show a downward trend in the number of incidents involving restraints at SYSC. The following is data provided by SYSC staff detailing incidents involving restraint at SYSC from January 1, 2009 to April 30, 2010.

**SYSC Incidents Involving  
Restraints by Year and Month**

Year	Month	Year_Month	Restraints
2009	Jan	Jan-09	18
2009	Feb	Feb-09	14
2009	Mar	Mar-09	17
2009	Apr	Apr-09	18
2009	May	May-09	24
2009	Jun	Jun-09	7
2009	Jul	Jul-09	23
2009	Aug	Aug-09	11
2009	Sep	Sep-09	11
2009	Oct	Oct-09	7
2009	Nov	Nov-09	11
2009	Dec	Dec-09	10
2010	Jan	Jan-10	3
2010	Feb	Feb-10	7
2010	Mar *	Mar-10	10
2010	Apr *	Apr-10	9

Data source: NH Bridges (SACWIS)

Data source: \* DJJS MS-Access Incident Tracking Database

While there has been some progress in reducing the number of restraint incidents at SYSC, the incidents of restraint of the 8 residents reviewed revealed that there remains a problem regarding the appropriateness of restraint use at the facility.

Except in rare instances, the incidents of restraint of the 8 residents reviewed did not seem justified. In fact, most appeared to be situations where staff wanted to take control. Some residents may present as more challenging to staff than others, by the attitude and stances they assume. In those cases every effort should be made to reduce conflict between and among the staff and resident. It would be very detrimental for staff to assume they need to be harsh in order to set an example.

A number of these incidents occurred in the residents' room. This means that there is no place where the resident is "in charge" or has control over his own environment. Recognizing

that these youth have come from difficult circumstances, are adolescents, and have lost their community, it would seem crucial to provide them with opportunities to earn status, personal space, and control over their environment, rather than always taking away that which is essential to their fragile identity. Loss of privilege would be a more appropriate consequence.

#### **d. Medication Practice**

The Center has on staff Psychiatrist specializing in Child and Adolescent mental health. While he is employed full time, he spends two days a week at the Seacoast Mental Health Center to stay well versed in community mental health issues. This particular Psychiatrist has extensive experience working with the population and is well versed in emerging trends in evidence-based treatment. The major limitation of the way psychiatry services are provided at SYSC is they are isolated from the teams and the overall treatment planning and review. Ideally, the Psychiatrist would benefit from the information shared at team meetings as well as being able to recommend appropriate individual and group interventions for any particular youth.

#### **e. Overall**

In general, especially given recent improvements and ongoing plans to import evidence-based treatment into the clinical program it would appear the Center is moving in the right direction. However given the constraints of the model relative to the Center's mission and given the lack of objective outcome data, it is difficult to draw definitive conclusions about the effectiveness of the Center's treatment and approach. It is also highly questionable why many of the youth are even there. The general belief at the Center and with others familiar with the system is that there just are not other options available for the youth. Staff are also acutely aware that the resources in the community are sparse or insufficient (not just availability but skill levels) to provide effective care and treatment to this population.

SYSC staff agree that there needs to be more evidence-based clinical care available in the community. They also agree that there are insufficient placement resources to hold youth while they are in the community, such as therapeutic Foster Care. As a result, many children with mental and emotional disorders placed at SYSC are likely being unnecessarily and inappropriately institutionalized.

This is consistent with national trends which indicate that a large number of youth in detention around the country are detained while waiting for community mental health treatment. In 2004, the Special Investigations Division of the United States House of Representatives,

Committee on Government Reform surveyed every juvenile detention facility in the United States to assess what happens to youth when community mental health services are not readily available.<sup>56</sup> Of the 698 juvenile detention facilities identified in the United States at that time, (75%) responded to the survey. Responses were received from every state except New Hampshire. Among other findings, the report found that two-thirds of juvenile detention facilities hold youth who are waiting for community mental health treatment.

In addition to the children being detained while they await community-based mental health services, there are also many children around the country already adjudicated and committed to juvenile facilities with mental health disabilities that could and should have been directed to community mental health services as an alternative to incarceration if those services were available.

Staff recognize that treatment would be more effective if it could take place in community based settings. There is no evidence to support that skills learned in an institutional setting can be transferred to the community, thwarting the stated mission of DJJS. Many youth could be returned to the community if adequate community based setting and supportive treatment were available.

Current research shows that institutionalizing youth does not further public safety and is not effective as community-based prevention programs and interventions. *See* the MacArthur Research Network’s multi-state, longitudinal study on felony youth offenders entitled “Pathways to Desistance”.<sup>57</sup> The latest series of findings from this study shows that: 1) institutional care provides no greater public safety benefit than being on probation; 2) short stays in institutional care can actually increase criminal behavior; 3) substance abuse treatment decreases youth offending; and 4) aftercare works.<sup>58</sup>

Incarcerating youth has been shown to have detrimental effects on youth, including their mental and physical well-being, education, employment and ability to reintegrate into their

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<sup>56</sup> Incarceration of youth who are waiting for community mental health services in the United States. Prepared for Sen. Susan Collins, and Rep. Henry A. Waxman.

<sup>57</sup> More information available at <http://www.modelsforchange.net>.

<sup>58</sup> Study entitled “Pathways to Desistance”. Available at <http://www.modelsforchange.net>.

communities.<sup>59</sup> There is clear evidence that incarcerating children can actually increase the risk of future delinquency while community-based interventions have been proven to reduce recidivism rates and actually work to reduce juvenile crime.<sup>60</sup>

#### **IV. Recommendations:**

##### **a. For SYSC**

1. Integrate family and vocational assessments into assessment and treatment planning to improve the overall effectiveness and prepare residents for return to the community.
2. Create a process to collect outcome data for group and individual treatments.
3. Integrate psychiatry and medication monitoring into regular team processes.
4. Create an independent review of all youth on two or more psychoactive medications.
5. Create an on-line clinical record that is available and shared among those with a need to know what is happening with a youth.
6. Based on the dangers associated with the practice, and on the fact that restraint is not an effective behavioral management tool, restraint should be limited to situations where there is an imminent threat of harm to the residents or others.
7. Provide regular reports on the incidence and use of restraint so that concerned parties can monitor progress.

##### **b. For DJJS**

1. Create an effective diversion program so that youth can successfully remain in their communities. The program will need family support and

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<sup>59</sup> See Holman, Barry and Jason Ziedenberg, “The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities” (Justice Policy Institute Report); “The Costs of Confinement: Why Good Juvenile Justice Policies Make Good Fiscal Sense” (Justice Policy Institute, May 2009) [hereinafter Costs of Confinement]; and “The Detrimental Effects of Group Placements/Services for Youth with Behavioral Health Problems” (2007 Bazelon Center for Mental Health Law).

<sup>60</sup> See “Pathways to Desistance”, available at <http://www.modelsforchange.net>; Holman & Ziedenberg, *supra* note 50; and Costs of Confinement, *supra* note 50.



evidence-based treatments programs as well as alternative living arrangements when the family is unavailable for the youth

2. Reduce the length of stay for both committed and detained youth.
3. Provide adequate community-based support following release to avoid return.
4. A major investment in home and community-based resources is crucial. Allowing budget difficulties to reduce community options and increase institutional care is unconscionable.
5. An integrated and coordinated community-based mental health program for youth is critical. A key component of a successful program includes interagency wraparound services in the community.

## Appendix C

### **NEW HAMPSHIRE LAW & USE OF FORCE**

The New Hampshire Child Protection Act does not specifically address the use of force or when the use of restraint could rise to the level of abuse or neglect.

The Act defines an “abused child” as “any child who has been: (a) sexually abused; or (b) intentionally physically injured; or (c) psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect; or (d) physically injured by other than accidental means. RSA 169-C:3(II).

The Act defines a “neglected child” as any child “...(b) Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, when it is established that his health has suffered or is very likely to suffer serious impairment; and the deprivation is not due primarily to the lack of financial means of the parents, guardian or custodian...” (Emphasis added). *See* RSA 169-C:3(XIX)

SYSC is operated in accordance with RSA 621 and RSA 621-A. This statute does not specifically address the use of force or restraints at SYSC, however does provide a general standard of care that should be applied at SYSC. This section provides that SYSC shall be administered to ensure the following purposes and policies:

- I. To provide a wholesome physical and emotional setting for each child detained at or committed to the center;
- II. To provide protection, care, counseling, supervision, and rehabilitative services as required by the individual child;
- III. To assure that the child has not been deprived of those rights to which he or she is entitled by law;
- IV. To teach the child to accept responsibility for his or her actions;
- V. To recognize that the child's interests are of major importance while also acknowledging the interests of public safety;
- VI. To cooperate with the courts, law enforcement agencies, and other agencies in juvenile matters to ensure that the needs of each child who is involved with these agencies are met with minimum adverse impact upon the child; and

VII. To return each child committed to the center to a community setting with an improved attitude toward society.

The other relevant statute that applies to the use of force and restraint is RSA 627:4 of the criminal code. This section provides that a “person is justified in using non-deadly force upon another person in order to defend himself or a third person from what he reasonably believes to be the imminent use of unlawful, non-deadly force by such other person, and he may use a degree of such force which he reasonably believes to be necessary for such purpose.” RSA 627:4(I).

This section also provides that force is not justified if: “(a) With a purpose to cause physical harm to another person, he provoked the use of unlawful, non-deadly force by such other person; or (b) He was the initial aggressor, unless after such aggression he withdraws from the encounter and effectively communicates to such other person his intent to do so, but the latter notwithstanding continues the use or threat of unlawful, non-deadly force; or (c) The force involved was the product of a combat by agreement not authorized by law.” RSA 627:4(I).

Lastly, the New Hampshire Legislature recently passed Senate Bill 396-FN, an act limiting the use of child restraint practices in schools and treatment facilities including SYSC. The majority of the bill became effective on September 1, 2010.

Under the new law, staff at SYSC will be prohibited from using or threatening to use any physical restraint or containment technique that (a) obstructs a child’s respiratory airway or impairs the child’s breathing or respiratory capacity or restricts the movement required for normal breathing; (b) places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child; (c) obstructs the circulation of blood; (d) involves pushing on or into the child’s mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or (e) endangers a child’s life or significantly exacerbates a child’s medical condition.

The new law will also prohibit the intentional infliction of pain, including the use of pain inducement to obtain compliance; the intentional release of noxious, toxic, caustic, or otherwise unpleasant substances near a child for the purpose of controlling or modifying the behavior of or

punishing the child; and any technique that unnecessarily subjects the child to ridicule, humiliation, or emotional trauma.<sup>61</sup>

Lastly, the new bill will place a limitation on the use of restraint to emergencies only, stating that “[r]estraint shall only be used in a school or facility to ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or others. It shall be used only by trained personnel using extreme caution when all other interventions have failed or have been deemed inappropriate” and “[r]estraint shall never be used explicitly or implicitly as punishment for the behavior of a child.”<sup>62</sup>

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<sup>61</sup> Section 126-T:4.

<sup>62</sup> Section 126-T:5.

## Appendix D

### **FEDERAL LAW & USE-OF-FORCE**

A recent U.S. Department of Justice report summarized the constitutional and federal statutory rights of youth in juvenile justice facilities:

“Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority with responsibility for the incarceration of juveniles to engage in a pattern or practice of conduct that deprives incarcerated juveniles of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to file a civil action to eliminate the pattern or practice.

The Due Process clause of the Fourteenth Amendment to the U.S. Constitution governs the standards for conditions of confinement of juvenile offenders who have not been convicted of a crime. Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); Jones v. Blanas, 393 F.3d 918, 931 (9th Cir. 2004). Confinement of youth in conditions that amount to punishment, or in conditions that represent a substantial departure from generally accepted professional standards, violates the Due Process clause. Youngberg v. Romeo, 457 U.S. 307(1982); Bell v. Wolfish, 441 U.S. 520 (1979); Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1245-46 (2d Cir. 1982)(extending Youngberg reasoning to children who are the responsibility of the state). The Fourteenth Amendment prohibits imposing on incarcerated persons who have not been convicted of crimes conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. at 539-540.

Youths in the custody of the State have a constitutional right to be free from physical abuse by staff and assaults inflicted by other youths. Youngberg, 457 U.S. at 315-16 (“personal security constitutes a ‘historic liberty interest’ protected substantively by the Due Process Clause”). Juveniles also have the right to be free from excessive use of force by staff and unreasonable bodily restraints. Youngberg, 457 U.S. at 315-16; Rodriguez v. Phillips, 66 F.3d 470, 477 (2d Cir. 1995)(holding that Fourteenth Amendment ensures freedom from excessive use of force in non-arrestee, non-prisoner context); Alexander S. v. Boyd, 876 F. Supp. 773, 786 (D.S.C.1995) (in absence of genuine risk of serious bodily harm to another, use of a form of tear gas on youth detainees merely “to enforce an order” violates Due Process).

Confined juveniles also must receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Martarella v. Kelley, 349 F. Supp. 575, 598 (S.D.N.Y. 1972) (holding that juvenile facilities operated by the State of New York were obligated to provide adequate treatment to youths in custody).<sup>63</sup>

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<sup>63</sup> Investigation of the Lansing Residential Center, Louis Gossett, Jr. Residential Center, Tryon Residential Center, and Tryon Girls Center, 4 – 5. (U.S. Department of Justice, Civil Rights Divisions) (August 14, 2009) [hereinafter NY DOJ investigation].

## Appendix E

### LITERATURE & RESTRAINTS

Limiting and ultimately reducing the use of physical restraint in juvenile justice facilities is critical because between 65% and 70% of youth involved with the juvenile justice system have at least one diagnosable mental health disorders.<sup>64</sup> Physical restraint is a controversial procedure that historically has been “abused and misused.”<sup>65</sup> Children are often restrained as a result of behavior that is directly related to their disability.

Placing limits and ultimately eliminating the need for physical restraints is also critical because restraining a child is inherently dangerous and has no therapeutic value.<sup>66</sup> Each time a child is restrained, there is a risk of physical injury to children and staff; psychological trauma particularly to victims of prior physical and sexual abuse; and even death.<sup>67</sup> While it is difficult to get an accurate estimate of deaths or injuries as a result of restraint, some have estimated that between 8 and 10 children in the United States die each year due to restraint procedures.<sup>68</sup>

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<sup>64</sup> Shufelt & Coccozza, *supra* note 7.

<sup>65</sup> Mohr, *supra* note 28, citing the U.S. General Accounting Office, 1999 report.

<sup>66</sup> See Achieving better outcomes for children and families, reducing restraint and seclusion, (Child Welfare League of America) (2004); Mohr, *supra* note 28; and MHA Position Statement 24, *supra* note 28.

<sup>67</sup> See Mohr, W. K., Petti, T. A., & Mohr, B. D., Adverse effects associated with the use of physical restraints (Canadian Journal of Psychiatry, 330–337) (2003); Singh, N. N., Singh, S. D., Davis, C. M., Latham, L. L., & Ayers, M., Reconsidering the use of seclusion and restraints in inpatient child and adult psychiatry (Journal of Child and Family Studies, 8(3), 243–253) (1999).; and Nunno, M., Holden, M., & Tollar, A., Learning from tragedy, a survey of child and adolescent restraint fatalities (Child Abuse & Neglect, 30(12), 1333–1342) (2006).

<sup>68</sup> **A.)** In 2002, the Child Welfare League of America (CWLA) estimated that 8 – 10 children in the U.S. die each year due to restraint procedures while numerous others suffer injuries ranging from bites, damaged joints, broken bones, and friction burns (CWLA, 2002). **B.)** In 1998, the Hartford Courant, a Connecticut newspaper, reported on 142 restraint-related deaths in the United States over a 10-year period. Over one-third of these deaths were due to the improper implementation of restraint procedures, resulting in death by asphyxia or suffocation. Those who died were disproportionately young children. (Weis, Hartford Currant, 1998). **C.)** In a 1999 report, the U.S. General Accounting Office (GAO) concluded that more than 24 patients died from restraint or seclusion related incidents in 1998. The GAO concluded that an accurate estimate of deaths or injuries due to restraint was impossible since only 15 U.S. states had established reporting procedures for such incidents at the time. (GAO/HEHS-99-176). **D.)** The Harvard Center for Risk Analysis estimated that 50 to 150 deaths occur in the U.S. each year due to restraint and seclusion. (NAMI, 2003). **E.)** According to the Coalition Against Institutionalized Child Abuse, 75 children in the United States have died in the last 22 years as a result of being restrained. Most of these deaths resulted from the child being restrained in the prone (or face-down) position. **F.)** The U.S. Government Accountability Office investigated allegations of deadly and abusive seclusion and restraint in schools and issued a report in May, 2009. The GAO found that children, especially those with disabilities, are reportedly being restrained and secluded in public and private schools and other facilities, sometimes resulting in injury and death. They concluded that “of the hundreds of allegations we identified, at least 20 involved restraints that resulted in death. Of the 10 closed cases we

In addition to being dangerous, the use of force and restraints also tends to escalate the emotional state of many adolescents and make them more, rather than less agitated.<sup>69</sup> Restraint not only agitates the youth, but also contributes to the escalation of the situation itself.

Unfortunately the use of restraint is particularly dangerous for children.<sup>70</sup> Children are subjected to restraint at a higher rate than adults and are at a disproportionately high risk of injury and death related to restraint.<sup>71</sup> Because restraint has not been proven to have any therapeutic value, current best professional standards recommends limiting the use of restraint to emergency situations where it is necessary for the immediate safety of the child or others.

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examined, 4 involved children who died as a result of being restrained. In all 4 cases, staff members used restraint techniques that restricted the flow of air to the child's lungs. In one of these cases, an aide sat on top of a child to prevent him from being disruptive and ultimately smothered him. The other cases related to the use of different types of prone restraints, a technique that typically involves one or more staff members holding a child face down on the floor. Although some of the teachers and staff involved in these cases were trained on the use of prone restraints, the children in their care still died as a result of its use." (GAO-09-719T)

<sup>69</sup> Judith G. Storandt, Esq., *Use of Force in Juvenile Correctional Facilities*, 16 (National Disability Rights Network) (2006); and Smith & Bowan, *The Restraint Spiral: Emergent Themes in Perceptions of the Physical Restraint of Juveniles*, 77 (Child Welfare, Vol. 88, #3) (2009).

<sup>70</sup> Children are at a disproportionately high risk of injury and death related to restraint and seclusion. See LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., et al., *Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care* (Journal of the American Academy of Child & Adolescent Psychiatry, 43(1), 37–45) (2004); and Weiss, *supra* note 59.

<sup>71</sup> The younger the child, the more frequent the use of restraint. See LeBel, *supra* note 61. The 1999 GAO report, reference in note 59, found conclusively that children are subjected to restraint and seclusion at higher rates than adults and are at greater risk of injury or death.



## Appendix F

### **PRONE (FACE-DOWN) RESTRAINTS**

Restraining a child in the prone or face-down position is extremely dangerous. There is a considerable amount of literature on the life-threatening dangers of prone restraints.<sup>72</sup> The prone position impairs a child's breathing and places a child at risk of positional asphyxia, cardiac arrest and ultimately death.<sup>73</sup> The majority of restraint-related deaths in the country are associated with the prone or face-down position and asphyxia is the most common cause of restraint-related death. When a child is restrained face-down, her airway may be constricted and she may be unable to express physical distress. In fact a child's struggle for air may even be misconstrued by staff as resistance, resulting in increased force on the child. While some may suggest that prone restraint is only dangerous if accompanied by chest compression, Dr. Andrew's, New Hampshire's Chief Medical Examiner confirmed that placing a child in a face-down or prone position carries extreme risks even when the chest is not compressed.

Prone restraint is a potentially fatal position with or without the presence of other risk factors or co-existing conditions. The mere fact of being a child places an individual at a higher risk of death. The research also says that while many restraint-related deaths occur as a result of improperly performed procedures; deaths occur even in cases where restraints are applied properly and where the individual restraining the child is highly training in its use. It is for these reasons that many experts agreed that the risks of using prone restraint so clearly outweigh any possible benefit.<sup>74</sup> Prone restraint is extremely dangerous and can be replaced by safer more effective interventions.

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<sup>72</sup> See Haimowitz, Stephan, et al., *Restraint and Seclusion: A Risk Management Guide* (National Technical Assistance Center for State Mental Health Planning) (September 2006); and Weiss, *supra* note 59.

<sup>73</sup> See Mohr, *supra* note 28; *The Lethal Hazard of Prone Restraint: Positional Asphyxiation* (California Protection & Advocacy Agency); and Nunno, M., Holden, M., & Tollar, A, *Learning from tragedy, a survey of child and adolescent restraint fatalities* (*Child Abuse & Neglect*, 30(12), 1333–1342) (2006).

<sup>74</sup> See Busch, A. B., & Shore, M. F., *Seclusion and restraint: A review of the literature* (*Harvard Review of Psychiatry*, 8 (5), 261–270) (2000); Mohr, Petti & Mohr, *supra* note 58; and Day, D. M., *Examining the therapeutic utility of restraints and seclusion with children and youth: the role of theory and research in practice* (*American Journal of Orthopsychiatry*, 72, 266 – 278) (2002).

Experts, clinicians and other advocacy groups support eliminating the use of prone restraint on children.<sup>75</sup> There are many states already moving towards the elimination of child prone restraint, including Pennsylvania<sup>76</sup> and Ohio.<sup>77</sup> Pennsylvania is working towards eliminating prone restraint in all child residential, day treatment and youth detention programs and has already seen a decrease in critical incidents.

The U.S. Department of Justice, Civil Rights Division recently conducted an investigation of conditions at four juvenile justice facilities in New York State pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 (“DOJ Report”).<sup>78</sup>

The DOJ specifically addressed the use of prone restraint in their report concluding that “[e]ven when staff are following approved practices, restraints can be dangerous. In particular, the use of prone restraints is controversial and has been banned by many facilities nationwide due to the high risk of serious injury or death. In spite of the known risk of prone restraints, staff at the facilities are trained to use prone restraints.”<sup>79</sup> The report documents an incident in November 2006, where a 15-year-old resident at Tryon Residential Center in New York died following a prone restraint. The youth allegedly pushed a staff member and was then pinned face-down on the floor and handcuffed by two staff. The youth stopped breathing only minutes later, and then died at a nearby hospital. His death was ruled a homicide by the medical

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<sup>75</sup> Standards developed by JDAI support a ban on restraining youth in a prone position and putting pressure on the youth’s back. These standards incorporate legal and accepted medical and mental health professional standards to protect the health, safety, and legal rights of detained youth. In their January 2009 and January 2010 reports, The National Disability Rights Network (NDRN) demanded that the use of prone restraint be banned in schools. The Council for Children with Behavioral Disorders recommends “banning” prone restraints in schools. The Council for Exceptional Children recommends that prone restraints or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck, or throat should never be used. The New Hampshire Department of Education’s “Guidance on Considering the Use of Physical Restraints in New Hampshire School Settings” recommends that NH schools select a training program that prohibits restraints that place a student face down on the floor or put pressure on a child’s back, head or neck.

<sup>76</sup> Bulletin available at <http://www.pabulletin.com/secure/data/vol39/39-51/2316.html> and [http://www.mhapa.org/pdf/122009\\_ProneRestraints.pdf](http://www.mhapa.org/pdf/122009_ProneRestraints.pdf).

<sup>77</sup> Executive order available at <http://www.governor.ohio.gov/Portals/0/Executive%20Orders/EO%2009-13S.pdf>.

<sup>78</sup> NY DOJ investigation, *supra* note 54.

<sup>79</sup> *Id.*

examiner. The DOJ concluded that “[d]espite this tragic death, a dangerous combination of high rates of prone restraints and a low standard for initiating a restraint remains at the facilities.”<sup>80</sup>

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<sup>80</sup> *Id.*

**Appendix G**  
**STANDARDS & USE OF FORCE**

**ACA Standards**

The American Correctional Association (“ACA”), an accrediting body, has Standards for Juvenile Detention Facilities and Standards for Juvenile Correctional Facilities. The ACA standards require a written policy, procedure, and practice that restricts the use of physical force to instances of justifiable self defense, protection of others, protection of property, and prevention of escapes, and then only as a last resort and in accordance with appropriate statutory authority. The standards also require a written policy, procedure, and practice provide that instruments of restraint, such as handcuffs, leg irons, and straightjackets, are never applied as punishment and are applied only with the approval of the facility administrator or designee.

These standards do not clearly limit the use of restraints to emergency situations, where it is necessary for the immediate safety of the child or others. They also permit the use of restraints to protect a jurisdiction’s property. This is contrary to the literature and the clear consensus among treatment providers across all settings and does not take into account the historical misuse and abuse of restraints on this vulnerable population.

**CJCA’s Performance-Based Standards**

The Performance-Based Standards for Youth Correction and Detention Facilities (“PbS”) is directed by the Council of Juvenile Correctional Administrators (“CJCA”). CJCA states in their position paper that “physical intervention and/or restraints should only be deployed when de-escalation of the crisis has failed and the need to protect staff, other youths or the jurisdiction’s property is necessary.” (Emphasis added). The paper also states that when “preventive measures fail, physical interventions and restraints should only be done by trained individuals and only used defensively and in a manner that provides maximum safety for the staff and youths.”<sup>81</sup>

Similar to the ACA standards, the CJCA’s position does not clearly limit the use of restraints to emergency situations, where it is necessary for the immediate safety of the child or others. It also permits the use of restraints to protect a jurisdiction’s property. Both positions are contrary to the literature and the clear consensus among treatment providers across all settings

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<sup>81</sup> CJCA Position Paper on: Physical and Mechanical Interventions with Juvenile Offenders (Available at <http://www,cjca.net>).

and does not take into account the historical misuse and abuse of restraints on this vulnerable population.

### **Mental Health America**

In a position statement, Mental Health America states that “[w]hen restraint must be used to prevent injury to self or others, there should be stringent procedural safeguards, limitations on time, periodic reviews and documentation” and that “these techniques should be used only in response to extreme threats to life or safety and after other less restrictive control techniques have been tried and failed.”<sup>82</sup>

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<sup>82</sup> Position Statement 51: Children With Emotional Disorders in the Juvenile Justice System (Mental Health America) (Available at <http://www.mentalhealthamerica.net>).