State of New Hampshire

Office of the Child Advocate

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Child Advocate responds to DHHS Summary Report on recent incidents at Granite Pathways Youth Treatment Center.

Concord NH: Yesterday the New Hampshire Department of Health and Human Services (Department) released a Summary Report on recent incidents involving children who were at the Youth Treatment Center (Treatment Center) operated by Granite Pathways for substance use treatment. Moira O'Neill, Director of the State Office of the Child Advocate, expressed relief that all former residents of the Treatment Center have been transitioned to other settings for appropriate care and treatment. However, O'Neill expressed disappointment in the apparent lack of oversight of a facility established to treat children, many of whom had complex mental health needs, including recent suicidality and self-harming behaviors. The Treatment Center was unusual in that it was a residential treatment program for children but it was not certified by DCYF. Without certification, the Treatment Center was not under DCYF's supervision for quality and safety. O'Neill said it is unclear who had oversight over the care of the children at the facility.

Although DCYF did not certify the facility and did not directly place children at the Treatment Center, some of the children were known to DCYF. In accordance with RSA 170-G:18, IV(a), the Office of the Child Advocate was notified of the critical incidents on Tuesday, November 26th. O'Neill stated a preliminary review of the children's records was immediately undertaken. "Several of the children placed at the substance use treatment program had far more complex needs than substance use. If we are going to understand the circumstances that prompted 7 ambulance transports, we must understand how those children came to be at the facility and what transpired in assessing and treating them." Having been assured of a full investigation, the Office of the Child Advocate forwarded a list of investigation questions to the Department on Wednesday, November 27th (see attached). The questions were intended to prompt examination of what the facility knew about the children, their capacity to match children's needs, and what supervision of the program existed. As of today, the Office has not received a response to the questions. "We cannot learn from these events and improve the system until we have looked at the whole situation from all angles," O'Neill said. "That includes better understanding what children need and making sure the array of services is equipped to meet those needs."

O'Neill noted that the Office of the Child Advocate is monitoring children removed from the Treatment Center with open DCYF cases to ensure they access appropriate care, including support for exposure to the traumatic events they experienced at the facility.

Pursuant to NH RSA 170-G:18, the Office of the Child Advocate provides independent oversight of the Department for Children, Youth and Families to assure that the best interests of children are being protected.

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Questions submitted by the Office of the Child Advocate to DHHS on Wednesday November 27, 2019 regarding Granite Pathways Treatment Center.

As your team is reviewing Granite Pathway's provision of care and steps of safety, I ask that close attention be paid to the following:

- What information did the Treatment Center have about each child's history prior to admission?
- What criteria were used to determine appropriateness of admission? (Was admission based solely on a history of having used substances or was admission based on the program's capacity to meet all individual needs of each child, including underlying mental health conditions to which substance abuse may have been secondary?)
- If children were admitted to the Treatment Center without the benefit of a full history, what assessments were completed to identify all evident and underlying diagnoses and needs of each child? And when?
- What therapeutic programming was available to address/treat each child's underlying and co-occurring conditions in addition to substance use treatment?
- What other medical and mental health resources were accessed for children's care when the Treatment Center did not have program capacity to address underlying or co-occurring conditions?
- What were the credentials of personnel providing care in the program? How often do they interact/provide services or supports to the resident children?
- What were patterns of supervision of the children throughout the day?
- How was a therapeutic milieu established and maintained as a means for safe space, trust building, relationship building, and trauma-informed cultural and gender sensitivity?
- What were the Treatment Center protocols for responding to emergencies?
- What were Treatment Center protocols for reporting emergencies to DHHS, DCYF, and any others?

In addition to reviewing the Treatment Center program itself, systemic factors that should be considered include:

- What was the oversight of this DHHS-licensed facility?
- How was the DHHS-licensed program assessed for safety and how often?
- How was the efficacy of therapeutic programming assessed and how often?
- How was the capacity of this DHHS-licensed program assessed to ensure it meets the needs of admitted children?
- What are the implications of institutional abuse or neglect when a parent or guardian places a child rather than a public entity such as DCYF or a school?
- Who should institutional abuse or neglect be reported to when a facility is not certified by DCYF?
- Why was the Treatment Center not certified by DCYF?
- Did the Treatment Center pay rent/utilities to the state for the space in which it operates the program? If not, what was the expectation for return on investment of valuable space?