What is a Psychiatric Residential Treatment Facility?

The Alabama Department of Human Resources (DHR) licenses fifteen psychiatric residential treatment facilities for youth under the age of 21 (PRTF). These facilities include Alabama Clinical Schools, Alabama Mentor, Bay Pointe, AltaPointe Transitional Living Group Home, Brewer Porch Children’s Center, Gateway, Glenwood, Hill Crest Behavioral Health, Laurel Oaks, Lee County Youth Development Center, Mountain View, Pathway, SafetyNet (three campuses), St Mary’s Home, Three Springs (three campuses).

To be admitted to a PRTF, a child must meet at least one of the following admission criteria: (a) inappropriate performance of activities of daily living; (b) impaired safety; (c) impaired thought process; or (d) otherwise demonstrate that inpatient treatment is required due to, for example, the failure of outpatient therapy, failure of social or family functioning which places patient at increased risk, or the need for 24-hour skilled and intensive observation. See Ala. Admin. Code 560-X-41-.09 (2)(a-d).

While these facilities are open to any child meeting admission criteria, a significant number of the children in PRTFs are in the custody of DHR. These children are some of the most vulnerable in our child welfare system. They have significant mental health needs and many have co-occurring cognitive impairments. Many have been subjected to repeated placement disruptions and rejections, heightening their need for security and continuity.

Serious Occurrence Reporting in PRTFs

The Children’s Health Act of 2000 requires PRTFs to report “serious occurrences” within 24 hours to ADAP, DHR and the Alabama Medicaid Agency. Serious occurrences include a resident’s death (for any reason), serious injury (for any reason), or suicide attempt by a resident. See 42 C.F.R. §483.352.

ADAP Serious Occurrence Investigations

ADAP is authorized under federal law to monitor in PRTFs and to investigate such serious occurrences. During FY11, ADAP undertook 46 such investigations. Of the incidents investigated, ADAP issued multiple corrective action recommendations to address safety and treatment for residents in areas such as: seclusion and restraint practices; suicide prevention and intervention practices, monitoring and training of staff; crisis intervention; and internal investigation procedures.

Below is a sample of some of the incidents which ADAP investigated:

• A 15 year old youth sustained a dislocated knee after a facility supervisor violated the facility’s restraint policy. Video footage shows the supervisor aggressively restraining the youth for having headphones that were deemed contraband.

• A 17 year-old resident was physically assaulted by a staff member when the staff member struck her in the face during a restraint. Video footage of the restraint shows two staff member sitting on the youth in their attempt to perform a “follow-to-the-ground” restraint.

• A 12 year old girl attempted suicide by wrapping jewelry and a shirt around her neck while in a seclusion room. ADAP investigated why the facility did not properly implement recently changed
protocols prohibiting residents having access to such items while in seclusion, especially residents with a history of suicide attempt.

- A 14 year old boy attempted suicide by trying to drown himself in a sink of water and by closing himself inside a clothes dryer on his unit. While staff responded quickly to the boy’s actions to prevent further harm, if resident observation protocol had been followed prior to the incident, it likely could have been prevented.