

# Transporting Forensic Psychiatric Patients

Charles C. Dike, MD, MPH, Elizabeth Nicholson, RN, and John L. Young, MD, MTh

Patients in a forensic psychiatric facility often require escorted transport to medical facilities for investigations or treatments of physical health ailments. Transporting these patients presents significant safety and custody challenges because of the nature of patients housed in forensic psychiatric facilities. A significant proportion of these patients may be transfers from the Department of Corrections (DOC) under legal mandates for psychiatric evaluation and treatment better provided in a hospital setting, and most of them will return to the DOC. Although departments of correction have protocols for escorting these potentially dangerous individuals, it is unclear whether receiving psychiatric hospitals have established procedures for maintaining the safety of others and custody of these individuals during transportation outside the hospital facility. The literature is sparse on precautions to be observed when transporting dangerous forensic psychiatric patients, including those with high escape risk. In this article, we describe one forensic inpatient facility's procedure for determining the appropriate level needed to transport these individuals outside of the forensic facility. We also describe the risk assessment procedure for determining level of transport. These are quality improvement measures resulting from a critical review of an incident of escape from the forensic facility several years ago.

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In September 2005, a patient acquitted by reason of insanity on a charge of attempted murder (of a state trooper) and residing in the maximum security service of Whiting Forensic Division (WFD) of Connecticut Valley Hospital (CVH), escaped from a scheduled medical appointment at an acute care hospital approximately 20 miles from WFD. Newspaper accounts reported a previous escape attempt from the enhanced service of WFD approximately two months earlier, during which the patient sustained the injuries for which he was receiving treatment from the acute care hospital.<sup>1,2</sup> After a frantic manhunt by the police, the patient was found and arrested three hours later at a pub from which he had called his girlfriend, asking her to meet him.

This incident generated much public outcry and added to the fears regarding forensic patients in the community. It prompted a critical incident review

of the procedures for transporting patients out of WFD, ultimately culminating in the development of a risk assessment process for planning the transportation of these patients, and the completion of a form developed specifically for that purpose (Figure 1) as a quality improvement initiative.

## Background

Although incidents such as that described above are relatively uncommon, each incident attracts generous media coverage and public angst that makes them appear more common than they actually are. For example, in July 2012, a 29-year-old psychiatric patient in Phoenix, Arizona, who was considered a danger to others broke free of his restraints and assaulted an emergency medical technician while he was being taken to another facility.<sup>3</sup> In another case in New Zealand in June 2013, a 22-year-old psychiatric patient escaped while being transported to a hospital by his psychiatrist and mental health nurse and ran into a stranger's house where he reportedly stabbed a 21-year-old man multiple times in the face, throat, and buttocks. A review of escapes from psychiatric hospitals after this incident showed a 63 percent increase in patients who were absent without leave (AWOL) in the past 3 years; despite this increase, there was no change in security measures.<sup>4</sup>

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CVH-473 CONNECTICUT VALLEY HOSPITAL - RISK ASSESSMENT Name: \_\_\_\_\_ MPI #: \_\_\_\_\_  
 Rev. 1/11 FOR TRANSPORTATION – HOSPITAL POST *Print or addressograph imprint*

**DIVISION:** \_\_\_\_\_ **CURRENT LEGAL STATUS (Key):** \_\_\_\_\_

[ ] Whiting Forensic Mental Health, Dept of Corrections or Substance Abuse 4 Competency Restoration 54-56d 10 60-day WFD Evaluation 17a-582a  
 [ ] General Psychiatry 1 Voluntary 17a-506, 17a-513, 17a-682, 5 Non-Restorable to Competency 54-56d(m) 11 Disposition After Report WFD 17a567  
 [ ] Addiction Services 2 Probate Court Commitment 17a-498c, PA98-219 6 Track II Voluntary 54-56d(h)(2)(A)ii 12 Substance Dependence Pre-Trial 17a-696  
 3 Physician Emergency Certificate (PEC) 17a-502, 17a- 7 Track II Probate Commit 54-56d(h) (2)(A)iii 13 Substance Dependence Post-Conviction  
 Unit: \_\_\_\_\_ 514, 17a-684 8 Commitment to PSRB 17a-582 14 Federal Detainer  
 9 Post-Conviction WFD Exam/Screen 17a-566a 15 Other : (specify): \_\_\_\_\_

**OCCASION FOR LEVEL OF SECURITY DETERMINATION:**  
 1 Admission  
 2 Treatment Plan Review  
 3 Major Changes in Patient's Clinical Status  
 4 Prior to Transport - *Police Verification for Escort Levels A-D*  
 5 Assignment of Hospital Post *and Hospital Posts G & H*

**LEVEL OF ESCORT:**  
 A 2 Officers, 1 Nursing Staff, Transport Belt, Leg Irons *WFD*  
 B 1 Officer, 2 Nursing Staff, Transport Belt, Leg Irons *WFD*  
 C 1 Officer, 1 Nursing Staff, Transport Belt, Leg Irons *WFD*  
 D 1 Officer, 1 Nursing Staff, Transport Belt *WFD*  
 E 2 Staff  
 F 1 Staff

**LEVEL OF HOSPITAL POST**  
 G 1 Officer, 1 Nurse, Leg Restraint *WFD*  
 H 1 Officer, Leg Restraint *WFD*  
 I 1 Nursing Staff  
 J No Staff Required

**CLINICAL RATIONALE (List below all that apply)**

**Current Clinical Status:**  
 1 Danger to Self  
 2 Danger to Others  
 3 Clinically Unstable  
 4 Impulsive  
 5 Aggressive Behavior

**Risk Factors (continued):**  
 11 Limitation on Communication/Threatening/Harassing  
 12 Unsuccessful Temp Leave/Conditional Release  
 13 DOC Tickets  
 14 History of Aggressive Behavior  
 15 Unknown History  
 16 Protective/Restraining Order  
 17 Bond (amount): \_\_\_\_\_

**Factors that Increase Risk of Elopement:**  
 6 History of Assault/Violence over one year  
 7 Assault/Violence less than one year  
 8 History of AWOL over one year  
 9 AWOL less than one year  
 10 Felony Charges

**Factors that Lower Risk of Elopement:**  
 18 Significant Clinical Stability  
 19 Cooperative with Treatment Plan  
 20 Geriatric Medically Compromised  
 21 Significantly Medically Compromised

Date Time	Transport On/Off Grounds		TRANSPORT Treatment Team Section				Risk Management Section			WFD Police Verification	
	On	Off	Legal Status (I-15)	Level of Post Recommended (I-5)	Level of Escort Recommended (A-F)	Clinical Rationale (I-21)	Attending Psychiatrist or On-Call Physician Signature/Print Name	Level of Post Approved	Clinical Rationale	Risk Management Committee (MD Only) Signature/Print Name/Date/Time	at Time of Transport Escort Levels A-D, G & H Only Police Signature/Print Name/Date/Time
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/											
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Date Time of Post	HOSPITAL POST Treatment Team Section				Risk Management Section			WFD Police Verification
	Legal Status (I-15)	Level of Post Recommended (G-J)	Clinical Rationale (I-21)	Attending Psychiatrist or On-Call Physician Signature/Print Name	Level of Post Approved	Clinical Rationale	Risk Management Committee (MD Only) Signature/Print Name/Date/Time	for Hospital Post G & H Only Police Signature/Print Name/Date/Time
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*File as First Page in the Assessment Section of the Medical Record*

Figure 1. Transportation Risk Assessment Form.

Correctional inmates with psychotic disorder transferred to forensic hospitals are similar in behavior to their nonpsychotic criminal peers. As a result, they are at higher risk of exhibiting behaviors associated with psychopathy such as violence, intimidation, and exploitation of others, and may be perceived to have a higher risk of escaping from the hospital.<sup>5</sup> Therefore, it would be prudent to review the risky behaviors exhibited by correctional inmates during transportation, as they are likely to apply to patients in a forensic psychiatric hospital facility, a significant proportion of whom are transfers from DOC. Understanding the risks posed by prison inmates to the public during transportation to acute care hospitals for evaluation and treatment, and the DOC procedures established to address those risks would likely prepare administrators of forensic psychiatric hospitals to anticipate the same risks from forensic psychiatric inpatients, especially those in maximum se-

curity settings. The following reported examples of perils experienced during transport of DOC inmates to acute care hospitals are pertinent. In 2010, an inmate of a county jail in Santa Cruz, California, overpowered his (female) police deputy escort while in a hospital for an MRI investigation, used the deputy's Taser to stun her, took her gun, and later held a preschool teacher at gunpoint at a nearby preschool facility.<sup>6</sup>

Perhaps one of the most tragic of these incidents occurred in June 2007 when an inmate of Utah State Prison being escorted to a University Hospital clinic killed his accompanying corrections officer and escaped from custody. This incident came on the heels of another tragic occurrence in Blacksburg Virginia in 2006, when an escaping inmate-patient at the Montgomery Regional Hospital shot and killed a hospital security guard.<sup>7</sup> In response to the Utah incident in 2007, the hospital and DOC officials increased the number of guards who escort inmate-

patients, and considered the use of telemedicine to decrease the need for transport.<sup>8</sup>

Transporting inmates, including those en route to health care facilities, is reportedly considered the most risky procedure in which corrections and law enforcement engage.<sup>9</sup> A study by the New York Police Department in 2002 found that 40 percent of inmate escapes happened during inmate transport for any reason.<sup>10</sup> A further analysis of data (from [www.troopertrap.com](http://www.troopertrap.com), 2008) regarding reported incidents emerging from transporting inmates from 2002 to 2007, showed that about 12 percent of the inmates were injured and 3 percent were killed, whereas about 12 percent of the officers were injured and less than 1 percent of the officers were killed as a result of inmate escape during transportation.<sup>10</sup>

In addition, a report published in 2011<sup>9</sup> on data collected from January 1, 2010, through December 31, 2010, reported that there were 72 incidents of attempted or completed escapes by inmates from acute care hospitals in 2010 while in custody of law enforcement or hospital security professionals. A breakdown of the data showed that 78 percent of elopements during transport to hospitals occurred when the inmate was in the custody of law enforcement or corrections, whereas 21 percent occurred when the inmate was in the custody of hospital security. The most frequent location of the escapes was in clinical treatment areas (39.4%), followed by restrooms (29.3%), emergency rooms (14.1%), and outside the hospital (e.g., hospital entrance or parking lot; 17.2%). Most of the escape incidents were associated with injury to others, and rarely, death; 26 law enforcement and corrections staff, 11 health care security staff, 3 health care staff, 1 patient, and 3 visitors were injured during the escapes, and 2 were killed.

In an article on inmate transport published in 2009, the authors recommended that a mini risk management assessment be made before any inmate is transported, paying attention to such factors as:

. . . selection and preparation of the vehicle; possible vehicle accidents; securing and placement of the prisoner in the vehicle; acquiring prisoner information; transporting special needs prisoners; gender of the prisoner; restraint equipment used; searching the prisoner; the number of prisoners to transport; nature of the transportation; distance and route of the transportation; medical purposes of the transportation; using commercial aircraft; officer weapons involved; number of officers required for the transport; and communications required during the transport.<sup>10</sup>

Although correctional institutions generally have protocols and procedures that they follow to protect their officers and the general public during transportation of inmates to health care facilities, a review of the literature suggested that most forensic psychiatric facilities that house individuals with similar characteristics as inmates (i.e., history of violence) have not established procedures for safety during transport of these patients, or if they have, they have not written about them. Further, although the International Association of Healthcare Security and Safety Statement on Prisoner Patient Security recommends that the secure treatment of the inmate patient must be addressed by all health care facilities providing treatment for this population,<sup>11</sup> there are no recommendations for identifying the risks posed by individual patients that would jeopardize safety during transportation outside the health care facility.

As was evident during our discussions with the medical staff of forensic psychiatric hospitals across the United States, Canada, and United Kingdom, there is great variability regarding safety precautions during patient transport. Decisions about level of transport are mostly made by the psychiatrist alone or by the clinical team and only sometimes in conjunction with security staff. One forensic psychiatric facility used a standard procedure for all transports regardless of risk: all patients are transported in wrist and ankle shackles by two hospital-employed security guards. There is also variability in the escort staff, including trained nursing staff, mental health workers, institutional attendees, contracted private security agents, and hospital-employed security personnel. We found no comprehensive risk assessment and management planning before transportation. Of note, one forensic facility in the United Kingdom reported that shackles are never used for patients transported outside of the facility. Notably, however, the facility also has a well-staffed intramural medical center, and medical specialists are invited to meet with the patients on hospital grounds, obviating, to a large extent, the need for transportation outside the facility. If there are concerns about risks, the number of escorts (all trained nursing staff) is increased accordingly.

Also of note, the escape of a forensic psychiatric inpatient during transportation outside of the hospital facility is a rare occurrence, irrespective of the category of staff providing the escort. For example, a hospital facility in the northeastern United States



that employs hospital security staff for escort reported the number of escapes from their facility as less than one per year, not different from hospitals that use private security agents.

A literature review on transporting forensic psychiatric patients conducted through PubMed, Psychiatry Online, PsycINFO, CINAHL, other EBSCO-host databases, Nursing Reference Center database, and other organizations and AHRQ guidelines confirmed that little has been published on this topic. The search terms used included patient transfer-[majr] OR "patient transfer"[ti] AND (mentally ill persons OR "psychiatric patient\*" OR psychiatric OR jails OR prisons OR prisoners OR criminally insane OR criminal\* OR prisoners OR criminally insane OR criminal\*) AND eng[la] AND (ambulances[mh] OR hospitals [mh]) AND (safety OR safety management OR security OR guideline[pt] OR recommendations. Other search terms included: transporting forensic psychiatric patients, transporting aggressive psychiatric patients, and transporting inmates with mental illness.

## Setting

The characteristics of a significant proportion of patients in a forensic psychiatric facility are identical to inmates in correctional facilities, and in fact, most still have connections to the Department of Corrections (DOC). Patients in the maximum security service of the Whiting Forensic Division (WFD) generally fall under one of four legal categories: restoration of competency to stand trial; evaluation and treatment of insanity acquittees (those found not guilty by reason of mental disease or defect (NGRI)); correctional inmates transferred to the hospital for evaluation, acute care or placement at end of sentence; and civil patients (either voluntary or involuntary) admitted because of agitation and risk of assault that cannot be managed in less restrictive environments. Most of the competency restoration patients and inmates transferred for evaluation or treatment will return to the DOC after their stay in the hospital. Therefore, the same attention to safety and security used by the DOC during transportation should also apply when the patients are in a forensic psychiatric facility.

By definition, those in each of the four categories described above are high-risk patients. Transporting them outside the confines of the forensic facility poses daily risk management challenges. A

careful risk assessment is needed to determine the level of escort necessary to manage the identified risks.

It is to be expected that DOC inmates and forensic patients will attempt to escape or cause serious harm to themselves or others while under escort. This is true even though they are making their escorted trip because they have a serious injury or a significant medical impairment that must be treated. Thus, it requires some effort to keep in mind the reality that patients who have been severely assaulted or who have urgent problems, such as chest pain, may pose an increased danger to themselves and others while they are being transported to an outside facility.

## Procedure

All patients admitted to the Whiting Forensic Division of Connecticut Valley Hospital are evaluated individually as it pertains to the restriction and supervision of transportation outside the facility. A transportation form was developed to provide a comprehensive and collaborative evaluative process for assessment of risk and determination of the security level needed for patients leaving the facility.

The attending psychiatrist initiates the transport risk assessment with input from the clinical team. Consideration for transport level of escort includes current legal status and history, severity of charges, and the superior court-mandated bond designation. The patient's clinical history, current clinical status, elopement risk, and transport compliance history are also assessed. In addition, clinical factors that lower risk of elopement such as being medically compromised are considered. The level of transport escort can range from accompaniment of one nursing staff member to the highest restrictive level involving agency police, nursing staff, and transport restraints.

The form completed by the attending psychiatrist in consultation with members of the treatment team, is reviewed in the Whiting Forensic Division Risk Management Committee (RMC) meeting held every morning. Members of the RMC include a representative from each unit (usually the unit director), nursing and medical leadership, facility police, quality management staff, program managers, and the directors of WFD. Should a consensus for level of escort not be met at the RMC, an intense clinical review including input from the patient's attending psychiatrist will ensue until an escort level determination is made.

Transport destinations include medical appointments, some court hearings, general hospital appointments, and transfers among the different services of WFD. Except for individuals on a promise to appear, all patients going to court for a competency hearing are transported by judicial marshals, thereby negating the necessity for completion of the transportation form. All escorts for patients' trips outside of the maximum security facility are evaluated. Patients in our enhanced-security service, a step down from the maximum security service akin to a medium-security unit, are evaluated for community trips only if they meet an identified level of high-risk concern.

Should a patient escort level designation be necessary, the form must be presented to the RMC at a time as proximal to the scheduled transport as possible and must be used within 48 hours of approval by the RMC. Each trip requires a separate discussion and signature, even if more than one trip occurs on the same day. Should the patient's clinical status change within that period, the form must be reviewed with an updated clinical assessment.

The transport form enables the RMC to act effectively as an important part of a quality assurance process, and to foster an institutional culture of violence reduction and control. As the pertinent patients' forms are reviewed, they paint a picture of the hospital's state at the moment. The agency police can anticipate the number of trips they will be expected to cover over the day and can make, in a timely manner, any adjustments or cancellations that may be indicated in view of the hospital's overall acuity state. Other opportunities for collaboration can arise as well, sharing for example the burdens imposed by limited resources. Perhaps some trips can be combined or other opportunities found for economizing on resources. Also differing views can be discussed and hopefully integrated or resolved.

All factors considered in the transport decision are documented on the transport form by numerical identification and confirmed by signature of the attending psychiatrist and the medical director. The agency police signs the form for escorts involving their custody, to acknowledge the ordered level of custody.

The attending psychiatrist and the medical officer on duty (MOD) may determine the level of escort for emergency transports to a hospital for acute medical conditions if the medical director (MD) is not readily

available during regular business hours. Outside regular business hours, the on-call MD (in consultation with the medical director reached by phone) determines the level of escort needed. For forensic patients transported and subsequently admitted to a general hospital, the attending psychiatrist (or on-call MD outside business hours) and the medical director will determine the level of hospital post needed. The transport level and hospital post assigned outside business hours will be reviewed by RMC the next business day.

The risk form is filed in the assessment section of the medical record. Only one risk assessment form for transport should exist at any time; it cannot be copied and all signatures must be original.

### **Description of Elements of the Form**

#### ***Demographic Data***

Name (of patient), hospital identification number, location of the patient (division and unit), and current legal status are required (Fig. 1).

#### ***Occasion or Reason for Level of Security Determination***

The risk form is routinely reviewed at admission, in treatment plan review meetings, and whenever changes in a patient's legal or clinical condition necessitate recording a change in the patient's level of risk. In addition, the form is reviewed before transportation outside of the facility and for assignment of hospital post for individuals admitted to a general hospital. Patients in the enhanced-security service of WFD who have access to the hospital grounds are generally exempt from this review process before their transport outside the hospital. That these patients are allowed to walk the hospital grounds is an indication that they will pose little risk in the community.

#### ***Clinical Rationale***

The clinical factors to be considered in making the determination of risks include current clinical status, factors that increase risk of elopement, and factors that lower risk of elopement. Each element under these subsections is given a numerical value for ease of documentation on the form. Numerical values are not assigned in order of importance. For example, in the Clinical Rationale box (Numbers 1–21), history of assault/violence over one year (Number 6) is

clearly of less importance than assault/violence less than one year (Number 7). Both of them carry less weight in risk determination than danger to self (Number 1).

### **Levels of Escort: A to F**

Level F, the least restrictive transport level, involves one nursing staff member, whereas Level A, the most restrictive, involves two agency police officers and one nursing staff member escorting the patient in leg irons and transport belt (for restriction of hands).

### **Level of Hospital Post: G to J**

When civil patients with minimal risk factors for violence to self or others are admitted to a general hospital, Level J of hospital post (no staff required) is assigned. Noncivil patients must always have a posting of an agency police officer to their unit in the general hospital. For high-risk patients, a nursing staff may be assigned regardless of a patient's legal status, not only to provide a comforting and supportive presence for the patient, but also to alert the general hospital staff of the patient's triggers (and early signs) of violence.

### **Transport Treatment Team**

The patient's attending completes this section of the form with input from the treatment team members. The attending assigns the treatment team's recommended level of escort (A–F) or hospital post (G–J), states the clinical rationale (1–21), and signs the recommendation.

### **Risk Management**

The unit director presents the form at the daily RMC meeting for review and discussion of the treatment team's recommended level of escort. The medical director subsequently approves the treatment team's recommendation, includes the clinical rationale for approval, signs and dates the approval. As noted above, any difference of opinion between the RMC and the treatment team regarding the recommended level of escort triggers more discussion between the RMC and the unit attending until a consensus level is reached.

### **Agency Police Verification**

For all escorts involving police custody, an agency police officer signs and dates the form and notes the time it was signed, to acknowledge the ordered transport level.

## **Discussion**

Risk assessment for determining level of escort for transport outside the hospital requires careful consideration of legal concerns and clinical stability. The patient's legal status (competency restoration, NGRI, DOC transfer, or civil patient) directly influences the risk assessment.

Patients referred for competency restoration who have serious legal charges or a high bond (often, but not always, secondary to serious charges) are usually assigned a level that includes escort by the police (Levels D–A), depending on the risk of elopement or violence. The same applies for sentenced inmates serving time in the DOC, or presentenced inmates convicted of serious charges (and facing lengthy prison sentences). Obviously, appropriate adjustments would have to be considered for fragile and frail elderly patients and severely medically compromised patients, including, for example, those with advanced dementia. Police restraints may not be indicated, but that decision must be carefully balanced with the crimes for which patients have been arrested and the current risk of dangerous behavior.

Conversely, clinically stable competency restoration patients (low risk of hurting themselves or others) with low or no bond (often indicating minimal charges) are occasionally considered safe to be transported by staff members alone on Levels E or F.

For insanity acquittees, clinical stability (including insight into their problems and expression of remorse), seriousness of the crimes for which the patients have been acquitted, and the presence of severe personality disorder with significant deceitful and manipulative behavior all play a role in determining a safe level of escort. On rare occasions, a decision is made that a police escort accompany a clinically stable and otherwise safe patient to community appointments if the crime for which the patient has been acquitted is so heinous that it causes sustained furor and angst in the community, because there are concerns that the patient-acquittee could be targeted upon recognition in the community.

Civil patients in a forensic unit fall into a special class by virtue of their having no legal entanglements and being entitled to the protections of the Patient's Bill of Rights<sup>12</sup> and of the federal and state policies that mandate treatment of patients in the least restrictive setting. Decisions about their level of escort outside the hospital are complicated by vigorous

challenge by patients' rights legal advocates of the use of police restraints to transport civil patients outside the facility. On the other hand, the police would not escort civil patients (or any patient for that matter) outside the hospital unless the escort has full custody (that is, restraints are in place).

As noted earlier, civil patients in the WFD maximum-security service are often too dangerous to be managed in a less restrictive environment, and their risk of violence is not mitigated by their civil status or trips for medical appointments outside the hospital. Most must have tight restrictions at appointments that can only be provided by police escort, thereby creating a dilemma for clinicians managing such patients and the RMC. To resolve this difficulty, the WFD administration, after consulting with the state's attorney general's office, determined that civil patients in the maximum security service of WFD require a second physician's opinion (usually by the medical director) in the form of a progress note in the patient's chart justifying the use of police restraints and escort for their transportation outside of the facility. Forensic facilities may find it prudent to seek guidance from their facility's attorneys.

### **Ethics-Related Concerns**

The need to recognize responsibly the serious hazards of escorted trips outside the secure forensic hospital is in inevitable tension with the authoritative urgings of private and government agencies to keep to a minimum any use of restraints on psychiatric patients. As highlighted by the *Hartford Courant's* investigative report in 1998, restraints pose physical and psychological problems for patients and may result in death or serious injury.<sup>13</sup> Seclusion and restraint can be misused when applied for nonclinical reasons by poorly trained custodial or clinical staff,<sup>14</sup> and failure to monitor the patient's physical status adequately may lead to fatal consequences. The Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health, issued by the American Psychiatric Association (APA),<sup>15</sup> cautions that seclusion or restraint for protective reasons (as contrasted with approved behavioral programs) is not primary treatment in itself, and does not take the place of efforts to understand and address the causes of the aberrant behavior. The Centers for Medicare and Medicaid Services (CMS) interpretive guidelines explain that "the decision to use a restraint is driven not by diagnosis, but by comprehensive individual

assessment that concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion."<sup>16</sup>

Even when it is understandable with legally involved patients, the use of police restraints for civil patients is always controversial. To these pressures, the growing strength of the recovery movement adds its force, calling our attention appropriately to concerns regarding the stigma, for example, of sitting in a waiting room in obvious restraints and in the company of a uniformed officer. Because of this stigma, more than a few providers simply decline to treat forensic patients at all except in an emergency, no matter whether their expertise is difficult or impossible to find for a patient in need of it. The point of tension is the competing right of the individual patient to be free of restraints versus the right of members of the public to conduct their affairs safely. The risk assessment form can be helpful in determining the precise level of police restraint to be imposed if indicated and specific reasons why it is warranted. Thus, the decision to restrain should avoid even the appearance of being arbitrary or lacking in fairness.

Over time, it is foreseeable that the accumulated body of completed risk assessment forms could constitute a database that would be valuable for clinical research on various aspects of risk reduction and violence prevention. Based on our experience and that of others,<sup>9</sup> it would be irresponsible not to make some effort to gather, organize, and review the data on the hospital's experiences regarding its escort decisions and their outcomes. Clearly the safety of patients, staff members, and the general public is squarely at stake. There is an additional obligation to use the public's resources with prudence and distributive justice. It is also of value in promoting the liberty interests of those being escorted. At the same time, their privacy rights need not be placed at any risk, since the data would be entered anonymously. In fact we find it rather difficult to discover any significant ethics-related cost that would be involved.

### **Conclusion**

By their very nature, trips outside the hospital tend to require the close collaboration of staff members who have a wide range of familiarity with the patient they are escorting. The staff may likewise vary considerably in their feelings toward the patient. The same applies to the knowledge of and feelings about staff members harbored by each patient. Having available the risk form,



initiated on admission, regularly updated as a part of each treatment plan revision, and finalized within hours of the trip, can be invaluable for staff members preparing for or participating in an escort without the benefit of knowing the patient involved.

It takes a tight structure, supervision, restrictions, environmental manipulation, and prompt intervention by skilled staff to maintain safety in a forensic hospital environment.<sup>17</sup> It is imperative that a semblance of the same be observed and adhered to during transport of forensic patients to appointments or activities outside of the hospital to maintain public safety. An easy proposition would be to require police escort and restraints for all patients leaving the facility, but that would be contrary to the core recovery principle of individualized assessment and interventions based on a patient's unique needs. There is also a risk that it would create an impression that forensic hospitals are really extensions of the DOC rather than hospitals. In addition, it may expose the facility to increased risk of potentially contravening the Patient's Bill of Rights. Therefore, if a one-size-fits-all order process for transporting forensic patients is more problematic than helpful, forensic psychiatric hospital facilities would have to develop procedures and guidelines for maintaining order and keeping patients and the community safe when patients go on trips outside the facility.

Since the introduction of the risk assessment form for patient transport, there has not been an escape from Whiting Forensic Division of Connecticut Valley Hospital or a serious incident during transport. The Risk Management Committee was already in existence before the escape of our index patient in 2005, but the role was expanded to include reviewing transportation of patients outside the facility. As a result, there has been no additional expense associated with the process. One could argue, however, that since escapes from forensic facilities are such rare events, implementation of the risk assessment form may have had little effect in preventing escapes. Although such an observation is understandable, the value of a robust discussion of the risk factors for escape during transportation by a group of seasoned clinicians and senior clinical administrators cannot be underestimated. The process also alerts hospital leadership to the especially dangerous patients in the establishment, individuals who could require increased monitoring, and resources for safety inside and outside the facility.

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