SPECIAL REPORT

Security Policies and Procedures at Larned State Hospital and Osawatomie State Hospital

Draft

Not for Release

October 4, 1977

Legislative Division of Post Audit
State of Kansas
Topeka

77-10

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

INTRODUCTION

At the direction of the Chairman of the Legislative Post Audit Committee, the Legislative Division of Post Audit gathered and analyzed information about the security control systems at two of the three Kansas mental health hospitals: Larned State Hospital and Osawatomie State Hospital. One auditor was sent to each of these institutions for from two to three days to observe and discuss security systems with hospital personnel, and to examine hospital and patient records as time allowed. The following is a summary of the conclusions and recommendations resulting from that review. The attachment is a summary of the field observations by Legislative Post Audit. The review focused on the following areas: general security measures; separation of voluntary and involuntary patients; patient privileges; dangerous list and criteria for dangerousness; and elopements and notification procedures.

General Security Measures

The primary concerns of both Larned State Hospital and Osawatomie State Hospital and, indeed, of any State mental health or retardation institution, are the care and safety of patients, staff, and the community-at-large. It is vitally important, therefore, that these hospitals' security control systems are adequate to meet and balance all these concerns. In general, this review seemed to indicate that there are some serious deficiencies in the security systems at both hospitals.

Larned State Hospital is housed in a campus-like setting several miles west of Larned, Kansas. Except for the State Security Hospital, the hospital grounds are not fenced off, and because there are no traffic booths or permanently posted guards on the grounds, auto and foot traffic is essentially unrestricted and unsupervised. The physical security measures at each Larned building vary according to the types of patients housed in those buildings. The State Security Hospital (which houses district court referrals, penal system referrals, minimum security patients, and the Security Behavior Ward) is surrounded by a 12-foot fence, and has barred windows, security screens, and electronically controlled gates. The Larned Youth Rehabilitation Center has bars and screens on all students' windows to prevent elopement

from the building. Adult patient wards at Larned State Hospital include three adult wards and an alcoholic treatment unit. There are no window bars on these buildings, and only one adult ward has security screens on all patients' windows. All seclusion rooms in all wards have security screens on the windows. During the last three months there were 34 elopements at Larned: 24 of these patients had been involuntarily committed (legally committed through court referral), and the remaining 10 patients were voluntary admissions (by themselves, a parent, a guardian, or as a condition of parole). Five of the 10 voluntary patients who eloped had been admitted by a parent, a guardian, or as a condition of parole. Voluntary patients admitted as a condition of parole may have a history of criminal or assaultive behavior.

Osawatomie State Hospital is located about one mile northeast of Osawatomie, Kansas. There is no fence around the hospital grounds, nor are windows barred on any of the buildings. However, most of the doors to wards are kept locked. Special security screens are on the restriction room(s) in each ward. The Youth Rehabilitation Center at Biddle includes a Security Cottage with a capacity of 8 boys, but that cottage is now vacant. During the month of July, 1977, 50 elopements occurred; 30 of them were by involuntary patients. Included in this involuntary group were 11 Youth Rehabilitation Center students.

At each hospital, current staff size is below the authorized level. For fiscal year 1978, Larned has 830 authorized positions, 756 of which are filled. Some of the 84 vacancies represent newly budgeted positions for two new security programs, one for the mentally retarded and the other for minimum security patients at State Security Hospital. Larned has 267 positions budgeted for psychiatric aides; of these, 58 positions are vacant. The duties of psychiatric aides include monitoring patients' wherebouts and activities on the ward, and escorting them off the ward to meals and other activities. Larned has eight full-time security officers.

For fiscal year 1978, Osawatomie has 640.5 budgeted positions, 610 of which are filled. The hospital currently has 71 mental health technicians, 167 psychiatric aides, and 21 persons in the Fire and Security Department.

In relation to patient security, training of psychiatric aides and mental health technicians appears to be adequate and appropriate at both hospitals. At Larned, the security officers are trained at the Hutchinson Law Enforcement Center, while members of the Osawatomie Fire and Security Department are not. The security systems at the two hospitals do not include traffic control booths at entrances to the grounds. Finally, hospital personnel have not compiled monthly and annual statistics on total elopements at each hospital, which could help them to identify and analyze the strengths and weaknesses of their security systems.

Recommendations

Larned and Osawatomie

--Larned State Hospital and Osawatomie State Hospital should consider placing bars and security screens on windows where dangerous patients might elope, such as at Osawatomie's Youth Rehabilitation Center.

--The hospitals should fill all staff vacancies among personnel involved in patient security measures as quickly as possible, so that all wards can function effectively and provide adequate patient supervision.

Osawatomie

--All security officers should receive formal law enforcement training, possibly at the Hutchinson Law Enforcement Center.

--The Security Cottage for the Osawatomie Youth Rehabilitation Center should be fully staffed so that it can be in use as soon as possible.

Separation of Voluntary and Involuntary Patients

At both Larned and Osawatomie, most wards do not have separate living quarters for voluntary or involuntary patients. Voluntary patients include those admitted by themselves, by a parent or guardian, or as a condition of parole. In some wards, patients who are considered dangerous or potentially dangerous are not separated from patients who are not dangerous. What this means, in effect, is that a voluntary patient who commits himself for a mental evaluation might be placed in the same ward--or even the same dormitory--as a patient who has committed a violent crime, such as rape or murder, and who is currently considered by the hospital staff to be dangerous or potentially dangerous. It would seem that one of the strongest arguments for separating voluntary and involuntary patients, or at least patients who might be a security risk to themselves or to others, is that tighter and more efficient security measures could be enforced over those patients.

At Larned, the Security Behavior Ward, which is housed in the State Security Hospital building, provides the additional security necessary for patients transferred there because of assaultive behavior or elopement risk; however, hospital administrators say that no voluntary patients, not even those who are voluntary as a condition

of parole, may be admitted to this ward. At Osawatomie, Adair C-1 is used to house district court referrals and other patients who are definite security risks. This separation is a definite asset in their total security system. While approving this use of Adair C-1, Legislative Post Audit raises the question of whether one floor of that building is sufficient to house all district court referrals and all patients who are definitely dangerous to themselves or others.

During the course of this review, personnel at both hospitals stressed the legal restrictions placed on them by K.S.A. 1976 Supp. 59-2928, which they felt bound them to treat patients with the "least restrictive" measures to achieve treatment goals and purposes. However, the statute requires that "The extent of the restraint or seclusion applied to the patient shall be the least restrictive measure necessary to prevent injury to the patient or others..." In Legislative Post Audit's view, this statute gives hospitals considerable leeway in providing the restrictions necessary to prevent patients who are dangerous or potentially dangerous from doing harm to themselves or to others, regardless of their voluntary or involuntary status. Hospital personnel should take more fully into consideration the protection not only of the patient, but also of other patients, hospital personnel, and the general public.

Recommendation

Larned and Osawatomie

Both Larned and Osawatomie should consider establishing a separate wing of a ward, or an entire ward if necessary, to house dangerous or potentially dangerous patients separately from patients who are not considered dangerous to themselves or to others. Such a separation would help the hospitals provide tighter and more efficient security controls over dangerous patients. The hospitals should consider providing greater staff supervision and fewer privileges for patients it considers to be dangerous or potentially dangerous, and should utilize appropriate physical security measures.

Patient Privileges

At both Larned and Osawatomie, most patients are given privileges, as an extension of their overall treatment program, to test their ability to handle a gradual increase in responsibilities. The hospitals, therefore, regard granting privileges and passes as a vital element

in determining the patient's eventual readiness to return to community life. The treatment team or the patient's doctor grants all privileges.

At Larned, the policy and procedure manual lists the following eight criteria for the issuance of a ground pass: The patient must be physically able to move about; not suicidal or an elopement risk; not currently dangerous to others or to property; not so confused or disoriented that the patient can't find his or her way around the grounds; responsible for following a time schedule; and participating in a treatment program. The pass must also be considered necessary for the patient's overall therapy and treatment. However, there is some confusion about the criteria used to grant ground passes, and about whether the ground pass policy and procedure is official. Therefore, enforcement of these criteria has not been uniform.

The clinical staff and the administrative staff at Larned view the establishment of criteria quite differently. The administrative staff feels that the surrounding communities and the press must be assured that some responsible, restrictive criteria are placed on patients who are allowed unescorted and unsupervised on the hospital grounds. Many clinical staff personnel, on the other hand, view the establishment of ground pass criteria as an encroachment on their decision-making process; they maintain that they are the only personnel qualified to determine a patient's ability to handle ground pass responsibilities, and that they must do so based on a clinical evaluation of each patient. The problem appears to lie in inadequate communication between administrative and clinical personnel as to the purposes and restrictions intended in the application of the eight established ground pass criteria. There is also a problem with the inadequate documentation in patients' records of the criteria used to grant or pull ground pass privileges.

There are widespread problems at Larned with the reporting and documentation procedures for patients who sign out for ground passes or other unescorted activities. Unless the sign-out sheets are filled in accurately and completely by the patients, unless ward aides supervise these sheets closely, and unless the aides check-in all patients after ground pass curfew, there will be a potential for patients to elope or at least be absent for some time before ward aides notice their absence.

At Osawatomie, no written ground passes are given to the patients. Instead, ground privileges are given by the treatment team and documented in each patient's medical record. According to the Superintendent, nearly 90% of all patients have ground privileges of some form. This procedure may be a contributing factor to the high number of elopements--50 in July--from Osawatomie.

Recommendations

Larned and Osawatomie

--Ward aides should closely observe all reporting and documentation procedures concerning ground passes or privileges, in order to reduce the possibility that an elopement could temporarily go unnoticed. At curfew time, each hospital should take a formal roll call of all patients who have been on evening ground passes or ground privileges.

Larned

--Hospital administrators at Larned should review ground pass criteria with the treatment teams and other personnel to determine whether they accurately reflect both the patient's ability to handle the responsibilities of a ground pass and the treatment and security concerns of administrative and clinical staff. Once agreed to, the ground pass criteria should be formally issued and followed.

Osawatomie

--Osawatomie should consider implementing a stricter control of patients on ground privileges, perhaps through a formal ground pass procedure.

Dangerous Patient List and Criteria for Dangerousness

A dangerous patient list was begun at Larned on June 20, 1977, to alert hospital personnel to patients who were considered dangerous, either currently or by history. Currently, the list includes 87 names; 30 of these are from State Security Hospital, 12 from the Youth Rehabilitation Center, and 45 from the various patient wards at Larned. Twenty-seven of the 57 patients on this list from Larned and the Youth Rehabilitation Center have ground passes.

Even though the dangerous list is meant to alert hospital personnel to dangerous or potentially dangerous patients, it does not necessarily mean that stricter or additional restrictions will be placed on those patients. At one ward, the treatment team has given an unlimited two hour ground pass to the "one really potentially dangerous" patient on the ward.

There is no list of dangerous patients kept at Osawatomie. According to the Director of Nursing, any assaultive, suicidal, or destructive patients are recognized by the ward staff, and such knowledge travels

informally around the hospital. When such a list was suggested, the Director of Nursing re-emphasized that Osawatomie is a hospital, not a prison.

Legislative Post Audit concludes that neither Larned nor Osawatomie has an adequate procedure for identifying and restricting those patients who are dangerous or potentially dangerous. While the recent efforts at Larned are a step in the right direction, the lists generated have not necessarily resulted in tighter restriction or observation of listed patients. Dangerous patient lists will be effective only when administrators and treatment teams can agree on the criteria for dangerousness, and on the restrictions to be placed upon dangerous patients.

Recommendation

Larned and Osawatomie

--A list of dangerous and potentially dangerous patients should be maintained at each State mental health hospital. This list should alert all hospital personnel to those patients who might be a security risk, either to themselves or others. In the event of an elopement, such a list would be a valuable reference for both the hospital and law enforcement officers. The purpose of a dangerous patient list should be clearly defined and communicated to the clinical staff. The hospitals should use the list for informational purposes and as a clinical guideline of patients whose privileges are to be restricted or completely eliminated.

Elopements and Notification Procedures

There have been 34 elopements from Larned in the past three months, and 50 from Osawatomie in the month of July alone. The frequency of elopements from Larned and Osawatomie is not in the best interests of the hospitals, the patients, or the citizens of Kansas. In Legislative Post Audit's view, the major factors which influence the number of elopements are:

--sound clincial judgement, based on the proper criteria
--adequate physical security measures
--adequate procedures and checks
--proper training and diligence of staff
--adequate staff.

A number of these factors have already been addressed in this report. The number of elopements at the hospitals indicates that the clinical criteria for patient privileges may not be sufficiently strict or may not be consistently enforced.

At Larned, the hospital's written procedure for "Reporting and Searching for Missing or Escaped Patients" was revised September 2, 1977 and distributed while this review was underway. This procedure replaced an earlier written procedure (May 10, 1977), essentially by requiring that any hospital staff member who discovers a patient is missing report directly to the security police, rather than to the patient's ward administrator or to the Central Nursing Office. However, under either procedure, there may be confusion about the prompt notification of security personnel. At least one ward administrator said she would search the ward's grounds or the patients' canteen before notifying security police, thereby delaying the notification procedure by as much as one-half hour.

Voluntary patients have the right to leave a hospital three days after they request discharge (K.S.A. 59-2907). At Osawatomie, some voluntary patients who elope are not pursued beyond the grounds, despite the fact that they did not follow the statutory request procedure. Of the 50 patients who eloped in July, 20 were voluntary admissions. For 11 of those 20 voluntary elopements, no pick-up order was issued, because, in the view of physicians and hospital administrators, the patients were apparently not dangerous and were capable of caring for themselves. According to Attorney General Opinion No. 77-223, law enforcement officers do have the authority to take into custody voluntary patients who have eloped without having followed the notice procedures under K.S.A. 59-2907.

The Osawatomie Youth Rehabilitation Center has experienced a high number of elopements since it was begun in 1971. This Center now houses up to 45 male offenders who have been referred by juvenile courts. In the first seven months of 1977, there have been 42 elopements, or an average of six per month. In fact, nearly 50 percent of all students admitted to the Youth Rehabilitation Center elope at least once. Under K.S.A. 1976 Supp. 21-3611, running away from a Youth Rehabilitation Center more than once constitutes aggravated delinquency. Persons charged with aggravated delinquency are prosecuted under the general criminal laws of the State, not under the juvenile code. Osawatomie students who have eloped more than once have been charged under the provisions of this statute.

Legislative Post Audit believes that both hospitals have adequate current written procedures for notification of law enforcement officers after an elopement has been reported to the Central Nursing Office and security personnel. However, breakdowns have occurred in the notification procedure when ward personnel have not followed the written

procedures. For example, not all ward personnel are aware that Central Nursing and security personnel should be notified immediately when a patient is missing, without first searching a wide area.

Recommendations

Larned

--Hospital administrators should initiate an adequate procedure to notify all personnel on all shifts of changes that affect procedures for the handling and security of patients, particularly the new notification procedure for escaped or missing patients.

Osawatomie

--In light of the recent Attorney General Opinion No. 77-223, Osawatomie should review its policy on issuing pick-up orders for voluntary patients who have eloped. Voluntary patients should be made aware that they have the right to leave three days after requesting discharge (K.S.A. 59-2907), and that they will be pursued if they elope without following proper procedures.

ATTACHMENT

INTRODUCTION

Areas Served

The State of Kansas is divided into three districts, each of which is served by one mental hospital. The Larned State Hospital district includes 51 counties, with a population of about 456,600 (19.6 percent of the State's population). The Osawatomie State Hospital district includes 23 counties, with a population of about 858,400 (36.9 percent). The Topeka State Hospital district includes the remaining 31 counties with a population of about 1,012,500 (43.5 percent).

Organization

Larned

Persons are assigned to one of Larned's four treatment units:

1. Larned State Hospital, which includes three adult wards, an Alcoholic Treatment Unit, an admissions hospital, and an adolescent ward;

2. State Security Hospital, for holding in custody, examining and treating persons committed by the courts as criminally insane, individuals determined unfit for trial, or prisoners with mental illness from Kansas penal institutions;

3. Security Behavior Ward, for treating and restricting patients who are transferred from Larned or any other State hospital whose behavior becomes assaultive or who are an elopement risk;

4. Youth Rehabilitation Center, for court-committed male juveniles.

In addition, Larned will be adding two new security programs during fiscal year 1978: a 30-bed annex to the State Security Hospital and a 30-bed security unit for the mentally retarded. Persons from any county may be referred for commitment to the State Security Hospital or the Youth Rehabilitation Center.

Osawatomie

For treatment purposes, Osawatomie State Hospital is organized into the following six sections:

1. Adair Section, which serves adult patients;

2. Medical Surgical Section, for patients who are physically ill;

3. Rush Section, which serves all patients aged 14 through 21;

4. Alcoholism Treatment Unit for alcoholic patients;

5. Senior Citizens' Section, for patients 65 and older;

6. Youth Rehabilitation Center, which provides rehabilitation for court-committed 16-and 17-year old male offenders.

Patient Population

Larned

Larned now has a patient capacity of 503, but with the addition of the two new security programs it will increase its total patient capacity to 563. As of September 5, 1977, the institution housed 443 patients. Of these, 139 (31 percent) were voluntarily admitted, usually by themselves, a parent, a guardian, or as a condition of parole. The remaining 304 (69 percent) patients were involuntary, or legally committed through court referral.

Osawatomie

Excluding the Rainbow Unit in Kansas City, Osawatomie has a total patient capacity of 505. As of September 14, 1977, the hospital's patient population was 439. Of these, 249 (57 percent) were voluntary, and the remaining 190 patients (43 percent) were involuntary.

Staff Size

Larned

For fiscal year 1978, Larned has 830 authorized positions, 756 of which are filled. Some of the 84 vacancies represent newly budgeted positions for the two new security programs. However, there has been some problem with vacancies among Larned's psychiatric aides, whose duties include monitoring patients' whereabouts and activities on the ward and escorting them off the ward to meals and other activities. Larned has 267 budgeted aide positions; of these, 58 positions are vacant (this figure includes the 35 vacancies for the new security programs). Larned has eight full-time security officers.

Osawatomie

For fiscal year 1978, Osawatomie has 640.5 budgeted positions, 610 of which are filled. The hospital currently has 71 mental health technicians, 167 psychiatric aides, and 21 persons in the Fire and Security Department.

Pressures on a Mental Health Hospital

During the course of this review, hospital personnel at both Larned and Osawatomie pointed out the numerous conflicting pressures that face a mental health hospital. These pressures result from differing opinions and perceptions about the function of mental health hospitals among the following groups and institutions:

--Patients;
--Patients' rights groups;
--Attorneys;
--Courts;
--Joint Commission on Accreditation of Hospitals;
--Doctors and hospital staff;
--State officials;
--Communities near hospital.

The challenge facing all mental health hospitals is to strike a balance between a treatment philosophy (individual treatment plan, least restrictive conditions necessary to achieve purposes of commitment) and a confinement philosophy (stop patient from harming self, other patients, hospital staff, persons in outside community).

OBSERVATIONS BY LEGISLATIVE POST AUDIT

The review and analysis of the security systems at Larned State Hospital and at Osawatomie State Hospital focused on the following areas: general security measures; separate treatment of voluntary and involuntary patients; patient privileges; dangerous patient list and criteria for dangerousness; and elopements and notification procedures.

General Security Measures

Larned

Larned State Hospital is housed in a campus-like setting several miles west of Larned, Kansas. Except for the State Security Hospital, the hospital grounds are not fenced off, and because there are no traffic booths or permanently posted guards on the grounds, auto and foot traffic is essentially unrestricted and unsupervised.

The physical security measures at each hospital building vary according to the types of patients housed in those buildings. The State Security Hospital (which houses district court referrals, penal system referrals, minimum security patients, and the Security Behavior Ward) is surrounded by a 12-foot fence, and has barred windows, security screens, and electronically controlled gates leading to the four separate wards. With two exceptions, all persons housed in the State Security Hospital are escorted by aides both within the fenced-in area and to any other areas on the hospital grounds. The two exceptions are men from the Minimum Security Ward who go unescorted to and from work assignments on the hospital grounds. The building in which the two new security programs will be housed will have a restrictive fence, locked windows, and security screens. The Youth Rehabilitation Center has bars and screens on all students' windows to prevent elopement from the building.

The various buildings and units that house patients at Larned State Hospital include three adult wards, Pinel, Meyers, and Sellers; and the Alcoholic Treatment Unit. Pinel, Sellers, and the Alcoholic Treatment Unit have no window bars, and only the seclusion rooms have screened windows. Meyers, which was originally designed for tuberculosis patients, has security screens on all patients' windows. Policies vary somewhat on when and whether the wards are locked: the Alcoholic Treatment Unit is an open ward from 8 a.m. to 9 p.m., and the three adult wards are all locked after 5 p.m., and are almost always locked during the day.

In addition to their duties as patient escorts, psychiatric aides and mental health technicians conduct a system of checks to ensure that all patients are accounted for. Basically, patients are checked at mealtimes, at bedtime, and when mediciation is given out. However, when the aide staff is too small or too busy on a particular shift, these checks are not always made or recorded. In addition, a written daily schedule of where and when patients are supposed to report to their scheduled activities or classes is given to all involved hospital personnel. If a patient fails to report to any of these activities, a staff member notifies the ward personnel.

Larned has eight full-time security officers, who are in charge of all security operations at Larned. Two security officers are on duty at all times throughout the day, and one security officer is on duty during the 11 p.m. to 7 a.m. shift. The security officers must meet all civil service requirements as policemen, and are formally trained at the Hutchinson Law Enforcement Center.

Psychiatric aides, mental health technicians, and nurses receive a formal two-week orientation program after they are hired. The second training step includes a 13-week in-service training program, based half on theory and half on clinical instruction.

Osawatomie

Osawatomie State Hospital is located about one mile northeast of Osawatomie, Kansas. There is no fence around the hospital grounds, nor are windows barred on any of the buildings. However, most of the doors to wards are kept locked. Special security screens are on the restriction room(s) in each ward. The Youth Rehabilitation Center at Biddle includes a Security Cottage with a capacity of 8 boys, but that cottage is now vacant.

Security matters at Osawatomie State Hospital are handled by the Fire and Security Department, which spends an estimated 70-75 percent of its time on matters relating to patients and security. Persons in this department receive no formal training relating to the security or handling of violent patients, but security procedures are discussed at monthly meetings within the hospital.

The primary security procedures are implemented by the hospital staff at the ward level. Nurses' training includes a four-week orientation period, which covers security policies and procedures. Training for mental health technicians and psychiatric aides includes on-the-job orientation under the supervision of ward nurses. After the patient's Comprehensive Treatment Plan is established, the ward staff makes a daily

schedule for each patient. The ward staff is supposed to check their patient rolls prior to meals, at shift changes, at curfew, and at bedtime.

In addition, the staff at each activity or class session has a list of patients who are scheduled each day. If a patient is not present at a scheduled activity or at a regular check, the ward staff will report to the Central Nursing Office, then begin a search of the immediate area. The Central Nursing Office coordinates the elopement procedure (except elopements at the Youth Rehabilitation Center), including searches and notification of law enforcement personnel.

If a treatment team thinks that a patient is dangerous, suicidal, or an elopement risk, they may restrict the patient to a room or a ward, require the staff to check the patient every 15 minutes, or assign a staff member to escort the patient when outside the ward. The degree of freedom allowed to a patient is decided by the patient's treatment team, especially the doctor. The treatment team is aware of any crimes committed by the patient, but recommends treatment based on current behavior and adjustment to responsibility. Very dangerous or violent patients at Osawatomie can be transferred to Larned, with the approval of the Division of Mental Health and Retardation Services.

Separation of Voluntary and Involuntary Patients

Larned

All persons at State Security Hospital (including the Security Behavior Ward) and the Youth Rehabilitation Center are admitted involuntarily. At Larned State Hospital, there are no separate wards for voluntary and involuntary patients. When a patient is admitted, he or she is assigned to one of the three adult wards depending on the bed spaces available, or, if the patient is an alcoholic, to the Alcoholic Treatment Unit. Because there are no facilities for women at State Security Hospital, ten women committed to Larned from the State's penal system, some with histories of violent crimes, are currently being housed in adult patient wards. The addition of the new Security Extension Ward, which will have facilities for women inmates, will help to alleviate this problem.

In the hospital administrators' and treatment team members' view, housing involuntary patients who could be considered currently or potentially dangerous in a separate building or in a separate wing of one of the adult wards goes against the dictates of a Kansas statute. K.S.A. 1976 Supp. 59-2928 says, "The extent of the restraint or seclusion applied to the patient shall be the least restrictive measure necessary to prevent injury to the patient or others..." The hospital sees such

a move toward separation as contrary to the treatment philosophy that grants a patient as much freedom and responsibility as he or she can handle, in as unstructured a setting as possible, to work toward an eventual return to community life.

Hospital administrators pointed to other problems that, in their view, would make such a separation infeasible. These include the lack of adequate physical facilities, the lack of funding resources, the lack of adequate staffing to provide the necessary additional supervision, and the disruptive nature of transferring patients back and forth to wards as their behavior dictates.

Osawatomie

Upon admission to Osawatomie State Hospital, patients are assigned to the appropriate section. Within the Adult Section, new patients are assigned to each Adair building in rotation. All district court referrals (involuntary) are assigned to Adair C-1. Likewise, all boys in the Youth Rehabilitation Center (involuntary) are separated from other patients. In all other sections, involuntary patients are placed in wards with voluntary patients. Patients' files, which are available to the ward staff, include the voluntary and involuntary status of each patient as well as the social or criminal history.

Patient Privileges

Larned

In general, when a patient is first admitted to a ward, he or she has no unescorted off-ward privileges. The treatment team on that ward reviews the patient's past history and present behavior within five days of admission and draws up a Comprehensive Treatment Plan based on the assessment of the patient's needs. Another formal review is made at the end of 30 days, and thereafter every 90 days. Among other things, the team determines how quickly a patient may be granted ground privileges. The following is a general breakdown of the steps most patients go through before receiving a ground pass:

1. Supervised off-ward activities--After admission, patients are normally escorted to and from their daily assigned activities, classes, or work programs, ranging from once to as long as the team determines this supervision is necessary.

2. Supervised group activities--Patients attend scheduled evening activities, escorted by an aide.

3. Limited off-ward activities--Patients are allowed to go unescorted to the daily activities prescribed by the treatment team.

4. Ground Pass--A patient may be given a 15-minute ground pass, and can work his pass up to a two hour pass, morning and evening.

At any time, any hospital staff member may rescind or "pull" a person's pass or privilege if that person becomes assaultive, agressive, suicidal, or an elopement risk, or violates the ground pass privilege in any way.

The hospital's policy and procedure manual lists the following eight criteria for the issuance of a ground pass: The patient must be physically able to move about; not suicidal or an elopement risk; not currently dangerous to others or to property; not so confused or disoriented that the patient can't find his or her way around the grounds; responsible for following a time schedule; and participating in a treatment program. The pass must also be considered necessary for the patient's overall therapy and treatment.

However, the treatment teams and patients' physicians do not always follow these criteria. For instance, one patient's file showed that he had a history of hostile behavior and that he was not participating in his treatment program, yet his pass was not pulled. In addition, 27 of the 57 persons the treatment teams have put on a dangerous list (excluding State Security Hospital) currently have ground passes. One problem with the use of these criteria seems to be that they are still unofficial: both the policy and procedure for granting ground passes have, so far, been issued "for review only." The treatment teams and physicians seem to be using varying criteria for issuing a ground pass, including the patient's overall behavior, the length of time the patient has been locked up, how likely it seems that the patient will violate the privileges and responsibilities of a ground pass, and clinical criteria, such as the treatment team's assessment of the patient's current needs, current mental status, mental functioning, and current behavior.

Information about why a patient received or was re-issued a ground pass is supposed to be documented in that patient's file by either an aide, a member of the treatment team, or a doctor. However, when a doctor's monthly notation of current privileges and prescribed medication for each patient is the only record made, information about why that person got the pass or had it reduced or expanded might not be fully documented or explained.

Whenever a patient leaves a ward unescorted, he or she is supposed to sign a sheet that lists the person's name, destination, time out, time due in, and time in. This sheet is placed near the aide station, but it is not supervised by an aide, so that the patient may not sign the correct time when he leaves and returns, and the aides might not be aware of when a patient left, returns, or is due back. This form is often not completely filled in by the patients. For example, of 25 names signed out between noon and 4:00 p.m. on September 8 at Pinel,

seven patients who were due back as long as two hours and fifteen minutes earlier had not signed in the "Time In" slot; four persons on that list had filled out neither the "Time Due In" nor the "Time In". This kind of record-keeping was prevalent at most of Larned's adult wards. Also, aides from at least one ward were unaware that procedures requiring patients to regularly report in from a ground pass had been changed from every two hours to every hour. This check was verbal, and not recorded, at all the adult wards. In addition, there is no formal check made at sunset to ensure that all patients who were out on an evening ground pass are accounted for.

Osawatomie

During their initial evaluation, the treatment team makes a judgment on whether a patient may be dangerous, suicidal, an elopement risk, etc. As a result of that judgment, the patient's Comprehensive Treatment Plan is formulated to fit the patient's current needs. Each new patient is restricted to the ward for 72 hours after admission. A patient who is potentially dangerous, suicidal or an elopement risk could progress through the following steps to achieve patient privileges, depending on how well the patient handles the responsibility at each step:

1. Room restriction;
2. Possible use of medicine or drugs to reduce aggressiveness;
3. Ward restriction;
4. One-to-one escort to all meals and activities outside the ward;
5. In an escorted group;
6. In an unescorted group;
7. Unescorted to individual classes and activities;
8. Complete ground privileges.

According to the Superintendent at Osawatomie, nearly 90 percent of all patients have ground privileges of some form. No written ground passes are given to patients at Osawatomie. Thus, ground privileges are clearly the rule, rather than the exception. The granting of ground privileges is a treatment team decision and is documented in the medical record by a doctor's order. Standard limitations on ground privileges include the following: the patient is not to be in "off-limits" areas defined by a map in the orientation manual; the patient's scheduled treatment program supersedes ground privileges; and the patient must return to the ward before meal time and before curfew.

Dangerous Patient List and Criteria for Dangerousness

Larned

A dangerous patient list was begun at Larned on June 20, 1977, to alert hospital personnel to patients who were considered dangerous, either currently or by history. When it was begun, the list was reviewed daily by the superintendent, director of nursing, directors of State Security Hospital and the Youth Rehabilitation Centers, and other hospital administrators. It is currently being reviewed weekly to add or delete names, or to bring up special problem patients. The security need and status of each patient on the list is not currently being reviewed weekly, but the superintendent has directed that this be done in the future. At the nurses' request, a copy of this list is now placed in each aide station. Persons in the two maximum security units at State Security Hospital are not included on the list because they are restricted to the Security building and fenced-in area.

The treatment team and patient's physician make the decision as to whether a patient should be considered dangerous. Although the criteria for dangerousness are not written, the treatment team coordinator listed the following criteria on which the teams make their decisions:

--patient's family relations
--past history
--primary reason for admission
--physician's examination
--observed ward behavior
--interpersonal relations with other patients and staff
--response to assigned treatment
--off-ward behavior.

Potentially dangerous patients include those patients who have a sudden change in behavior patterns, demonstrate depression or threaten suicide. (Potential suicides are supervised around the clock by aides.)

Currently, the list includes 87 names; 30 of these are from State Security Hospital, 12 from the Youth Rehabilitation Center, and 45 from the various patient wards at Larned. Twenty-seven of the 57 patients on this list from Larned and the Youth Rehabilitation Center have ground passes.

Even though the dangerous list is meant to alert hospital personnel to dangerous or potentially dangerous patients, it does not necessarily mean that stricter or additional restrictions will be placed on those patients. At one ward, the treatment team has given an unlimited two hour ground pass to the "one really potentially dangerous" patient on the ward.

The treatment team coordinator said that a team might "go slower in granting privileges," to a patient on the list, but added that it was still the treatment team's decision as to what privileges or restrictions a patient should have, based on clinical judgement. According to one doctor, of the 14 patients from his ward listed on the dangerous list, only one was truly dangerous and in need of constant supervision or other security restrictions.

Osawatomie

There is no list of dangerous patients kept at Osawatomie. According to the Director of Nursing, any assaultive, suicidal, or destructive patients are recognized by the ward staff, and such knowledge travels informally around the hospital. When such a list was suggested, the Director of Nursing re-emphasized that Osawatomie is a hospital, not a prison.

Elopements and Notification Procedures

Larned

During the last three months, there were 34 elopements at Larned: 13 in June, 14 in July, and 7 in August. Twenty-four of these (77 percent of elopements) were by patients from the three adult wards. In addition, 24 of these persons had been involuntarily committed. Five of the 10 voluntary patients who eloped had been admitted by a parent, a guardian, or as a condition of parole. For example, the patient who escaped from Larned State Hospital in June of 1977, who later allegedly kidnapped and raped a woman from Larned, was actually a voluntary patient by condition of parole. Seven of the persons who eloped were on the dangerous list, and two eloped while on a ground pass. One of the primary purposes of the Security Behavior Ward, which is housed in one wing of State Security Hospital, is to provide a more secure setting for patients who are or who become elopement risks.

The hospital's written procedure for "Reporting and Searching for Missing or Escaped Patients" was revised effective September 2, 1977. It replaced an earlier (May 10, 1977) procedure, essentially providing a more direct communication that a patient is missing or has escaped. The new procedure requires the hospital staff member who receives information that a patient is missing to notify the Security Police immediately, giving all available information. That person should then relay the same information to the Central Nursing Office and to his or her immediate supervisor. The Security Police officer in charge begins a search of the grounds and notifies the Pawnee County Sheriff's office and Larned Police Department immediately. The security officer's are also developing a program to use CB radios to alert farmers in the area to watch for signs of the missing patient. The Central Nursing Office determines whether a patient is dangerous to others or to himself.

The earlier procedure required the hospital staff member who learned a patient was missing to notify the patient's ward or the Central Nursing Office. The Central Nursing Office informed the ward administrator, who then initiated a search and notified Security Police. The security officer in charge notified local law enforcement personnel.

As can be seen, the new procedure seems to be more direct than the earlier one. However, because this new procedure was sent to the various wards and units throughout the hospital during this review, Post Audit could not consider how well hospital personnel knew the new procedure. When questioned about general reporting and searching procedures, most personnel were familiar with the older procedure. There did appear to be some potential for breakdown, however, in the prompt notification of security or law enforcement personnel under either procedure. At least one ward administrator said she would search the ward's grounds or the patients' canteen before notifying security police, delaying the notification by as much as one-half hour.

Osawatomie

Elopements appear to be a significant problem at Osawatomie State Hospital. For instance, in the month of July, 1977, 50 elopements occurred, 30 of them by involuntary patients. Included in this involuntary group were eleven Youth Rehabilitation Center students.

The number of elopements by students from the Youth Rehabilitation Center is quite high: in fiscal year 1976 there were 91 juvenile elopements; in fiscal year 1977 there were 58; and in the first seven months of calendar year 1977 there have been 42 elopements, or an average of six per month. In fact, nearly 50 percent of all students admitted to the Youth Rehabilitation Center elope at least once. Under K.S.A. 1976 Supp. 21-3611, running away from a Youth Rehabilitation Center more than once constitutes aggravated delinquency. Persons charged with aggravated delinquency are prosecuted under the general criminal laws of the State, not under the juvenile code. Osawatomie students who have eloped more than once have been charged under the provisions of this statute.

Following an elopement, pick-up orders are issued automatically for all court-committed patients and patients under 18. For voluntary patients over 18, pick-up orders may or may not be ordered by the patient's physician. Voluntary patients have the legal right to leave the hospital three days after they request to be discharged (K.S.A. 1976 Supp. 59-2907). For this reason, hospital administrators sometimes choose not to search for voluntary patients who have eloped, if they believe the patients are capable of taking care of themselves and are not dangerous to themselves or others. During July, 1977, pick-up orders were not issued for 11 voluntary patients who had eloped. According to Attorney General Opinion No. 77-223, law enforcement officers do have the

authority to take into custody voluntary patients who have eloped without having followed the notice procedures under K.S.A. 59-2908.

The hospital has an established procedure for reporting elopements. Once a person is noticed to be missing, the ward staff notifies the Central Nursing Office, relaying most relevant information on the patient; however, that information may not include past violent crimes. If a pick-up order is issued, Central Nursing notifies the Fire and Security Department, which begins a search. If elopement occurs during regular working hours, maintenance and grounds personnel may assist in the search. The Central Nursing Office then calls the Osawatomie police department, the Miami County Sheriff's Office, and the sheriff's office in the patient's home county. The communication and cooperation between the hospital and local law enforcement offices is good, according to the head security officer (Fire Chief).

Besides walk-away elopements, patients have also eloped by car. The two main entrances are not guarded or continually observed. Personnel in the Fire and Security Department estimated that unauthorized vehicles enter the hospital grounds about ten times per month.