International Journal of Health Sciences and Research
www.ijhsr.org ISSN: 2249-9571

Review Article

A Focus on Absconding in Mental Health: A Review of the Literature

Russell James[1], Phil Maude[2]

[1]Alfred Psychiatry, RMIT University;
[2]Associate Professor Mental Health Nursing RMIT University (Health Sciences), Adjunct Professoriate University of Tasmania (Health Sciences)

Corresponding Author: Phil Maude

Received: 20/10/2015 *Revised: 19/11/2015* *Accepted: 24/11/2015*

ABSTRACT

This paper reviews the literature concerning absconding in mental health. Absconding from mental health in patient units remains a concern and challenge to the therapeutic work conducted in the ward and can result in adverse events such as injury, suicide and even harm to others especially relatives. Careful assessment of absconding risk must occur upon admission and appropriate care interventions implemented. The literature offers insights into ways to promote a therapeutic environment and understand reasons why mental health consumers leave in patient units without pre arranged leave. If clinicians view absconding form the consumer's perspective and consider risk management interventions can be implemented in partnership with the consumer. The clinical aim should be to plan care within a therapeutic alliance with the mental health consumer.

Keywords: Absconding, Mental Health, Psychiatry, Absent Without Leave, Therapeutic Alliance

INTRODUCTION

Defining absconding can be a complicated matter. Most often thought of as any unauthorised absence of a consumer from a ward, the definition is complicated by the diversity in data collected across studies. Studies may include short absences, only absences greater than 24 hours and only failure to return from leave. In particular studies often fail to identify all absences by not including those who are discharged after absence against medical advice as well as those discharged whilst actually absent without leave. This paper reviews the literature on "absconding" or "absence without leave (AWOL)" as well as drawing upon best practice interventions to increase awareness and support high risk patients within the acute psychiatric setting. In doing so it is hoped that the management of absconding can shift from a post-incident management to a prevention and early intervention model of care. Building a therapeutic alliance with patients to best support their individual needs is central to understanding an individual's need to leave the clinical environment without notifying staff.

BACKGROUND

Within acute Mental Health Services (MHS), incidents of absconding or 'absence without leave' (AWOL) remain a significant concern, with social, economic and emotional costs. [1] Literature suggests that incidents of absconding from the mental health setting can be high, with rates of reported incidents of up to 35%. [2] Risks associated with absconding are confronting, with high incidents of harm to self and others; [3-5]

missed and cessation of treatments resulting in longer admission and rehabilitation times; medication non-compliance and substance use associated with absconding. [1,6-8] Implications of absconding are far reached, with a number of negative consequences including self-neglect or exposure to violence, aggression and homicide, loss of contact with psychiatric services as well as the potential for legal liability of hospitals. [9] Current practice and management of absconding prevention focuses on risk assessment and clinical observations. [8,10-12] The literature supports a trend towards managing the risks of hospitalization itself. The idea being that through basic nursing strategies like psychosocial interventions, managing the therapeutic landscape and supporting and nurturing the relationships between patients and MHS, absconding rates are likely to reduce.

MATERIALS AND METHODS

A broad search of the literature was conducted using several electronic databases: CINAHL, PsycINFO and Cochrane Library (Wiley Interscience). Keywords used where "abscond", "elope", "AWOL" as well as variants of these. Results incorporated English-language and peer-reviewed publications, however grey literature (e.g. conference proceedings) where not searched. A result of the search uncovered52 articles ranging from 1968 to 2014.

RESULTS

Absconding defined

From the literature, 'Absconding' or 'Absent without leave' (AWOL) are common terms used to describe the departure of a patient without staff consent or sanction from the physical boundaries of the hospital or MHS. Reported rates of absconding found in the literature range from 2.5 to 34%. [13] In spite of this, a significant problem identified in the literature was a lack of uniform definition of absconding. In particular was the failure to distinguish between patients classed as 'AWOL' and those as 'discharged against medical advice' which had contributed to much of the variation reported. [1,14] Other widespread classification inconsistencies where of patients deemed having absconded at the moment they could not be located on the ward, whilst others omitted this group and include only those patients who failed to return to hospital by midnight on the day of the incident [14] which sanction these incidents as unreliable. A realistic definition of absconding, which was highly supported in the literature following its publication was that adopted and identified by Bowers [9] who defines an incident of absconding as the absence of a patient from the ward, without permission, for more than 1 hour.

The identification of a potential absconder

The literature outlines that the typical characteristics of an absconder as being young, [5,8,9,13,15] male, [1,15] compulsory detained [2,16] having a diagnosis of schizophrenia [5,7,17-20] or personality disorder [21] and having a prior history of absconding. [13,16,17,22] Additional characteristics outlined in the literature included that of alcohol/drug misuse, [23] being single, [22] having a diagnosis of dysthymia, mania or affective disorder [1,24] and admission to hospital via the police, courts or prison. [15] A study [22] investigating characteristics of absconders, described an incident rate of up to 67% and found that most first time absconders had been formally detained in the hospital setting. Furthermore, findings from the same study suggest that once a patient had absconded, the risk of that same patient absconding again increases. This finding serves as a predictor for future absconding. [1,13] Despite this patients formally detained under mental health legislation, during their first admission, were found to be over represented in absconding statistics, whereas non-detained patients under-

represented. Another finding was that married or patients in relationships were found to be less likely to be involved in absconding incidents compared to their single/divorced or separated counterparts. [22] In addition the typical profile of patients deemed at high risk of absconding was someone who is: young; male; with a diagnosis of schizophrenia; a history of refusal of medication, involvement in officially reported ward incidents in the previous week and someone who has absconded during previous admissions. [19] In fact a mental health consumer, who has absconded on a previous admission, is roughly nine times more likely to do so again. The most alarmingly statistic found in this study was that patients who abscond are also those who are likely to refuse medications, are involved in violent incidents, and have needed to be transferred between wards (i.e. from low dependency (observation) unit to high dependency (observation) units). Subsequently, absconding rates were relatively higher in the Adolescent and Adult Challenging Behaviours areas and also in the Developmental Disability Divisions. [22] This suggests that additional strategies are required for this patient population in creating a safe and supportive environment.

What makes patients abscond?

Studies investigating patient perspectives of absconding have identified that patients abscond for many reasons, and that patients who do abscond often carry more than a single reason for doing so [7] with no main reason clearly identified. Boredom, lack of interesting activities, disturbed or challenging ward environments, perceptions of the need for and continued hospitalization as well as concerns about issues at home have all been linked to absconding. [14] Other reasons found where that there was no one reason for leaving which predominates over another. Some patients report leaving because they feel well, others to drink alcohol, others leave because they are angry about a particular care decision, whilst others because they feel neglected by staff. [7] A perceived rejection or complaint from patients, however, is identified by [14] as a major precipitating factor. It was reported that upon their return to the MHS from absconding, patients received more attention and had greater access to nursing staff, which was identified as a positive experience.

Other reports throughout the literature identified 'treatment failure' (symptoms, medication, and failure of the doctor-patient relationship) and family troubles as the main cause driving patients to abscond Likewise, while psychiatric symptomatology is linked to absconding, [7] patients often cite other rational reasons for leaving psychiatric settings. [5,14,25,26] For instance McIndoe [27] interviewed five absconders upon their return to the MHS who described the key reason for absconding was a 'sense of meaningless' on the part of the patient about hospitalisation. As well as this disturbance by other patients, stigma, disliking the staff or the food has been identified as main factors in a decision to leave without permission. [7,21] In conjunction with this, the need for hospitalisation is often questioned by patients, and absconding can be a reaction to rejecting diagnosis and subsequent treatment. Despite patients recognising the role treatment plays in recovery, many patients believe that they are not sick enough to have been detained and forced to stay in hospital. [14] It is also commonplace for media to picture the idea of mental illness as uncontrolled violence thus it is difficult for a person to identify with mental health services as fitting their need for care [28] which may permeate patients' views of one another. This notion is exacerbated within the often crowded and highly charged environment of the psychiatric setting [29] where any confrontation between patients, or between patients and staff, raises anxiety to

unbearable levels. [7] This in turn, may rouse fear and lead to absconding. Concern for home and/or property, household and family responsibilities are identified reasons from patients for absconding. [7] For some patients, admission to hospital can be a traumatic and chaotic event, especially if police are involved and when the admission process is hurried. [13,19,25,26]

Are there high risk times for absconding?

Many studies published investigated the so called 'peak time' for absconding. The distribution of time for absconding has been the subject of varying reports, with peak rates being reported during the week, [16,17,30-34] and others of no difference by day of the week. [35] Throughout the literature it is reported that absconding can and does occurs at any time of the day, however high prevalence times have been linked to reduced staffing times i.e. nursing handover. [7,22] Seasonal variations may also be a contributing factor, however strong support for this does not exist. [13] Bowers *et al.* [36] investigated the relation between junior staffing changes and adverse incidents and distribution of incidents over the working week. Findings returned inconclusive, however it was suggested that high levels of staff with reduced levels of experience had no impact upon incidents of absconding.

Return rate

The literature generally supports the notion that families and friends, ward staff, and the police all share a role in the return of patients to the clinical setting following an absconding incident. [14] However, there remains a great variation in the reported rate of absconders returning to hospital. In one study it was found that up to 63% of patients returned on their own or when encouraged by others, whilst 2% were returned by ward staff, 8% by a relative or friend, and 13% by the police. [7] A comprisable difference was found [22] with the police returning 23.6%. [13] The reason for absconding needs to be considered when examining return rates of people AWL as the literature suggests that absconding patients simply returned home to engage in normal day-to-day activities, [4,7,17,25] whilst others visited or stayed with relatives or friends. [13] Some patients absconding to pay bills or rent, whilst others to arrange the care of pets and children may have been averted if their concerns were acknowledged by staff.

How absconding occurs?

There is great variation in the ways which absconding occurs across the literature. A retrospective descriptive study of absconding and escape incidents [37] makes useful conception distinction between those who abscond, and those patients who choose to stay on the inpatient wards. Likewise, it is reported that over half of the patients who abscond voice their intention to leave prior to an event, [7] 82% leaving directly from the ward, 14% left whilst temporarily off the ward, and 3% who failed to return when permitted leave. [25] So too 61% of absconds occurred during either community outings with a reported 38% running away from the hospital site. [38] As with most absconds on these occasions appearing to be impulsive or opportunistic.

The contentious debate over locked doors vs. unlocked doors in psychiatric care continues to remain an issue. Both positive and negative ideals strew the literature for either practice. The fact remains that locking doors alone does not prevent incidents of absconding. [29] Locking doors to anywhere within a hospital setting, accentuates patient's feelings of powerlessness hopelessness and depression, excluding them from the normal, everyday world. As well as this the locking of the doors symbolises an image of mistrust of the patient by the staff. This in turn, lays a foundation to patients of negative feelings when the doors are locked. [29] Mistrust, stigmatisation, separation from normality,

and the identification of the hospital with that of a prison appear to be inextricably linked with the act of locking the doors.

Doors Locked

Despite the effectiveness of locking ward doors not being clearly established, the practice of locking the doors to the psychiatric inpatient setting remains a common intervention used in the reduction of absconding. [1,4] However, the consequences of locking doors for one individual results in an over restriction of all patients, visitors and staff. [22] Furthermore, these physical containment measures do not seem to be sufficient to reduce absconding. Absconding is often the outcome of the interaction between precipitating environmental factors, organic variables and psychological traits. [6] A conclusion can be drawn that the strategy of locking the doors is indicative and does not necessarily serve as a deterrent for the patient who wishes to abscond. [13]

Additionally, there remains some division throughout the literature with regards to the practice of locking doors to mental health units, especially when units are located within the hospital setting. It has been suggested that while locking the doors ought not to be the norm, it can be a useful adjunct in the provision of care, freeing up nursing staff from continued occupation of locking and unlocking doors, resulting in more times spent with patients engaging in therapeutic activity. [39] Besides, in some circumstances, MHS are reluctant for safety and legal reasons to keep psychiatric wards open, which further potentiates the notion of psychiatric patients as dangerous and to be feared by the community (Gudeman 2005). [40] As well as this, patients have reported that the notion of locking doors further increases feelings of being trapped and confined, leading to exacerbation of fears, and discouragement of involvement in their care. [39] Furthermore, locking doors has been associated with additional work loads of staff, as well as creating a negative atmosphere. [41]

It was reported that when the door to the inpatient wards are locked, patients report negative feelings like that of mistrust from the staff and feel the staff have of them. [29] Stigmatization, and the separation from normality are inextricably linked with the act of locking the doors. A Dutch study [42] found that there was an increase in the reported cases of aggressive occurrences which took place directly in front of the locked door. This indicates that the locking in of patients may trigger additional violence. Despite this it is suggested that it is unrealistic in striving for a 100% absconding-proof ward environment, however what is realistic is the adoption of alternative measures in order to reduce absconding through better engagement with patients in their care and treatments. [43] Nursing interventions designed to reduce absconding and better engage patients showed to be effective without the use of door locking. [4] In fact absconding rates fell significantly by 25% during the intervention period. Interventions adapted to absconding include; (i) Use of a signing in and out book for patients; (ii) Careful and supportive breaking of bad news to patients; (iii) Post ward incident debriefing of patients; (iv) Multidisciplinary review; (v) Identification of patients at high risk of absconding; (vi) Targeted nursing time daily for those high absconding risk patients; (vii) Facilitated social contact for those at high risk of absconding. A report [20] that was a reflection of Bowers work [4,5,7,9,11,19,36] reported that not only do nursing interventions intend to decrease incidents of absconding, but they appear efficacious and are aimed at improving the overall care of patients.

How do MHS manage absconding incidents?

The aftermath of an incident of absconding can leave nursing staff feeling overwhelmed. For many nurses a common

response is to contact the police. [10] Alarmingly, it was reported in the literature that police were contacted only when nurses viewed the absconding patient to be at high risk of harm to self or others and/or were legally detained. What is more alarming is that it was found that nurses commonly overlook short disappearances due to patients being perceived as low risk. [13] It is widespread practice though for staff to be willing to wait a little while to see if the patient returns independently before contacting the police. [10] There is little evidence however, in the literature for the use of community teams, in the return of an absconder to the ward. Furthermore, it is suggested that the use of patient supports should be utilised in this practice, due to the advantages for the patient and community. It is also acknowledged that should there be any safety concerns with the return of the patient to the MHS, it is ideal that the patient receive adequate intervention. Interventions accommodating pre-established relationships, providing familiarity, knowledge of possible risks and treatments which are known to the team, and it is considered to be a less threatening and coercive measure. [10]

The impact of absconding

The risks associated with absconding, to the individual, staff and public are identified in the literature. These risks provide a compelling argument for the need to develop tools and strategies to identify potential absconders. Four areas of risk associated with absconding have been identified; [9] these include; (i) risk of suicide and self-harm, (ii) risk of aggression and violence, (iii) risk of self-neglect or death, and (iv) risk of loss of confidence in the service and damage to the organisation. Furthermore, there continues to be a number of negative consequences include self-neglect or exposure to violence, aggression and homicide, loss of contact and confidence with psychiatric services. [22,44]

For those staff caring for patients who abscond, feelings of anger, guilt, responsibility, disappointment, embarrassment and a sense of failure are all well documented responses. What is more, staffs have reported that they even fear that their job could be at risk. [3,19] In one study, nurses reported that absconding caused great disturbances to the ward atmosphere, as well as producing feelings of concern and anxiety which they had not predicted, or a failure that they had not prevented the incident from occurring. [13] Incidents of absconding created issues around trust, with nurses feeling betrayed by the patient, and with families losing confidence in psychiatric services. [45] More alarmingly however, was the community's response, with the confidence of hospital services eroding following absconding events. [18]

INTERVENTIONS AND RECOMMENDATIONS FOR PRACTICE

The literature indicates that it may be possible to achieve a good level of accuracy in predicting absconding. For example the finding that patients who refuse medication on the ward are three times more likely to abscond in the following 48 hours provides a useful indicator to nursing staff. In addition to this, targeted interventions are required in allowing the event to be prevented. Additionally, a common belief amongst nursing staff working within these settings, is that in order to reduce absconding incidents, increased staffing levels are necessary to improve patient observation. [3] However, within the MHS risk assessment and observation combined are the main strategies used to maintain patient safety. [5,8,10,12]

The over arching aim of risk assessment is that of reducing harm. This is obtained through the estimation of the probability and the magnitude of future harm. [46] Within the psychiatric setting,

patients do not voluntarily enter into risk assessment nor do they often volunteer information sharing schemes in an attempt to reduce potential harm. What is noted in the literature is that the outcomes of risk assessments may not be shared with the patient deemed 'high risk' as well as the interventions adopted to manage the perceived level of risk. In some cases these interventions involved use coercive treatments, whether or not they have the potential to cause actual harm. [46] Another common strategy used in managing risk is an increase in the level of clinical observations. [8,10,11] In psychiatry, when the risk assessment is undertaken a categorisation of the level of observation is made. Categorisation involves gathering information associated with the potential of future harms. Once this has been determined, the patient is placed in a risk category that is used to guide subsequent management. This may include more restrictive care, including the implementation of care under Mental Health legislation and detention, higher doses of medications and the increase of supervision. [46] Furthermore, there is a strong trend towards managing risks through hospitalisation itself, however without utilising structured therapeutic interventions. [8] In other words, there is no expectation to proactively engage clients in psychosocial interventions as a means of managing risk. [12]

The environment within the inpatient setting has come under some criticisms from the literature, with some publications calling for a change in practice due to the overtly custodial approach taken in terms of patient management. It is within the ward environment where patients are largely supervised and observed by nurses in similar ways to that of correctional facilities. [12] Being overly controlling or paternal, or where strict limit setting measures are regularly used, are common features of psychiatric settings adopted and reported throughout the literature. [47,48] This practice has been widely viewed as counterproductive, especially when the denial of requests by patients is linked with violence, and the imposing of restrictions with acts of absconding. [8,16,42,48,49] For staff working in these environments and in managing patients who pose a risk of absconding, the application of limits attempts to actively manage and control difficult behaviours by further exacerbating problematic behaviours. Furthermore, by adopting other strategies, like that of psychosocial interventions in providing structure and alliances with patients reduces the disparity between clinicians and patients.

Psychosocial interventions have been widely used within the psychiatric setting for effective management of stress enabling, self-coping skills, aiding in relapse prevention, and psychoeducation. Mental health nurses can utilise these interventions as well as those of psychological therapies, such as cognitive behavioural strategies or motivational interviewing techniques. [12] A method of employing beneficial support to individuals is the concept of 'therapeutic time'. These periods are allocated during which nurses spend uninterrupted time with patients. [50] Benefits attributed to the use of psychosocial interventions include: improving understandings of illnesses; reframing troubled thoughts and cognitions; building motivation; enhancing treatment adherence and high levels of patent interaction which is a proactive intervention in addressing possible causes/ triggers of absconding. [12] A common complaint however, is of nurses' report that there is no time for engagement in these activities. [51] However, literature suggests the opposite for there is a greater role of these strategies within the often chaotic and busy environments of the inpatient setting, for there is a much greater need of the staff to ensure and construct useful and proactive

interventions. Additionally, mental health nurses are well placed to provide a number of these interventions due to the close involvement they have in patients care. [12] Since psychosocial interventions are collaborative and skills based, mental health nurses and patients work together by encouraging a greater sense of responsibility for each individual which in essence places trust and respect to the patient. [52]

CONCLUSION

Staffs working within the psychiatric inpatient settings need to be able to identify patient needs and respond accordingly. Careful assessment of absconding risks in patients at the point of admission, continuing through to the provision of a caring and supportive environment may be employed to reduce absconding. Furthermore, in cases of patients being identified as at risk of absconding, staff can adapt plans of care to accommodate the individualised needs of the individual. Here the literature has identified various interventions from psychosocial interventions like allocated therapeutic time, to the adoption of a holistic and multidisciplinary review process in actively engaging patients in their care. What has been well documented throughout the literature is that absconding from the psychiatric setting poses significant risks to individuals, and that the effects of incidents have a rippling effect. What has been well documented is that MHS can incorporate basic interventions to tackle absconding and shift management from post incident response to early intervention and preventative models of care, which benefit overall patient care.

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How to cite this article: James R, Maude P. A focus on absconding in mental health: a review of the literature. Int J Health Sci Res. 2015; 5(12):400-409.

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