Title

Seeking freedom: a systematic review and thematic synthesis of the literature on patients' experience of absconding from hospital

Abstract

Introduction: Absconding from psychiatric hospitals is associated with significant risks, but is difficult to assess. It is often considered a form of challenging behaviour for mental health nurses, yet there is little evidence considering the behaviour from the patient perspective.

Aim: To identify and review evidence pertaining to the experience of patients who abscond from hospital, paying particular attention to their reasons for doing so.

Method: A systematic review and thematic synthesis of eight peer-reviewed studies.

Results: The meaning patients associate with absconding is best characterised as an act of seeking freedom. Within this, four sub-themes were identified: 1) seeking freedom to find relief, 2) to regain power and control over their lives, 3) to address unmet needs and 4) opportunistically.

Discussion: Perspectives on absconding are markedly different between nurses and patients. Nurses may view absconding as challenging or deviant behaviour, whilst patients understand it as a positive experience. This is because the hospital environment is not meeting their needs.

Implications for practice: Patients decide to abscond from hospital for valid and rational reasons. Mental health nurses are in a position to understand and address the issues underpinning them with a view to reducing absconding. Further research on absconding from hospital, taking the patient's perspective, is needed.

Relevance statement:

To the best of the authors' knowledge, this paper is the first to systematically review evidence regarding patient experiences of absconding from hospital and encourages mental health nurses to consider the evidence as a whole. This insight can help mental health nurses to better understand the experience of hospital admission from the patient perspective; in doing so, they may improve standards of care and address the reasons patients abscond.

Accessible summary

What is known on the subject:

- Absconding refers to patients leaving psychiatric hospitals in an unexpected and/or unauthorised way and is often recognised as a form of challenging behaviour

- There is some research about the rates of absconding, risks associated with it and interventions to try and reduce it; however, relatively little is known about the experience

from the perspective of patients and this evidence has not previously been systematically reviewed.

What this paper adds to existing knowledge:

- Patients abscond to find relief, to regain power and control over their lives and/or to address unmet needs.
- Absconding can therefore be viewed as a means of seeking freedom.

What are the implications for practice:

- Nurses need to be aware that absconding is a positive act from the patient perspective, and work collaboratively with them to reduce factors which motivate this behaviour.
- From the point of admission, nurses have an important role to play in reducing the sense of fear, isolation and powerlessness which motivates patients to abscond.
- Practical interventions such as giving patients the time and information necessary to be involved in decision-making, or asking about their responsibilities and commitments outside of hospital, may have a significant impact on the experience of admission and reduce the risk of absconding.

Introduction

In recent years, there has been a paradigm shift in the way mental health care is delivered, as the number of psychiatric beds per capita and the average length of hospital admissions have reduced globally (Babalola et al. 2014; Muir-Cochrane et al. 2011). Consequently, the role of psychiatric hospitals has shifted from a mainstay in the provision of care to a 'last resort' option for the highest risk and most unwell patients. This has significant ramifications for nursing staff when a patient absconds (leaves hospital without permission), as their wellbeing is potentially at significant risk. Despite this, surprisingly little is known about patients' experiences of, or reasons for absconding. The aim of this review is to identify and thematically synthesise studies which address patient perspectives on absconding.

Absconding is a difficult matter to understand for several reasons. First, there are different definitions of 'absconding' and 'absconders', which causes variations in reporting and creates a methodological problem for researchers. For example, Bowers et al. (2000:646) define an incident of absconding as *"the absence of a patient from the ward, without permission, for more than 1 hour"*, whereas Dickens & Campbell (2001:545) do not specify a timeframe, they simply say, *"when (a patient's) whereabouts cannot be ascertained"*. In other cases, absconding is reported when staff are sufficiently concerned about the patient involved (Stewart & Bowers, 2010). Martin et al. (2018) have also highlighted that there is a difference between a patient truly absconding, and returning late from authorised leave; a distinction which is not consistently observed in the literature. Furthermore, some researchers distinguish between voluntary and detained patients (Dickens & Campbell, 2001), whereas others exclude those who are in hospital voluntarily or focus on clinical areas where all patients are detained under mental health legislation, such as forensic units (Mosel et al., 2010; Wilkies et al., 2014). Lastly, the legal frameworks, which determine the nature of voluntary and involuntary admissions, vary between countries and regions (Zinkler & Priebe, 2002). These variations make the recording of incidents, and comparison of results difficult (Bowers et al., 1998; James & Maude, 2015; Muir-Cochrane & Mosel, 2008; Stewart & Bowers, 2010).

Evidence is strongest regarding the risks associated with absconding. This research suggests that absconding poses a significant threat to patient safety and wellbeing. Bowers et al. (1999a) considered the risks for patients who absconded and found significant percentages to have known risks of attempted suicide (21%), self-harm (32%), substance misuse (27%) and self-neglect (16%). More recently, James & Maude (2015) identified four areas of risk associated with absconding: (i) risk of suicide and self-harm, (ii) risk of aggression and violence, (iii) risk of self-neglect or death and (iv) loss of confidence in services or damage to the organisation. A study conducted in Australia

suggests that of inpatient deaths by suicide, 20% occur after the person has absconded, although it should be noted that this study included patients with a diagnosis of depression only, and may not be representative of all inpatients (Shah & Ganesvaran, 2000). Other research has found that some will commit offences after absconding, although this occurs in relatively few cases, with suggested figures ranging from 1.4-4.6% (Wilkie et al., 2014). Absence from the ward may also result in interruption of treatment, and can result in consequently longer admissions (James & Maude 2015). There are ramifications for staff, who may respond to a patient absconding with feelings of anxiety, anger, embarrassment, guilt and a sense of failure (Bowers et al., 2005; Grotto et al., 2015; Meehan et al., 1999). Furthermore, the process of reporting incidents, conducting searches and efforts to return the patient requires resources from hospital staff and potentially police, which detracts from the care of other patients, and the disruption can have a deleterious effect on the social climate of the unit (Alexander, 2006; Bowers et al., 2005; Meehan et al., 1999). Absconding can also result in a loss of confidence in the safety of mental health services by relatives and carers, and exacerbate stigma associated with mental illness (Bowers et al., 2005). Overall, the potential harm because of absconding, highlights the importance of enhancing understanding of this phenomenon.

Discussions of absconding are often couched in a rhetoric of risk management and prevention, characterising it as a challenging behaviour (Cullen et al., 2016; Muralidharan & Fenton, 2006). Existing literature often focuses on demographic and behavioural characteristics of patients who abscond, e.g. age, ethnicity, gender, diagnosis, recent medication refusal, seasonal variation or environmental disruption (Bowers et al., 1998; Bowers et al., 2000; Gerace et al., 2015; James & Maude, 2015; Martin et al., 2018; Meehan et al. 1999; Mezey et al., 2015; Mosel et al. 2010; Muir-Cochrane & Mosel 2008; Muir-Cochrane et al. 2011; Wilkie et al., 2014). Some of the literature also examines measures to reduce absconding through restrictive interventions, such as locking ward doors (Nijman et al., 2011; Stewart & Bowers, 2011; Van der Merwe, 2009), enhanced observations (Stewart et al., 2012) and using GPS location devices to monitor patients' whereabouts (Hearn, 2013). Other studies approach the phenomenon through a more therapeutic lens and focus on models of care to reduce absconding, as well as education and support (; Bailey et al., 2016; Bowers et al., 2003; Bowers et al., 2005; Bowers et al., 2006; Bowers et al., 2014). However, even this work often takes the perspective of nursing staff or the health care organisation, rather than patients. As such, absconding is understood in a one-dimensional way, as a negative act to be addressed. To counterbalance this bias in the research literature, the aim of this review was to analyse absconding from the perspective of patients aged between 18 and 65 years of age, residing in a mental health inpatient service.

Methods

Search strategy

A detailed search strategy was devised in order to systematically identify all sources of available evidence, and applied to CINAHL, MEDLINE, PsycINFO and the Cochrane Library. Title and abstract searches were conducted using the following keywords, which were combined with the Boolean operators 'AND' and 'OR': **"**Abscond*", "AWOL", "absent without leave", "Psychiatry", "mental health", "mental disorders", Hospitals, Psychiatric", "Psychiatric Department, Hospital", "Inpatient*", "hospital*", "psychiatric unit".

Subject heading searches were conducted using the keywords "Absenteeism", "Mental Disorders", "Hospitals, Psychiatric" and "Psychiatric Department, Hospital". Where the functionality of the database allowed, these headings were 'exploded' and applied as umbrella terms to maximise the number of relevant papers identified. The subject heading searches were then combined with the title and abstract searches to create one pool of suitable results. Reference lists of appropriate papers were hand-searched for additional, relevant studies.

Inclusion and exclusion criteria

The focus of this review was patients aged between 18 and 65 years of age, residing in a mental health inpatient service, including acute admissions wards, short and long stay treatment wards and forensic services, with experience of absconding. Studies that examined absconding in the context of other clinical settings such as emergency departments or care homes were not included, as this would have broadened the scope of the review to the point where results would not have been comparable to a useful extent. Similarly, a decision was taken to exclude research pertaining to children, adolescents and older adults as the care of these populations is more specialised and the contexts of the patient experience was felt to be too diverse compared with that of working-age adults. To be included in the review, papers needed to be published in the English language. Papers published between 1986 and 2018 were considered for inclusion; those published prior to this were considered too outdated to be of relevance.

The Critical Skills Appraisal Programme (CASP) tool for qualitative research was used to assess the quality of evidence and ensure relevance to the research question (CASP, 2015). CASP allows researchers to systematically and objectively analyse the validity, results and value of qualitative research. Detailed appraisals were undertaken and then summarised in Table 2.

Analysis

Thematic synthesis was employed to extract and analyse data. This approach translates the methods used for thematic analysis of primary research for use in reviews which synthesise findings from

qualitative research. The techniques employed are commonly described as thematic analysis, however the approach allows reviewers to 'go beyond' merely summarising collective findings, by translating relevant concepts between studies (Thomas & Harden 2008).

Data were extracted from the papers in line with Vaismoradi et al.'s (2016) staged model of theme construction. The papers were initially read and re-read to ensure an understanding of the data. Meaning units, defined as *"words, sentences or paragraphs containing aspects related to each other, their content and context"* (Graneheim & Lundman, 2004:106), were then highlighted and colour-coded to combine relevant data. These groups of data were recorded in an extraction table prior to theme identification.

The entirety of the data were analysed by the first author before any decisions were made regarding the significance of codes, to ensure a broad focus and an inductive approach (Vaismoradi et al., 2016). The broad groups of colour-coded data were used to identify preliminary codes, which were compared and clustered into groups with a common meaning. This was an iterative process, whereby continual revision and comparison allowed for commonalities and connections between codes to be identified. In cases where the data was ambiguous, the first author used intellectual judgement to identify a 'best fit'. This stage of the process allowed recurrent unifying ideas to emerge as initial themes (Vaismoradi et al., 2016). Labels were subsequently devised for the emerging themes.

As noted by Vaismoradi et al. (2016), researchers must paradoxically be both immersed within the data to ensure a comprehensive understanding, yet maintain sufficient distance to allow a critical approach. In the rectification phase of analysis, they recommend that researchers distance themselves from the data for a period before verifying the themes to allow greater certainty. Therefore, following a period of distancing from the data, themes were reappraised for further verification in collaboration with the second author to ensure discussion of alternative interpretations, provide confirmability of themes and awareness of author bias.

Results

Selection of studies

From the database searches, 383 papers were identified, once duplicates were removed. The abstracts of these were screened against the inclusion criteria and 322 were excluded. The remaining 60 papers were reviewed in-depth, and five were found to meet the criteria for inclusion. The reference lists of those 60 papers were hand-searched for additional titles and three further papers identified, resulting in eight papers for review. Figure 1 depicts the results of the search

strategy. Table 1 highlights key information regarding the characteristics of each paper. Details of the characteristics of the patient samples were not always available, nor consistently recorded. However, where stated there were more men than women in most of the samples. Schizophrenia, psychosis of some type (with or without comorbid substance use) and personality disorder were the most commonly stated diagnoses. Where information was available on the legal status of the sample, they were either all involuntary or a combination of voluntary and involuntary patients. Caucasian was the most common ethnic group in all studies providing this data, followed by African or African-Caribbean and then Asian.

Quality of studies

The quality of the evidence was limited. There was no discussion of ethical approval or considerations in four of the papers (Bowers et al., 1999; Falkowski et al., 1990; McIndoe, 1986; Meehan et al., 1999). Bowers et al. (1999) referred to 'ward staff' being responsible for determining whether patients were able to give informed consent to participate in the research, but did not specify which professional groups this included or whether those staff were sufficiently skilled to make such judgements. This omission is significant, particularly as one or two interviews were terminated prematurely as it transpired the participants were too unwell to participate. The more recent papers (Martin et al. 2018; Mezey et al., 2015; Muir-Cochrane et al., 2013; Wilkie et al., 2014) showed greater consideration of ethical considerations. Furthermore, all of the papers lacked an explicit discussion of the potential role, bias or influence of the researchers in the research process; this lack of transparency indicates a lack of reflexivity, which is fundamental to rigorous qualitative research (Engward & Davis, 2015).

Five of the papers employed a semi-structured interview design (Bowers et al., 1999; Falkowski et al., 1990; McIndoe, 1986; Meehan et al., 1999; Muir-Cochrane et al., 2013), which allows for understanding of subjective, individual perspectives and the meaning which people attach to their experiences (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews are of particular value in offering a voice to those who may feel disempowered with regards to their health and illness, and may otherwise have limited opportunity for involvement in research activities (Low, 2013). Interviews were generally recorded and transcribed verbatim, which enhances the reliability of the data (Jamshed, 2014). The data resulting from these five papers was considered either quite valuable or highly valuable in terms of its contribution to the review question. However, the remaining three papers employed case note analysis (Martin et al. 2018; Mezey et al., 2015; Wilkie et al., 2014) which relied upon clinical documentation of the patients' reasons for absconding. These papers did not engage patients first-hand and may have been biased by the staff completing the

documentation. Accessing such data retrospectively also precluded the researchers from clarifying points of ambiguity with participants. Careful consideration was given to whether the papers contributed sufficient value to be included within the synthesis. Whilst the methodological limitations of doing so were noted, there is a dearth of primary qualitative research on this topic, hence the importance of including all studies which aimed to understand patient motivations for absconding was considered to outweigh the potential risks to the quality of the findings. Furthermore, these papers were all conducted in forensic services, hence the choice of methodology may reflect ethical or practical complexities in engaging directly with that population, although this was not explicitly addressed in the papers.

The sample size of the papers included in the review ranged from five (McIndoe, 1986) to 76 (Falkowski et al., 1990). Muir-Cochrane et al. (2013) included 12 participants in their study, and explained clearly the process through which data saturation was reached. However, they failed to address the inherent limitations of their recruitment strategy, which involved advertising in a community-based not-for-profit organisation; this method of purposive sampling excludes participants who are not engaged with such community services and the findings may not be generalisable to the wider population. Recruitment for all of the remaining papers involved data from participants with recent experience of having absconded during a contemporaneous hospital admission.

Quality of data collection and analysis was variable. Bowers et al. (1999) were rigorous, insofar as they interviewed participants shortly after each absconding event using an evidence-informed semi-structured interview schedule and the data were analysed using an appropriate software programme. Similarly, Muir-Cochrane et al. (2013) adopted an evidence-based checklist of criteria to ensure the efficacy of their analysis and imported data into a programme, followed by a process of repeatedly cross-checking their themes between multiple authors. Conversely, several papers failed to provide a comprehensive account of how data were analysed, or steps taken to mitigate against researcher bias and influence (Falkowski et al. 1990; Martin et al. 2018; McIndoe, 1986; Meehan et al. 1999; Mezey et al., 2015; Wilkie et al. 2014).

Analysis

Findings from these research papers were synthesised across one overarching theme of seeking freedom. Within this, four sub-themes were identified: 1) seeking freedom to find relief, 2) to regain power and control over their lives, 3) to address unmet needs and 4) opportunistically.

Seeking freedom

The overarching theme identified was *seeking freedom*. The analysis identified that the word 'abscond' or variants thereof were not used by patients, and their understanding of absconding was best conceptualised as an act of *seeking freedom.* This reflected the meaning patients attached to the behaviour and validated their experience. For some, *seeking freedom* related to having the ability to do what they wanted, when they wanted to. For example, when asked what stood out most in their mind about the time they spent away from the hospital, one participant in McIndoe's (1986:20) paper, responded "The freedom to do what I wanted to do. Freedom to feed the chickens. Make bacon and toast. Eat real food." For others, *seeking freedom* described a drive to escape the psychological and physical restrictions of the hospital; a sense of needing to "leave this place" (Wilkie et al 2014:8). This motivations was also reflected in Bowers et al.'s (1999) categorisation of participants "angrily leaving" out of frustration at being restricted, vs. "going to" somewhere they could be afforded greater liberty.

Motivations for *seeking freedom* were variable, and four subthemes were identified that described these: *seeking freedom to find relief, to regain power and control over their lives, to address an unmet need* and finally *seeking freedom opportunistically.* The themes were interrelated in many ways and it was the complex interaction between them which ultimately motivated patients to seek freedom.

Seeking freedom to find relief

A theme identified in seven papers was seeking freedom to find relief from a place that patients found intolerable, namely a psychiatric hospital. Each paper referred to aspects of the environment that they sought freedom from, including fear of other patients, unpleasant interactions with hospital staff or discomfort due to mental state.

Some patients sought freedom to find relief from the hospital environment. This could involve the physical environment, such as the noise, temperature, food, décor, lack of privacy and stuffiness (Bowers et al., 1999b; Falkowski et al., 1990; Muir-Cochrane et al., 2013) but could also relate to the hospital atmosphere, which was considered alien, stressful, volatile and claustrophobic (Bowers et al., 1999b; Meehan et al., 1999; Muir-Cochrane et al., 2013). Boredom was also raised, with patients finding it difficult to pass the time and finding little relief from hospital activity programmes (Bowers et al., 1999b; Meehan et al., 1999; Muir-Cochrane et al., 2013). Overall, patients identified the hospital environment as intolerable, driving them to abscond and seek solace elsewhere.

The stress of interacting with other patients in hospital was also identified (Bowers et al., 1999b; Falkowski et al., 1990; Meehan et al., 1999; Muir-Cochrane et al., 2013). Being around others was

described as inconvenient, irritating or anxiety-provoking; patients recounted being disrupted at night or resenting the presence of others in groups where they were expected to discuss personal issues (Falkowski et al., 1990; Meehan et al., 1999). In other cases, the experience was frightening and traumatic. Patients felt fearful of others who seemed unpredictable or behaved strangely (Bowers et al., 1999; Muir-Cochrane et al., 2013), highlighting a possible lack of understanding of others' experiences of mental illness. Patients also felt fearful of physical altercations, sexual harassment and bullying (Bowers et al., 1999b; Falkowski et al., 1990; Muir-Cochrane et al., 2013). One participant in Muir-Cochrane et al.'s study (2013:308) had witnessed another patient returning to the ward after an attempt to end their life. This sight compelled them to leave the hospital in case something similar happened to them, stating "that really frightened me, freaked me out and I thought 'hell I'm not going this way', so I took off." Interacting with other patients is inevitable in hospital, yet this evidence indicates that patients absconded to find relief from doing so when the experience was aggravating or frightening.

Of note, the physical environment, hospital atmosphere, boredom and fear of other patients were not identified by participants in the studies undertaken in forensic settings (Martin et al., 2018; Mezey et al., 2015; Wilkie et al., 2014). However, in these settings patients were more likely to identify tribunals and hearings as contributing to the mental stress of the environment and motivating them to abscond; either the anticipation of impending events, or disappointment where results had been unfavourable (Mezey et al., 2015; Wilkie et al., 2014).

In some cases, patients left hospital to find relief from their interactions with staff (Falkowski et al., 1990; Bowers et al., 1999b; McIndoe, 1986; Mezey et al., 2015; Muir-Cochrane et al., 2013). Nursing staff were the only professional group to be specifically identified and the phrases 'staff' and 'nurses' were used interchangeably. Patients described feeling neglected, ignored or belittled (Bowers et al., 1999b; McIndoe, 1986; Mezey, 2015; Muir-Cochrane et al., 2013). There was a sense of conflict between staff and patients and an 'us and them' dynamic was mentioned, with nurses being described as "the enemy" in "a garrison" (Muir-Cochrane et al., 2013:308). However, the dissatisfaction was also borne of ambiguity regarding the role of the nurse. Nurses were described as failing to meet expectations or being unable to help patients (Bowers et al., 1999b; McIndoe, 1986; Muir-Cochrane et al., 2013), yet patients were unclear about what nursing staff could or should be doing. McIndoe (1986:19) noted that patients "felt clearer guidelines were needed as to what nurses could help them with." For various reasons, nursing staff made the experience of admission more difficult and contributed to the decision to abscond.

Lastly, hospital was unbearable for some patients as a result of their mental state and they were driven to abscond by distressing thoughts or feelings which related specifically to the hospital environment (Bowers et al., 1999b; McIndoe, 1986; Mezey et al., 2015; Muir-Cochrane et al., 2013; Wilkie et al., 2014). These included paranoid delusions about the hospital environment, such as the presence of "harmful vapors" (Wilkie et al., 2014:98) or people being "after me" (Muir-Cochrane et al., 2013:307). Some also experienced command hallucinations "telling me to run away" (Wilkie et al., 2014:98).

Seeking freedom to regain power and control over their lives

The subtheme of seeking freedom to regain power and control over their lives was identified in seven of the papers. Patients associated their absconding behaviour with a need to regain control when they felt disempowered. The source of this disempowerment was failing to recognise the necessity of admission, a sense of being confined and denied autonomy, exclusion from decision-making and the broader stigma associated with being in a psychiatric hospital.

Patients did not identify as being 'unwell' or recognise the need for admission, which imbued in them a sense of futility regarding their hospital stay. Perceptions ranged from denial to ambivalence (Bowers et al., 1999b; McIndoe, 1986; Meehan et al., 1999; Muir-Cochrane et al., 2013). In some cases, patients recognised they were experiencing difficulties, but did not recognise how admission might address their problems (Meehan et al., 1999). McIndoe (1986) noted that patients' opinions diverged from that of professionals and family members involved in their admission, with patients considering their issues as more 'manageable'. Therefore, the decision to abscond was driven by this sense of futility and frustration (Bowers et al., 1999b; Martin et al., 2018; McIndoe, 1986; Meehan et al., 1999; Muir-Cochrane et al., 2013).

Frustration was also directed at the confines of the hospital, which was considered 'prison-like', with patients identifying a need to overcome a sense of physical and psychological oppression (Muir-Cochrane et al., 2013; Wilkie et al., 2014). Feeling disempowered in the hospital environment was a combination of feeling literally confined but also infantilised by their treatment. One participant described being made to "paint like a baby. You've got to clean up all the time" (McIndoe 1988:19). Another also clearly stated "I feel often disempowered because no one listens to me" (Muir-Cochrane et al., 2013:307). Absconding was therefore "not just running away from the hospital, it's telling the staff something too" (McIndoe 1986:20).

The need to *regain power and control over their lives* also related to the way decisions were made and enacted in hospital, particularly regarding treatment. Patients who absconded often assigned a

low value to their treatment and saw little meaning in decisions made about them; they identified a lack of agency and a sense of infantilization as motivating them to leave the hospital (Bowers et al., 1999b; McIndoe, 1986; Meehan et al., 1999). Decisions regarding medications were of particular significance. One patient in Bowers et al.'s (1999b:201) study epitomised this issue when they described being surrounded by staff and told to take medication; their response was "How do they know that these drugs do to people unless you take 'em yourself?" For patients who absconded, hospital became associated with coercion and dehumanisation, whereby they were not in control of what happened to them and professionals held all the power. In this regard, absconding became a way of regaining autonomy and communicating a sense of intense dissatisfaction with their circumstances.

The sense of disempowerment felt by patients could also originate from their broader social experience of living with mental illness and the associated stigma. Two papers identified that long-term dissatisfaction with being a 'psychiatric patient' (Bowers et al., 1999b; Falkowski et al., 1990), could contribute to the decision to abscond. Falkowski et al. (1990) found that 17% of their participants identified the stigma of being in psychiatric hospitals as contributing to their decision. These findings indicate that patients' need to regain power and control over their lives can also be fuelled by longer term factors, and the behaviour may indicate a generalised sense of dissatisfaction and disempowerment.

Seeking freedom to address an unmet need

The subtheme of seeking freedom to address an unmet need was identified in seven of the papers. Where patients had needs which they were unable to meet in hospital, they sought freedom to do so elsewhere. These included tending to day-to-day responsibilities, having social contact with others or acting on impulses and desires.

Patients were conscious of their usual responsibilities and obligations being neglected while they were in hospital. These were often everyday tasks, such as checking the security of their property, paying bills, checking on dependents and tending to pets (Bowers et al., 1999b; Falkowski et al., 1990; McIndoe, 1986; Meehan et al., 1999). These motivations were rational and clearly goal-directed (Martin et al., 2018).

Patients identified a need for social contact as a reason for absconding and often left in order to see friends or family. Hospital was described as a profoundly isolating place, where patients felt homesick; cut off from usual networks of support (Bowers et al., 1999b; Mezey et al., 2015). Social

needs were particularly salient when related to life events, such as the birth of a child or death within the family (Bowers et al., 1999b; Mezey et al., 2015).

A minority of patients sought freedom to act on an impulse or desire which could not be fulfilled in hospital. Such impulses included obtaining drugs or alcohol (Bowers et al., 1999b; Mezey et al., 2015; Wilkie et al., 2014;) and self-harming (McIndoe, 1986; Mezey et al., 2015). The context of these behaviours was not explored in depth, but may reflect how patients can employ maladaptive coping mechanisms in efforts to self-manage their illness. As such unmet needs are not recognised as valid or appropriate by professionals, patients may seek freedom to achieve them. Whilst this finding may seem to reinforce perceptions of absconding as a challenging or deviant behaviour, we argue that it highlights the opposite; that is, the importance of professionals acknowledging the validity of clients' desires to abscond, and addressing them accordingly.

Seeking freedom opportunistically

The final subtheme was identified by a minority of the patient sample in half of the papers (Bowers et al., 1999b; Martin et al., 2018; Meehan et al., 1999; Mezey et al., 2015). These patients were anomalous insofar as they were not necessarily finding hospital unbearable or restrictive, although this may have also been the case, but were impulsively motivated by the "visible presentation of an opportunity to leave" (Bowers et al., 1999b:201). Martin et al. (2018) noted that these patients demonstrated very few concerning behaviours or clinical indicators in the weeks preceding their absconding, unlike others within their sample. The finding that some patients made the decision to abscond simply because the opportunity presented itself is significant and provides an insight into the decision-making of those patients when offered a choice regarding whether to remain in hospital or to abscond.

Discussion

This review of eight papers was undertaken to enhance understanding of the reasons why patients abscond from psychiatric hospitals. The results of the thematic synthesis have identified that patients sought freedom from hospital to find relief, regain power or control, address unmet needs and opportunistically. Critically, the review has found that the phrase 'absconding' was absent from patients' discourse; the behaviour may be better characterised from their perspective as an act of seeking freedom. Perceived lack of freedom by patients in psychiatric hospitals and associations with prison are not novel, nor limited to those who abscond (Andes & Shattell, 2006; Gilburt et al., 2008; Lindgren et al., 2019; Valenti et al., 2013). However, this review indicates that the desire for freedom is complex, multifaceted and goes beyond an interpretation of the physical environment, but relates

also to patients' psychological experiences of admission, relationships with nursing staff and separation from their usual ways of existing and coping. The resulting desire for freedom ultimately motivates some patients to abscond from hospital.

The review identified that patients were often motivated to leave hospital by a need to find relief from the physical, psychological and social environment. The impact of the ward environment on patient experience is widely acknowledged in the literature (Donald et al., 2015; Kanerva et al., 2013; Mahoney et al., 2009;). Hence, it is unsurprising that where the environment is considered unpleasant or unsafe, it can contribute to absconding. Within the theme of seeking freedom to find relief, the role of both staff and other patients was significant. Previous studies have identified that patients may experience nursing staff as being too busy or unavailable (Donald et al., 2015; Walsh & Boyle, 2009), yet the finding that their presence can actively make hospital more unbearable is significant and raises concerns about the adverse role of the nurse in the inpatient environment. It should be noted that papers which address patient experience in general, rather than that of those who abscond, have identified interaction with staff as a positive element of the hospital experience, offering companionship and support (Nolan et al., 2011; Walsh & Boyle, 2009). This highlights that neither nursing staff nor patients can be considered as homogenous groups and subjective experiences of hospital will vary significantly. What this review has identified is that for the minority of patients who abscond, hospital is more likely to be viewed as an intolerable environment.

The finding that patients may seek freedom from hospital in order to regain power and control indicates the longstanding issue of power imbalance in mental health care remains pertinent (Kumar, 2000). The review has found that patients feel disempowered as a result of the way decisions are made and the sense of confinement, but also because of the experience of being a 'psychiatric patient' and the stigma associated with this. It has long been considered the role of mental health nurses to be aware of power imbalances and potential coercion in mental health practice, and overcome these by empowering those in their care (Miller, 2017). However, there is evidence to suggest that nurses struggle to find a balance between using power appropriately and being unnecessarily coercive; considering the need to maintain safety in the hospital environment as being in conflict with the principles of individual autonomy and recovery-oriented practice (Gerace et al., 2018; Wyder et al., 2017). Henderson (2003) found that nurses considered the involvement of patients in decision-making as requiring them to give information and share power, which most were not willing to relinquish. It is therefore unsurprising that patients interpret decision-making in hospital as paternalistic, coercive and indicative of their lack of freedom ((Andes & Shattell, 2006; Gilburt et al., 2008; Lindgren et al., 2019; Valenti et al., 2013).

The finding that services users sought freedom from hospital to address their unmet needs is an important one, which staff could easily overlook. Such unmet needs included attending to ones' usual responsibilities (such as tending to property, addressing financial matters and supporting dependents) seeking contact with familiar social networks and acting on urges or desires (such as self-harming or obtaining illicit substances). Walsh & Boyle's (2009:34-35) used-led research into how acute psychiatric services can be improved from patients' perspectives identified a similar theme of "Self-Help", i.e. "a cognitive or behavioural strategy initiated to relieve mental or psychological distress". They note that this could include maintaining contact with home, entertaining oneself through normal activities or more unconventional means of managing distress, such as self-harming, smoking and comfort-eating. They characterise behaviours as individual ways of coping, rather than challenging behaviours. In practice, whilst staff may be able to recognise the legitimacy of a need for social contact or tending to one's home, the function of behaviours such as self-harm and substance misuse are more challenging to reconcile with the role of the nurse in maintaining the safety of those in their care. However, evidence suggests that by making the conscious effort to understand patients' perspectives, the validity of their needs and their personhood beyond the inpatient unit, nurses can be empathetic even in conflictual situations (Gerace et al., 2018).

The results of this review, considered in conjunction with existing evidence, allow further understanding of absconding as a means of regaining power and control for patients, in an environment where they may feel dehumanised, confined and frustrated. This understanding challenges the conceptualisation of absconding as a deviant behaviour and illustrates that more must be done to redress the imbalance of power that exists within psychiatric hospitals and empower patients who are admitted. As the recovery model, which emphasises the importance of collaboration and partnership working (Stenhouse & Muirhead, 2017), continues to be operationalised within mental health services internationally, there is potential for progress to be made in this regard, and further research may consider the impact that the model is having.

It should also be noted that the results of this review indicate a contrast between patient reported motivations for absconding and current nursing practice in terms of assessing and managing the risks of absconding. Grotto et al. (2015) identified that mental health nurses primarily consider patients' past history of absconding and their current mental state, as observed through their conversation and behaviour, when assessing the risk of absconding. The greater the perceived risk of absconding, the more restrictive the management strategy, which may include seclusion, door-locking, increased observation and use of chemical restraint. This is at odds with the findings of this review, which suggest that such practices may in fact exacerbate a sense of powerlessness and increase a desire to

seek freedom. It is also important to note that whilst some patients identified that their desire to leave hospital could be motivated by mental state factors, this referred to specific thoughts or feelings about hospital, such as voices directing them to leave. The impact of mental state on decisions to abscond may well have been underreported in the research owing to lack of insight or a reluctance to discuss symptoms, however it seems inadequate to base an assessment of absconding risk on a general "level of unwellness" (Grotto et al., 2015:15), but rather to consider whether the patient is having specific thoughts about the hospital. Future research might consider the discrepancies between staff and patient perspective on absconding and the implications for clinical practice.

This review incorporated evidence from three different countries: the UK, Canada and Australia. No major differences were found in terms of patient motivations from these three countries despite their geographical and contextual differences, suggesting the experience of inpatients in these places are relatively similar. However, the finding that certain factors were more or less prevalent in forensic settings raises the question of why the patient experience in these environments differ from those in general acute settings and suggests that there may be lessons to learn from each in terms of improving experience.

Implications for practice

This review has highlighted a stark difference between professionals' and patients' understanding of not only absconding, but the overall experience of psychiatric hospital. Yet these findings also offer an opportunity to improve the patient experience. From the point of admission, patients' perceptions of the hospital environment should be assessed in order to identify concerns. In doing so, nurses have an opportunity to reduce the sense of fear, isolation and discomfort that drives some patients to abscond. Nurses must recognise that patients are individuals with responsibilities and commitments outside of hospital; offering practical help to ensure these are being met during admission could have a significant impact. Lastly, there is a need for greater consideration of how mental health nurses, and indeed health services in general, can offer patients a greater sense of agency during a hospital admission and overcome the pervasive sense of disempowerment which so many associate with the experience.

Conclusion

Overall, this review has highlighted that many of the reasons why patients abscond from hospital are understandable; mental health nurses are uniquely positioned to address many of these concerns and in doing so could improve standards of care for those at risk of absconding.

Declaration of interest

None. This review was carried out as part of a dissertation for the Masters in xxxxxxxxxx, xxxxxxxxxx.

There were no conflicts of interest.

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Table 1: key characteristics of studies analysed

Study	Country	Participants	Setting	Aim of study	Data collection	Key findings
McIndoe (1986)	Canada	5	Acute care	"a study that examined elopement from the perspective of the patient"	Interviews	Patients had a sense of "meaninglessness" regarding hospitalisation. Three broad themes were identified: perception of the need for hospitalisation, dissatisfaction with treatment/ward programme and the role of the nurse
Falkowski et al. (1990)	UK	76	Acute care and forensic services	"to study a new series of absconding patients in order to examine the extent of the problem, outline the patients' characteristics, and determine the outcome of absconding and its management."	Interviews	Various reasons identified as important factors in decision to abscond. Many were concerned with the hospital itself e.g. stigma of admission, disliking staff, the ward, the food and the lack of privacy. Nineteen per cent felt disturbed by other patients. Worries about homes and families were also important. A few patients left due to abnormal beliefs, fears or command hallucinations.
Meehan et al. (1999)	Australia	14	Acute care	"The aim of this study is to identify patient and environmental characteristics associated with absconding behaviour, and to gain an understanding of the behaviour from the patients' perspective."	Interviews	Six issues emerged from the study: boredom, lack of activities, disturbed ward environment, perception of need for hospitalisation, concerns about issues at home and perceived rewards from absconding
Bowers et al. (1999)	UK	52	Acute care	"A prospective study of absconding was undertaken in three NHS Trusts in the East End of London."	Interviews	Not always one, clear-cut reason. Often overlapping. Patients tended to either be "angrily leaving" or "going to" elsewhere when they absconded. Illness symptomatology alone is too simplistic to explain behaviour.
Muir-Cochrane et al. (2013)	Australia	12	Any inpatient mental health unit	"In this paper we explore why people abscond from inpatient psychiatric units and how this is	Interviews	Identified that individual, social, symbolic and physical aspects of environment all

				related to the notion of the psychiatric unit as a 'risky' environment".		contributed to absconding behaviour
Wilkie et al. (2014)	Canada	57	Forensic services	"The current study expands upon the existing literature by describing the frequency, timing, characteristics and predictors of absconding behaviours among a sample of forensic patients within a larger psychiatric hospital in Toronto, Canada."	Case note analysis	Four profiles of behaviour were identified: frustration/boredom, goal directed, symptomatic/disorganised and accidental/no intent.
Mezey et al. (2015)	London	47	Forensic services	"Our aim was to describe and differentiate factors associated with absconds and escapes by patients from medium and low security hospital facilities."	Case note analysis	Nine participants cited conflicts with staff and patients. Three referred to outside events, three identified stress due to an impending tribunal, six were driven by illness, three were accidental.
Martin et al. (2018)	Canada	33	Forensic services	"Therefore, the aim of this project was to characterize a sample of forensic inpatients who absconded in a specified time period and determine if risk factors could be identified that predicted this behavior."	Case note analysis	The majority of patients described motivations that were goal-directed. The second most common motivation was frustration. Symptomatic/disorganized and impulsive/opportunistic motivations were less common but still significant.

Table 2: Summary of critical appraisal for studies analysed

Study	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
McIndoe (1986)	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	Can't tell	Yes	Quite valuable
Falkowski et al. (1990)	Yes	Yes	Can't tell	Yes	Can't tell	No	Can't tell	No	Yes	Quite valuable
Meehan et al. (1999)	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	Can't tell	Yes	Highly valuable
Bowers et al. (1999)	No	Yes	Yes	Can't tell	Yes	No	No	Yes	Yes	Quite valuable
Muir-Cochrane et al. (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Quite valuable
Wilkie et al. (2014)	No	Yes	Yes	Yes	Can't tell	No	Yes	No	Yes	Limited value
Mezey et al. (2015)	Yes	Yes	Yes	Yes	Can't tell	No	Yes	No	Yes	Limited value
Martin et al. (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Limited value