



Archived at the Flinders Academic Commons:

<http://dspace.flinders.edu.au/dspace/>

'This is the peer reviewed version of the following article:

Mosel, K.A., Ziaian, T., Gerace, A. and Muir-Cochrane, E.C. (2010). An exploration of absconding behaviours from culturally and linguistically diverse psychiatric hospital patients in Australia. *International Journal of Culture and Mental Health*, 3(2) pp. 96-106

which has been published in final form at

DOI: <http://dx.doi.org/10.1080/17542863.2010.488324>

"This is an Accepted Manuscript of an article published by Taylor & Francis in [*International Journal of Culture and Mental Health*] on [19 Nov 2010], available online: <http://www.tandfonline.com/10.1080/17542863.2010.488324>."

Copyright (2010) Taylor & Francis.

Running title: Absconding by CALD psychiatric in-patients

An exploration of absconding behaviours from culturally and linguistically diverse psychiatric hospital patients in Australia

Krista Mosel¹, Tahereh Ziaian², Adam Gerace¹ and Eimear Muir-Cochrane^{1*}

¹ School of Nursing & Midwifery, Flinders University, Adelaide, South Australia

² School of Nursing and Midwifery, University of South Australia, Adelaide, South Australia

*Professor Eimear Muir-Cochrane

Chair of Nursing (Mental Health Nursing)

School of Nursing & Midwifery

Flinders University

GPO Box 2100 Adelaide SA 5001

eimear.muircochrane@flinders.edu.au

Abstract

Psychiatric morbidity among minority populations is believed to be higher than in the general population due to unmet health care need, and where significant health inequalities are experienced within culturally and linguistically diverse (CALD) populations (WHO 2004, 2007). Absconding (psychiatric patients running away from hospital) is a high risk event and has been linked to harm to self and others. Very little research has been conducted into the absconding behaviours of people from a CALD background. In this study, a population of in-patients from a CALD background who absconded from a psychiatric hospital were examined. Areas of analysis included identification of CALD patients that absconded more than once, diagnosis, age, ward of absconding and time of absconding events. Approximately one in six patients from a CALD background absconded in the present study, indicating that absconding is a problem of sufficient extent to warrant greater attention. The authors conclude that more efforts should be made to restructure pathways to mental health care needs among CALD populations.

Keywords

abscond, ethnicity, inpatient, multicultural, psychiatry, mental health.

Introduction

Mental health has assumed a prominent place in the agenda of international health and development and has been acknowledged as an essential ingredient to both quality of life and to physical health (Herrman 2001; Judd & Humphreys 2001; Weiss et al. 2001). The level of mental health is an important dimension of global health, with poor mental health recognized as a major health issue significantly contributing towards the burden of disease (Gispert et al. 1998; Judd & Humphreys 2001; Sanderson & Andrews 2001). Poor mental health contributes towards increased morbidity, mortality, social isolation and exclusion, and other economic and societal costs affecting the individual, families and the wider community (Weiss et al. 2001).

Mental health is a construct that remains dependent upon situation, society and culture (Herrman 2001; Summerfield 2008), yet there remains a paucity of mental health knowledge relating to those people from a culturally and linguistically diverse CALD background who come into contact with mental health services (Patterson 2000; Bhugra & Flick 2005; Hickie *et al.* 2005; Summerfield 2008). While Australia has introduced a series of program initiatives to increase access and equity in mental health service provision to CALD populations with special attention to refugees, there is very little research knowledge to guide these efforts (deAnstiss et al. 2009). The Senate Select Committee on Mental Health (SSCMH) (2006, pp. 433) found that service provision to ethnic minority populations in Australia was ‘patchy at best’, due to limited funding, inadequate performance and accountability measures to improve service access, a shortage of bilingual mental health professionals, and a lack of capacity and/or willingness among mainstream services to accommodate the needs of ethnic minority populations. Culture is recognized as one of the key contributing factors towards the determinant of health; with presentation, classification and

attribution of mental disorders varying significantly between cultures (WHO 2004, 2007; Summerfield 2008). However, data regarding the mental health of CALD populations are scarce despite experiencing significant health inequalities (WHO 2004; Resnik & Roman 2007; WHO 2007). Generating new knowledge that is specifically focused on CALD population groups and their experiences of mental health services and treatment has the ability to facilitate a greater understanding of mental health on both a multicultural and a global level. One particular area of concern involves CALD patients' experience of psychiatric hospitalisation, and the risk of patients absconding while acutely ill.

Absconding

Absconding from acute care psychiatric settings is a significant issue, with a review of literature by Bowers, Jarrett and Clark (1998) reporting a mean absconding rate of 12.6% (*Range*=2-44%), while a more recent review reported similar absconding rates between 2.5 and 34% of all admissions (Muir-Cochrane & Mosel, 2008).. This recent systematic review identified that absconding was linked to serious self-harm and harm to others, medication non-compliance, alcohol consumption, aggression and violence (Muir-Cochrane & Mosel 2008). The prevalent profile across the reviewed studies of the patient that absconded was that of a young male diagnosed with schizophrenia and detained for treatment under mental health legislation. However, over the 12-year period investigated (1996–2008) only two of 39 articles reviewed investigated ethnicity within the context of absconding. While Dickens and Campbell (2001) reported no association between ethnicity and absconding behaviour, Pages et al. (1998) asserted that many 'against medical advice' discharges (which included patients who absconded) were most likely to be non-Caucasians. The lack of investigation in

this area highlights that in-depth knowledge of the relationship between absconding and ethnicity in an Australian (neither study originated here) or overseas context does not yet exist.

Vicary and Westerman (2004) indicate that persons of Aboriginal and Torres Strait Islander (ATSI) descent are particularly disadvantaged, citing behaviours within the context of mental health that may be a reaction to dispossession, racism and oppression. There are also the factors identified by Vicary and Westerman of cultural genocide, economical disadvantage, trauma, grief and poor health outcomes. Within Australia, a number of other culturally and linguistically diverse population groups exist in addition to the ATSI population, in particular refugees, whose personal history often encompasses displacement, genocide, dispossession, war and trauma. Refugees entering Australia represent over 12% of total permanent additions to Australia, with the highest being born in Sudan and Iraq (ABS 2007). CALD population groups in Australia have been identified as bearing a disproportionate burden from unmet mental health needs when entering asylum countries, which results in significant loss to overall health and productivity (Silove 2002; Shelton 2004).

The present study examines the absconding behaviors of CALD psychiatric inpatients, in order to generate knowledge of this phenomenon within this population.

Methods

A retrospective data analysis on absconding events over 12 months from September 2006 to August 2007 within three acute care wards of a large Australian psychiatric hospital was completed. Comparisons of the CALD consumer data with the inpatient population of the wards, as well as examination of absconding events are presented.

The data examined was collected by the hospital as a normal function of their organisational audit. This study did not engage in contact with human participants, but did involve analysis of patient information that was provided to the researchers in a non re-identifiable format. Ethical approval was sought and granted by the University of South Australia and the hospital. .

Data provided to the researchers included information on consumer admissions to the hospital, detention status, gender, diagnosis, CALD status, and (for those consumers who absconded) information on absconding events such as time and date of absconding and return to ward. The number of discharges for all wards over this time period was also collected.

Data Analysis

This study was necessarily explorative and descriptive in nature, and endeavoured to describe characteristics of the CALD absconding patient and absconding events, comparing overall demographics. In this study, two types of calculation were used to determine rates of absconding: *event-based* (number of absconding events divided by number of discharged patients), and *patient-based* (number of absconding patients divided by discharges, regardless of number of absconding events per patient) calculations (see Bowers, 2000).

Definitions of terms

For the purposes of this study, absconding was defined as any time that a patient who is involuntarily detained under a mental health act leaves the premises (ward) without approval. Currently, voluntary patients who leave the ward without permission are not

recorded at this psychiatric facility as having absconded, thus data is only available concerning involuntary patients that leave without permission.

CALD patients were defined as those patients who identified themselves as ATSI or Other (i.e. non Caucasian, but not ATSI). For the purposes of this research, CALD refers to '*minority ethnic groups*', where the population in *minority* refers to those in the minority from a social, political and economic standpoint within the dominant culture (d'Ardene & Mahtani 2006), and *ethnicity* has both racial and cultural connotations, but its main characteristic is that it implies a sense of belonging or relates to a person's identity, belonging to a specific, defined group (Fernando 1991).

Results

Patient data

The three wards recorded 620 (66.13% males, 33.87% females) discharges during the period of data collection. The average age of patients was 37.37 years with the average age of CALD patients being 32.5 years. 65.32% of all patients were Caucasian ($n=405$), 11.45% were CALD ($n=71$), though 23.23% did not state their ethnicity ($n=144$). The main principal diagnoses were schizophrenic disorders ($n=57.74\%$), Major Affective Disorders (23.23%) and Personality Disorders (8.23%). The median length of stay was 22 days ($Range=<1-352$).

Of the 620 patients, 480 (337 male, 143 female) were involuntarily hospitalised. Table 1 presents the detention rates of the hospital population by ethnicity (Caucasian, CALD and Unknown).

Table 1 Involuntary hospitalisation (detention) rates of the population per ethnic group

Population groups	Hospital discharges: voluntary and detained <i>n</i> (%)	Hospital discharges: detained only <i>n</i> (%)	Detention rate of each population group %
Caucasian	405 (65.32)	318 (66.25)	78.52
CALD	71 (11.45)	60 (12.50)	84.51
Unknown	144 (23.23)	102 (21.25)	70.83
Total patients	620 (100)	480 (100)	77.42

Absconding rates – total sample

There were 64 absconding events, with the absconding rate (event-based) being 10.32% ($n=64/620$) and the rate per number of detained patients was 13.33% ($n=64/480$). Forty-nine patients were responsible for these events with 10.21% of involuntary patients absconding. 10.98% ($n=37$) of males absconded, while 8.39% ($n=12$) of females absconded. 69.39% ($n=34$) of patients that absconded were diagnosed with schizophrenic disorders, and 12.25% ($n=6$) with Bipolar Affective Disorder, while 8.16% ($n=4$) had no recorded diagnosis.

Absconding rates by ethnicity

The absconding rate of CALD detained patients was 26.67% (16/60), compared with a rate of 13.21% ($n=42/318$) Caucasian patients. This indicates an over representation of CALD patients in absconding events, based on the proportion of detained Caucasian (84.13%, *expected value* $n = 48.80$) and CALD patients (15.87%, *expected value* $n = 9.20$) in the studied wards, $\chi^2(1, N = 58) = 5.96, p = .02$ (two-tailed).

Of the 49 patients who absconded, 20.41% ($n=10$) were patients from a CALD background (60% male and 40% female). In contrast, 33 Caucasian patients absconded (87.88% male and 12.12% female). Patients from a CALD background were 1.72 times (odds ratio) more likely to abscond than Caucasian patients, a non-statistically significant result, $\chi^2(1, N = 378) = 1.98, p = .159$ (two-tailed; $p = .08$, one-tailed).

Table 2 Patients that abscond: a comparison of population group, diagnosis and sex

Principal diagnosis	Caucasian			CALD			Not Known			Total Overall (TO)		
	M <i>n</i> (%)	F <i>n</i> (%)	TO <i>n</i> (%)	M <i>n</i> (%)	F <i>n</i> (%)	TO <i>n</i> (%)	M <i>n</i> (%)	F <i>n</i> (%)	TO <i>n</i> (%)	M <i>n</i> (%)	F <i>n</i> (%)	TO <i>n</i> (%)
<i>Patients that abscond</i>												
Schizophrenic disorders	21(42.86)	2(4.08)	23(46.94)	5(10.20)	2(2.04)	7(14.29)	2(2.04)	2(2.04)	4(8.16)	28(57.14)	6(12.25)	34(69.39)
(% per population group)	(63.67)	(6.06)	(69.70)	(50.00)	(20.00)	(70.00)	(33.33)	(33.33)	(66.67)	—	—	—
(% of patients that abscond per sex)	(56.76)	(16.67)	—	(13.51)	(16.67)	—	(5.41)	(16.67)	—	(75.68)	(50.00)	—
Bipolar affective disorder	4 (8.16)	1(2.04)	5 (10.20)	1 (2.04)	—	1 (2.04)	—	—	—	5(10.20)	1 (2.04)	6 (12.25)
(% per population group)	(12.12)	(3.03)	(15.15)	(10.00)	—	(10.00)	—	—	—	—	—	—
(% of patients that abscond per sex)	(10.81)	(8.33)	—	(2.70)	—	—	—	—	—	(13.51)	(8.33)	—
Severe depressive episode	—	—	—	—	—	—	—	1 (2.04)	1 (2.04)	—	1 (2.04)	1 (2.04)
(% per population group)	—	—	—	—	—	—	—	(16.67)	(16.67)	—	—	—
(% of patients that abscond per sex)	—	—	—	—	—	—	—	(8.33)	—	—	(8.33)	(2.04)
Mental & behavioural disorder	—	—	—	—	1(2.04)	1 (2.04)	—	—	—	—	1 (2.04)	1 (2.04)
(% per population group)	—	—	—	—	(10.00)	(10.00)	—	—	—	—	—	—

(% of patients that abscond per sex)	—	—	—	—	(8.33)	—	—	—	—	(8.33)	—	
Unspecified nonorganic psychosis	1 (2.04)	1(2.04)	2 (4.08)	—	—	—	—	1(2.04)	1 (2.04)	1 (2.04)	2 (4.08)	3 (6.12)
(% per population group)	(3.03)	(3.03)	(6.06)	—	—	—	—	(16.67)	(16.67)	—	—	—
(% of patients that abscond per sex)	(2.70)	(8.33)	—	—	—	—	—	(8.33)	—	(2.70)	(16.67)	—
Not stated in data	3 (6.12)	—	3 (6.12)	—	1(2.04)	1 (2.04)	—	—	—	3 (6.12)	1 (2.04)	4 (8.16)
(% per population group)	(9.09)	—	(9.09)	—	(10.00)	(10.00)	—	—	—	—	—	—
(% of patients that abscond per sex)	(8.11)	—	—	—	(8.33)	—	—	—	—	(8.11)	(8.33)	—
Total patients that abscond	29(59.18)	4(8.16)	33(67.35)	6(12.25)	4(8.16)	10(20.41)	2(4.08)	4(8.16)	6(12.25)	37(75.51)	12(24.49)	49 (100)
(% per population group)	(87.88)	(12.12)	(100)	(60.00)	(40.00)	(100.00)	(33.33)	(66.67)	(100.00)	—	—	—
(% of patients that abscond per sex)	(78.37)	(33.33)	—	(16.22)	(33.33)	—	(5.41)	(33.33)	—	(100)	(100)	—

Table 2 provides a breakdown of diagnosis of those who absconded by gender and ethnicity. 69.70% of Caucasians ($n=23$) and 70% of CALD ($n=7$) patients who absconded were diagnosed with schizophrenic disorders, while 66.67% of patients whose ethnicity was unknown ($n=4$) were diagnosed with schizophrenic disorders. Schizophrenic disorders were by far the highest diagnosis for all groups of patients that absconded.

Gender and age in relation to principal diagnosis was compared, with the highest absconding groups then being identified. Overall, Caucasian patients who absconded were aged 33.12 years, while CALD patients who absconded were aged 32.5 years. Of Caucasian patients who absconded, 63.67% were male, diagnosed with schizophrenic disorders ($n=21$) and were aged 33.29 years. When analysing the CALD data, 50% of patients who absconded were males diagnosed with schizophrenic disorders ($n=5$) aged 31.60 years. For females who absconded, two absconding Caucasian patients (6.06%) and two absconding patients from a CALD background (20%) were females diagnosed with a schizophrenic disorder. They were aged, on average, 23 years (CALD) and 44 years (Caucasian). The detention rates of the hospital population were considered within this context. Of the overall inpatient population 11.65% were patients from a CALD background, this being comparable to the overall detained inpatient population, whereby 12.50% were patients from a CALD background. However, population groups were also examined, showing that CALD patients were detained at a higher rate (84.51%) than Caucasian patients (78.52%); and within the CALD inpatient population, the ATSI inpatient population was detained at a rate of 84.78%. Detention status was not significantly related to whether the patient was Caucasian or of a CALD background (unknown was excluded

from analysis), $\chi^2(1, N = 476) = 1.33, p = .250$ (odds ratio=patients from a CALD background were 1.49 times more likely to be on a detention order).

Comparison: patients that abscond more than once

Of ten patients who absconded more than once (and who were responsible for 25 absconding events), 70% were Caucasian ($M=32$ years) and 30% were from a CALD background ($M=29$ years). 67% of CALD patients that abscond more than once were male, while 100% of repeat Caucasian patients were male. 85.7% of Caucasian patients that absconded more than once had been diagnosed with schizophrenic disorders, while 67% of CALD patients that absconded more than once were diagnosed with schizophrenic disorders.

Ward absconding events

For CALD patients, four absconding events occurred in an acute care unit (Ward A), where the front door was locked, with the remaining twelve occurring in an open ward which catered for rural patients (Ward B). Ten absconding events from that ward were by ATSI patients. When the all patient discharges were analysed in Ward A, there were 285 discharges during the 12-month period. 75.44% of patients in this ward were Caucasian ($n=215$), with 8.77% being CALD ($n=25$), thus 8% ($n=2/25$) of patients from a CALD background absconded. In Ward B, there were 335 discharges during this period. 56.72% of patients in this ward were Caucasian ($n=190$), while 13.73% were of a CALD background ($n=46$). Therefore, in Ward B, 17.04% of CALD patients absconded ($n=8/46$).

When CALD patients abscond

All absconding patients were returned to the psychiatric facility, and no fatalities were recorded during this time period. 43.75% of absconding events from CALD patients occurred within the first 7 days of admission to hospital. CALD patients that abscond are 'absent without leave' for less time (2.79 days) than the overall absconding population (3.81 days). 56.25% of CALD patients that absconded returned within 24 hours, while 87.76% of *all* patients that absconded returned within 24 hours. When considering ATSI patients that abscond only, the days spent away increase to an average of 3.27 days.

Discussion

This research offers useful information about this psychiatric in-patient group. The findings of this study demonstrate that male and female patients that abscond from a CALD background tend to be younger than Caucasian patients that abscond and that female CALD patients abscond in higher proportions to that of female Caucasian patients.

From the available literature, the broad profile of patients that abscond are young, detained males diagnosed with Schizophrenia (Farragher, Gannon & Ahmad 1996; Quinsey & Coleman 1997; Bowers *et al.* 1999a; Meehan, Morrison & McDougall 1999; Bowers *et al.* 2000; Bowers, Alexander & Gaskell 2003; Carr 2006) and this research is in keeping with the profile of patients that abscond previously identified. Patients from a CALD background diagnosed with schizophrenic disorders who absconded were younger than their Caucasian counterparts.

Most absconding events have been identified as occurring within the first few weeks of admission, and the data collected demonstrates that this is no different for patients from a CALD background. A 100% absconding return-rate for any

population group is extremely high and is likely to be explained by the involuntary nature of absconding patients and the mandatory police involvement in ensuring their safe return. Very few studies have examined absconding return rates with Walsh *et al.* (1998) reporting return rates of 91%, with 80% returning in the first 24 hours. However, this was for the overall population of absconders, and ethnicity within this context was not examined.

The rate with which CALD patients absconded in this study suggests that it may be useful to include these population groups within an absconding risk profile. However, while these findings are suggestive that CALD patients are overrepresented as a whole, and abscond at higher rates than the dominant population group, there is not enough data to make a meaningful comparison, since the ethnicity of 23.23% of the hospital population was not known.

Concern has been expressed that there may be exaggerated assessments of risk for culturally diverse patients (Prins 1993 cited in Bowers *et al.* 2008, p. 199) and that they are more likely to be perceived as violent than their Caucasian counterparts. Exaggerated assessments of risk may also be reflected in the criteria for involuntary hospitalisation orders; whereby clinicians determine the level of risk of harm to self and others as being the basis for a detention order being issued (*Mental Health Act 1993 (SA)*, s.2 (12)). While the difference between detention orders for Caucasian and CALD patients was not significant in the present study, almost 85% of CALD patients were detained. In other studies, overall higher detention rates of the CALD inpatient population than that of Caucasians has been reported (Clark & Bowers 2000; Pierre 2002; Bhugra & Flick 2005; Nagel & Thompson 2006). However, the reasons for why the detention and absconding rates of CALD population groups are higher than other population groups are unknown, warranting further examination. Nevertheless, the

comparison between patients from a Caucasian background, versus those from a CALD background has enabled a greater understanding of the profile of CALD patients that abscond. These findings may also aid in the compilation of risk assessment upon admission and when involuntary hospitalisation through detention orders and renewal of detention orders occurs. However, generalisation from these results cannot be made as only three acute-care wards in one large Australian psychiatric hospital data were used in this research.

There are a number of possible reasons why the CALD psychiatric inpatient population absconding rates are high. These may include environmental factors, social factors and family commitments, among other considerations. However, literature to date has failed to explore the rates of absconding from this population group. Nor has it explored the higher detention rates, as well as the reasons for them absconding. There appear to be a number of reasons that may precipitate absconding (patient fear, treatment failure, boredom); however, none of them has been explored yet in the context of cultural groups, in Australia or overseas. Unsafe cultural practices within treatment units (no staff of the same origin as the patient or same-sex staff), cultural prejudices of health organisations, linguistic barriers, poor literacy and communication may facilitate a patient absconding (Brown 2001; Bhugra & Flick 2005; DOH 2005; Thomas & Anderson 2006).

Cultural safety is an important issue for psychiatric in-patients. Understanding cultural traditions and beliefs may also contribute to an understanding of patient experience and their reasons for absconding. For example, Janca and Bullen (2003) established that ATSI populations do not view *time* as a linear concept. Time is perceived as static, with important events being viewed as closer in time than less relevant events—of which hospitalisation is but one (Janca & Bullen 2003). Vouching

is also an important tool used by ATSI communities, and refers to the communication of positive and negative information about health professionals to each other. Many ATSI's will not see a non-indigenous health professional if they have not been vouched for in a positive way. This can be problematic in the case of involuntary psychiatric admissions (Vicary and Westerman 2004). Perceptions of racism result in reluctance to access mental health services (Kowanko *et al.* 2004; Larson *et al.* 2007), and may in turn lead to feelings of being unsafe and therefore lead to absconding. The forced dislocation of CALD populations (DOH 2005) can create difficulties for the recovering patient and may be inconsistent with the principles of 'least restrictive care' (WHO 1996). Loss of family and separation from own kin, together with separating an indigenous person from their land; 'missing country' (Brown 2001; Zeldenryk & Yalmambirra 2006) may also serve to provide an impetus towards absconding. Given the incidence of absconding by CALD populations, further examination of these cultural factors is warranted to explore the reasons why this population leave hospital and to address such issues.

Acknowledgements

Funding for this research was provided by a 2007 University of South Australia NHMRC Project Development Scheme Grant. Eimear Muir-Cochrane was an Associate Professor at the University of South Australia in 2007, and is now at Flinders University.

Notes on contributors

Krista Mosel, BNurs, BNg (Hons), RN, MRCNA, is a doctoral candidate and Research Assistant in the School of Nursing & Midwifery, Flinders University. She is

involved in research on risk assessment, absconding and the practices of seclusion and restraint. Krista is particularly interested in ethical issues in mental health care and the unique needs of culturally and linguistically diverse mental health consumers in Australia.

Tahereh Ziaian, BSc (Hons), MEdPsych, PhD (Health Psych), MAPS, is a Senior Lecturer and Course Co-ordinator in the School of Nursing and Midwifery, University of South Australia. She is a Community Health Psychologist with a long and extensive engagement and research experience in transcultural psychology and public health in the primary health care and mental health areas both in private and public settings.

Adam Gerace, BPsych (Hons), PhD (Psychology), MAPS, is a Postdoctoral Research Fellow (Mental Health) in the School of Nursing & Midwifery, Flinders University. He is currently involved in research on psychiatric risk assessment, as well as investigation of patient absconding. Adam's other research has focused on the psychological process of perspective taking and related empathic responses, and the evaluation of prison-based offender rehabilitation programs.

Eimear Muir-Cochrane, BSc (Hons), RN, RMHN, Grad Dip Adult Education, MNS, PhD, FACMHN, Credentialed Mental Health Nurse, is Professor and Chair of Nursing (Mental Health) within the School of Nursing & Midwifery, Flinders University, and is also a Visiting Professor at City University, London. She is Australasian Editor for the Journal of Psychiatric and Mental Health Nursing (UK). Her current research projects focus on a number of areas including absconding,

restraint and seclusion of psychiatric patients, community mental health nursing, the role of peer support workers in research and teaching, interdisciplinary education, ethics, and youth homelessness, mental health and medication issues. As a consultant, Eimear has been involved in evaluation and policy development commissioned by health departments in the Northern Territory, Australian Capital Territory and South Australia and has senior roles within the Australian College of Mental Health Nursing.

References

- Australian Bureau of Statistics (ABS). (2007). *Migration: Permanent additions to Australia's population*. Retriever 15 May 2009, from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/0/928AF7A0CB6F969FCA25732C00207852?opendocument>.
- Bhugra, D. & Flick, G.R. (2005). Pathways to care for patients with bipolar disorder. *Bipolar Disorder*, 7, 236–245.
- Bowers, L. (2000). The expression and comparison of ward incident rates. *Issues in Mental Health Nursing*, 21, 365-374.
- Bowers, L., Alexander, J. & Gaskell, C. (2003). A trial of an anti-absconding intervention in acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 10, 410–416.
- Bowers L, Jarrett M, & Clark N. (1998) Absconding: A literature review. *Journal of Psychiatric and Mental Health Nursing* 5, 343-353.
- Bowers, L., Jarrett, M., Clark, N., Kiyimba, F. & McFarlane, L. (1999). Absconding: How and when patients leave the ward – part 2. *Journal of Psychiatric and Mental Health Nursing*, 6, 207–211.
- Bowers, L., Jarrett, M., Clark, N., Kiyimba, F. & McFarlane, L. (2000). Determinants of absconding by patients on acute psychiatric wards. *Journal of Advanced Nursing*, 32(3), 644–649.
- Bowers, L., Simpson, A., Nijman, H. & Hall, C. (2008). Patient ethnicity and three psychiatric intensive care units compared: The Tompkins acute ward study. *Journal of Psychiatric and Mental Health Nursing*, 15, 195–202.
- Brown, R. (2001). Australian Indigenous mental health. *Australian and New Zealand Journal of Mental Health Nursing*, 10, 33–41.

- Carr, S. (2006). *Evidence summary: Absconded patient: clinician information*.
Retrieved 3 June 2009, from <http://www.joannabriggs.edu.au/about/home.php>
- Clark, N. & Bowers, L. (2000). Psychiatric nursing and compulsory psychiatric care.
Journal of Advanced Nursing, 31(2), 389–394.
- De Anstiss, H., Ziaian, T., Procter, N., Warland, J. & Baghurst, P. (2009). Help-seeking for Mental Health Problems in Young Refugees: A Review of the Literature with Implications for Policy, Practice, and Research. *Transcultural Psychiatry*, 46(4), 584-607
- d'Ardenne, P. & Mahtain, A. (2006). *Transcultural counselling in Action* (2nd ed.).
London: Sage.
- Department of Health (DOH) (2005). Review of mental health legislation in South Australia. Retrieved 3 June 2009, from www.dh.sa.gov.au/mental-health-unit/publications.asp
- Dickens, G.L. & Campbell, J. (2001). Absconding of patients from an independent UK psychiatric hospital: A 3-year retrospective analysis of events and characteristics of absconders. *Journal of Psychiatric and Mental Health Nursing*, 8, 543–550.
- Farragher, B., Gannon, M. & Ahmad, I. (1996). Absent without leave: Can we predict those who go AWOL? *Irish Journal of Psychological Medicine*, 13, 28–30.
- Fernando, S. (1991). *Mental health, race and culture*. London: Macmillan Mind Publication.
- Gispert, R., Ritchie, K., Rajmil, L., RuC, M., Glutting, J.P. & Roset, M. (1998). Mental health expectancy: An indicator to bridge the gap between clinical and public health perspectives of population mental health. *Acta Psychiatrica Scandinavica*, 98, 182–186.

- Herrman, H (2001). The need for mental health promotion. *Australian and New Zealand Journal of Psychiatry*, 35, 709–715.
- Hickie, I.B., Christensen, H., Davenport, T.A. & Luscombe, G.M. (2005). Can we track the impact of Australian mental health research? *Australian and New Zealand Journal of Psychiatry*, 39, 591–599.
- Hunter, E. (1996). Genocide: A public health issue. *Australian And New Zealand Journal of Public Health*, 20(6), 565–566.
- Janca, A. & Bullen, C. (2003) The Aboriginal concept of time and its mental health implications. *Australasian Psychiatry*, 11, 40–44.
- Judd, F.K. & Humphreys, L. (2001). Mental health issues for rural and remote Australia. *Australian Journal of Rural Health*, 9, 254–258.
- Kibreab, G. (2003). Citizenship rights and repatriation of refugees. *International Migration Review*, 37(1), 24–73.
- Kowanko, I., de Crespigny, C., Murray, H., Groenkjaer, M. & Emden, C. (2004) Better medication management for Aboriginal people with mental health disorders: a survey of providers. *Australian Journal of Rural Health*. 12, 253–257.
- Larson, A., Gillies, M., Howard, P.J. & Coffin, J. (2007) It's enough to make you sick: The impact of racism on the health of Aboriginal Australians. *Australian And New Zealand Journal of Public Health*, 31, 4, 322–329.
- Meehan, T., Morrison, P. & McDougall, S. (1999). Absconding behaviour: An exploratory investigation in an acute inpatient unit. *Australian & New Zealand Journal of Psychiatry*, 33, 533–537.
- Muir-Cochrane, E, & Mosel, K, (2008). Absconding: A review of the literature 1996–2008. *International Journal of Mental Health Nursing*, 17, 370–378.

- Nagel, T. & Thompson, C. (2006). Aboriginal mental health workers and the improving Indigenous mental health service delivery model in the 'Top End'. *Australasian Psychiatry*, 14(3), 291–294.
- Pages, K.P., Russo, J.E., Wingerson, D.K., Ries, R.K., Byrne, P.P. & Cowley, D.S. (1998). Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital. *Psychiatric Services*, 49, 1187–1192.
- Patterson, C. (2000). Systematic overview of rural health research In Australia published in the serial literature. *Australian Journal of Rural Health*, 8, 286–293.
- Pierre, S.A. (2002). Legal, social, cultural and political developments in mental health care in the UK: The Liverpool black mental health service users' perspective. *Journal of Psychiatric and Mental Health Nursing*, 9, 103–110.
- Quinsey, V.L. & Coleman, G. (1997). Proximal antecedents of eloping and reoffending among supervised mentally disordered offenders. *Journal of Interpersonal Violence*, 12, 794.
- Resnik, D.B. & Roman, G. (2007). Health, justice, and the environment. *Bioethics*, 21(4), 230–241.
- Sanderson, K. & Andrews, G. (2001). Mental disorders and burden of disease: How was disability estimated and is it valid? *Australian and New Zealand Journal of Psychiatry*, 35, 668–676.
- Senate Select Committee on Mental Health. (SSCMH) (2006). *A national approach to mental health: From crisis to community*. Retrieved 11 March 2009, from http://www.aph.gov.au/SENATE/committee/mentalhealth_ctte/report/index.htm

- Shelton, D. (2004). Experiences of detained young offenders in need of mental health care. *Journal of Nursing Scholarship*, 36(2), 129–133.
- Silove, D. (2002). The asylum debacle in Australia: A challenge for psychiatry. *Australian and New Zealand Journal of Psychiatry*, 36, 290–296.
- Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal*, 336, 992–994.
- Thomas, D.P. & Anderson, I.P.S. (2006). Use of emergency departments by Aboriginal and Torres Strait Islander people. *Emergency Medicine Australasia*, 18, 68–76.
- Vicary, D. & Westerman, T. (2004). That's just the way he is: Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3(3), 1–10.
- Walsh, E., Rooney, S., Sloan, D., McCauley, P., Mulvaney, F., O'Callaghan, E. & Larkin, C. (1998). Irish psychiatric absconders: characteristics and outcome. *Psychiatric Bulletin*, 22, 351–353.
- Weiss, M.G., Isaac, M., S.R., Parkar, S.R., Chowdhury, A.N. & Raguram, R. (2001). Global, national, and local approaches to mental health: Examples from India. *Tropical Medicine and International Health*, 1, pp. 4–23.
- WHO. (1996). *Mental health care law: Ten basic principles*. Geneva: WHO. Retriever 11 May 2009, from http://www.who.int/mental_health/media/en/75.pdf
- WHO. (2004). *Gender in mental health research*. Geneva: WHO. Retrieved 31 May 2009, from <http://www.who.int/gender/en/>
- WHO. (2007). *Mental health*. Geneva: WHO. Retrieved 23 May 2009, from http://www.who.int/topics/mental_health/en/

Zeldenryk, L. & Yalmambirra, L. (2006). Occupational deprivation: A consequence of Australia's policy of assimilation. *Australian Occupational Therapy Journal*, 53, 43–46.