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Absconding: A review of the literature 1996–2008

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Abstract

Absconding is a significant problem with potential for harm to patients or the general public. The consequences of absconding include physical harm, prolonged treatment time, and substantial economic costs. The aim of this systematic literature review is to synthesize quality literature about absconding from psychiatric facilities, identify gaps in knowledge, and make recommendations for practice. An electronic search yielded 39 journal articles that met the review criteria. Findings demonstrate that a single definition of absconding remains elusive, making the prevalence of absconding difficult to establish. Absconding events are multifactorial, with environmental, psychosocial, and organic aspects. Negative consequences exist including violence, aggression, and self-neglect and harm to self and others. Papers are clustered around the following themes: harm and risk, absconder profiles, absconding rates, and perceptions of nurses and patients. Nursing interventions designed to decrease absconding have been implemented with success, but only in a few studies and in Australia, none have been reported in the literature to date. Further research is required to identify appropriate nursing based interventions that may prove useful in reducing the risk of absconding.

Keywords: absconding, inpatient, literature review, management strategies

BACKGROUND

Absconding from hospital wards (leaving without permission) remains a significant health issue with social, economic, and health costs. The mean rate of absconding has been previously documented as 12.6 per 100 patients with a range of 2–44 (Bowers et al. 1998). The effects of absconding can be devastating, with studies reporting suicide rates between 20% and 30% of patients who have left the ward without permission (Crammer 1984; Niskanen et al. 1974). A previous literature review was conducted on papers written on absconding between 1950 and 1996 (Bowers et al. 1998) reflective of patient absconding behaviours and the nature of acute inpatient psychiatric units a decade ago. However, a comprehensive profile was not established from this review. In addition, evidence summaries regarding absconding were compiled on behalf of The Joanna Briggs Institute (Carr 2006; Lockwood 2007), yet only nine studies were included in these summaries. A recent Cochrane review of containment strategies for people with serious mental illness (Muralidharan & Fenton 2006) found that current practices are not evidence-based, but derive from local beliefs about the efficacy of locking doors to increase the safety of the ward population. Absconding has also been linked to harm to others (infrequently homicide) and to illegal drug use (Bowers et al. 2005). There is a large social and economic cost of absconding with police involved in returning between 13% and 33% of absconders to the ward (Bowers et al. 1998; 1999a) – clearly a drain on their resources. Additional risks of absconding include missed treatment, resulting in longer rehabilitation times, or lack of treatment altogether. Bowers et al. (1998) identified a number of negative consequences evident from the act of absconding, in addition to the aforementioned, and include self-neglect or exposure from the elements, violence, aggression, homicide, loss of contact and confidence with psychiatric services, and potential legal liability for the hospital. In addition, very little research in Australia has been conducted into absconding behaviours of psychiatric patients with only four Australian papers being published between 1996 and 2008.

AIM

This paper examines literature on absconding from January 1996 to April 2008 to examine and synthesize current knowledge about absconding worldwide, identify gaps in the literature, and make recommendations for best practice in the care of people at risk of absconding from psychiatric institutions.

REVIEW METHODOLOGY

Type of review

The exponential growth of literature available to assist in developing best health practices has resulted in systematic literature reviews, providing a useful tool for the nursing profession (Mulrow 1994; Schneider et al. 2004). Such a review enables the reduction of large quantities of information to more manageable levels, allows integration of critical pieces of information, is an efficient technique, can establish generalizability, assesses consistency of relationships, may explain data inconsistencies or conflicts, and may increase power by pooling results (Bowman 2007; Mulrow 1994). This systematic literature review is based on the guidelines outlined in the Centre for Reviews and Dissemination (2007), The Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green 2006), and the Journal of Advanced Nursing (2007).

While some of the literature contained aspects of quantitative data, the majority of findings were qualitative in nature. Hence, a thematic synthesis of the data was undertaken, using quality appraisal as a basis to judge findings. To ensure rigour within the review, the data were thematically analysed beginning with a basic reporting of results (Rodgers et al. 2007; p. 9) 'developing a preliminary synthesis; exploring relationships in the data; explanation on why and how these interventions are with effect; developing a theoretical model of how the interventions work, why and for whom and assessing the robustness of the synthesis product' (Popay et al. 2006; p. 12) By utilizing this framework, a concise and rigorous narrative synthesis in this systematic literature review occurred.

Electronic search process and strategy

Databases searched were CINAHL (1996–2008), the Cochrane Library, Academic Search Elite, The Joanna Briggs Institute, Health Source Academic Version, PsycInfo through Ebsco, Wiley Interscience, and the British Medical Journal. Keywords were 'abscond', 'escape', 'elope', 'AWOL', 'runaway', and variants between the years 1996 and 2008.

The literature were analysed using a mixed-method approach adapted from The Joanna Briggs Institute (2007b) and the Cochrane Handbook (Higgins & Green 2006), in conjunction with Graneheim and Lundman (2004) and Schneider et al. (2004). Each article was reviewed in its entirety and key phrases were pasted onto a computerized spreadsheet to ensure that the context of meanings were intact. Qualitative articles were judged for trustworthiness, encompassing credibility, dependability, and transferability (Graneheim & Lundman 2004), with credibility being assessed as unequivocal, credible, or unsupported (The Joanna Briggs Institute 2007b). Articles that contained

quantitative data were ranked in terms of levels of evidence, with Level 1: evidence obtained from review of all randomized control trials (RCTs); Level 2: evidence from at least one properly designed RCT; Level 3(1): well-designed control trial without randomization; Level 3(2): comparative study without randomization but with control and allocation; Level 3(3): comparative study with the control being historical; and Level 4: evidence obtained from case series, audits questionnaires, surveys, and literature reviews (Schneider et al. 2004; p. 99; The Joanna Briggs Institute 2007b).

Inclusion/exclusion criteria

English language peer-reviewed literature (between January 1996 and April 2008) that referred to absconding from psychiatric wards/units or hospitals were included (Schneider et al. 2004).

SEARCH OUTCOME

Of the abstracts and articles reviewed, 39 articles were subsequently included for review based on relevancy and quality. Regarding the country these articles referred to, 51.28% were from the United Kingdom, 15.38% from the United States of America, 10.26% from Australia, 5.13% from Ireland, 2.56% Spain, 2.56% Canada, and 12.82% worldwide review. Titles and citations of the literature from each database were reviewed and inclusion/exclusion criteria were applied, with literature judged for relevancy.

RESULTS

Of the 39 studies included in this review, only one (Muralidharan & Fenton 2006) met the Level 1 standard. RCTs on absconding have not yet been undertaken, and consequently, current practices are informed by evidence from other sources. All other studies in the review fell into Level 3 (n = 19), Level 4 (n = 17), unequivocal (n = 2), and credible (n = 32) evidence categories. Emergent themes included definitions of absconding, profile, harm and risk, rate of absconding, return rate, how and why patients abscond, and perceptions of nurses and patients about absconding.

Definitions

From the literature reviewed (n = 39 articles) only 10 defined absconding (Andoh 1999; Bowers et al. 1999a,c,d; Dickens & Campbell 2001; Farragher et al. 1996; Manchester et al. 1997; Meehan et al.

1999; Moore 2000; Walsh et al. 1998). Absconding was defined as patients being absent without permission; however, the length of time for such absence ranged from more than 1 hour to 'when noticed missing' (Meehan et al. 1999). Farragher et al. (1996) defined absconding as once the patient physically left the hospital grounds. Andoh (1999) defined absconders as those who left the hospital grounds and failed to return by midnight, whilst others viewed it occurring once the patient left the ward. However, since the majority of papers did not define absconding, generalizability of findings is difficult to establish. Absconding may be understood differently across health services, making comparisons between settings difficult. For example, if a voluntary patient leaves the hospital without permission, this may not be recorded as an absconsion, whereas all detained patients who abscond are recorded as such. This is most likely because detained patients are likely to be perceived to be high risk, and because of their involuntary status, such reporting is mandatory, whereas voluntary patients are perceived to be at less risk of harm to self or others. Despite increasing recognition of absconding as a significant health issue, definitions and data collection procedures remain unsophisticated, disallowing a comprehensive picture of absconding to be gained.

Absconding profiles

The profile of the absconder is usually a young male (under 26 years of age), diagnosed with schizophrenia and legally detained (Bowers et al. 1999a,c; Bowers et al. 2000; Carr 2006; Dickens & Campbell 2001; Farragher et al. 1996; Manchester et al. 1997; Meehan et al. 1999; Quinsey & Coleman 1997; The Joanna Briggs Institute 2007a); however, Walsh et al. (1998) suggests that there is no gender effect. The absconder is likely to have a history of substance abuse (Andoh 1999), previous admissions to hospitals, and a history of absconds, with most absconding events occurring within 7 days of admission. However, if the patient absconded and was aggressive, they were more likely to be young and detained, but not necessarily male (Bowers et al. 2003a). There was only minor evidence supporting absconding patients having a history of self-harm (Bowers et al. 1999c; Carr 2006; The Joanna Briggs Institute 2007a). Two papers suggest that the prediction of absconding risk is possible (Brook et al. 2006; Moore & Hammond 2000).

Carr (2006) and Lockwood (2007) compiled evidence summaries on behalf of The Joanna Briggs Institute regarding the phenomenon of absconding; however, only nine studies were reviewed. From the 2006 evidence summary (Carr 2006), The Joanna Briggs Institute (2007a) published 'Recommended Practice' guidelines for when a patient absconds, which outlines procedures that should be taken when an absconsion is noticed and omits a definitive profile. Only

two articles mentioned ethnicity in this current systematic literature review, with Dickens and Campbell (2001) finding ethnicity was not a contributing factor in absconding behaviour, while Pages et al. (1998) stated that against medical advice discharges were most likely to be non-Caucasians. Other variables include the absconding person's personality traits and the nature of the environment (Manchester et al. 1997).

Rate of absconding

A review of the literature found absconding rates of between 2.5 and 34% of all admissions, with only six articles quantifying rates of absconding (Meehan et al. 1999). Meehan et al. (1999) identified an abscond rate of acute psychiatric admissions of 13% (n = 390), while Pages et al. (1998) found 16% (n = 2425) of discharged patients were discharged against medical advice (which included absconding patients). Bowers et al. (1999d) state that 34.5% of patients at risk absconded (n = 175). Dickens and Campbell (2001) found 148 absconds involving 88 patients, with Williams et al. (1999) reporting 66 absconds in 13 years. Since rates are reported variously using differing numerators and denominators, comparative data does not currently exist to aid in interpretation about trends in the rate of absconding worldwide. Given the assertion that up to 50% of absconsions are not reported (Bowers et al. 2005), the true extent of the problem remains unknown.

When does absconding occur?

Nursing handover times appear to be the peak time for an abscond to occur (Bowers et al. 1999b; Dickens & Campbell 2001), with most absconsions occurring in the first 3 weeks of admission. Seasonal variations may be a contributing factor but strong support for this is does not currently exist (Dickens & Campbell 2001).

Absconder return rate

Papers concentrated on where patients were found or who returned patients. There was significant variation in the small statistical samples provided. Williams et al. (1999) reported that all patients who absconded were returned (n = 66), with 69% returned in the first 24 hours, while 11% were absent for more than a month. However, this literature review focused solely on UK Special Hospitals (forensic), hence a 100% return would be expected (Butwell & Jamieson 2000).

Bowers et al. (1999c) found that 63% of patients returned on their own (encouraged by others), 2% were returned by ward staff, 8% by a relative or friend, and 13% by the police (n = 175), whereas Dickens and Campbell (2001) state that 35.1% of patients were returned whilst on hospital grounds, with the police returning 23.6% (n = 148). Another study found that 33.8% were returned by the police, 22.1% by their own volition or by friends and family, and 14.3% were returned by the staff or community (n = 51) (Meehan et al. 1999). Walsh et al. (1998) states that patients returned 91% of the time, 62% returned on their own, 19% were accompanied by family or friends, 6% by the police, and 5% by the hospital staff; with 80% returning within 24 hours. Literature generally supports the notion that families and friends, ward staff, and the police have all returned a patient at some point, with patients themselves occasionally returning of their own volition. It would seem that relatives can play a vital role in returning or persuading the patient to return to the hospital (Carr 2006).

Harm rate

There is considerable literature regarding the incidence of harm and absconding with small samples evident, ranging from 22 to 175. There was an agreement that an absconding event may eventuate in significant harm to the patient or members of the public, supporting absconding is a major public health concern (Bowers et al. 1999b,c; Bowers 2003; Bowers et al. 2003a; Dickens & Campbell 2001; Farragher et al. 1996; King et al. 2001; Shah & Ganesvaran 2000).

There was strong support in the literature for the link between absconding and serious harm to self and others, including suicide (Bowers et al. 1999b,c,d; Bowers 2003; Carr 2006; Dickens and Campbell 2001; King et al. 2001; Meehan et al. 1999; Pages et al. 1998; The Joanna Briggs Institute 2007a). An Australian study reported a suicide rate of 20% for absconders (Shah & Ganesvaran 2000). Violent methods (including jumping in front of trains, trams and road traffic, jumping off buildings, hanging, and drowning) were used in over 65% of completed suicides, while either on approved leave or after an absconding episode (Shah & Ganesvaran 2000; p. 25). Variations in the rates of harm to self and others were difficult to compare, with Bowers et al. (1999c) finding 2.4% that harmed themselves and 1.6% that harmed others, while Bowers (2003) states that 4% of absconders harmed themselves or others. Incidences of harm and serious adverse events (Brook et al. 1999; Dickens & Campbell 2001) including one report of sexual assault (Tammelleo 1999) occurred. Other risk behaviours associated with absconding include medication non-compliance, alcohol consumption, and aggression or violence (Bowers 2003; Bowers et al. 2003b; Carr 2006; Dickens & Campbell 2001; Pages et al. 1998; The Joanna Briggs Institute 2007a).

How patients abscond

Only four articles provided data on how patients absconded. Bowers et al. (1999a) identified that over half of the patients who absconded voiced their intention to leave prior to the event, with 82% leaving directly from the ward, 14% left when temporarily off the ward, and 3% failing to return from leave with permission. Brook et al. (1999) state that absconds occurred during either community outings (61%) or running away from the hospital site (38.8%), with most absconders appearing to be impulsive or opportunistic. Carr (2006) found that over half of absconds occur while the patient was on leave with permission; however, this was based on the aforementioned literature review conducted over a decade ago (Bowers et al. 1998). In one study, 80% of patients in an unlocked ward walked out, while 29% of those in locked wards were on agreed leave inside or outside the grounds and failed to return (Dickens & Campbell 2001). Breaching a locked environment occurred in 6.1% of cases. Others escaped by means of stealing keys, taking advantage of staff being distracted, escaping through windows, or taking advantage of doors inadvertently being left unsecured (Dickens& Campbell 2001). Enser and MacInnes (1999) found that building design had little to do with absconding; however, the height of the fence surrounding the perimeter was a large determinant of absconding overall, whilst Walsh et al. (1998) maintain that high staffing levels does little to deter absconders. This is supported by Bowers (2000) who found that ward observation had no significant relationship to absconding. Bowers (2003), Bowers et al. (1999c), Carr (2006) and Farragher et al. (1996) found that most absconders simply went home and engaged in normal day-to-day activities, while some visited or stayed with relatives or friends.

Post-abscond issues

There is scant literature concerned with what happens when patients return to the ward. In one study, one-fifth of patients were transferred to a high-dependency unit, for closer observation and containment (Meehan et al. 1999). Conversely, a study by Bowers et al. (1999c) found that in 73% of cases, no changes were made to the management plans for the patient. Another paper indicated that no special measures were taken with patients who were known as repeat absconders compared with single-event absconders (Dickens & Campbell 2001).

Patients' and nurses' perceptions about absconding

Patients

There are a number of reasons why patients abscond (Bowers 2003; Meehan et al. 1999). Bowers et al. (1999d) interviewed 52 patients, discovering that 42% of patients felt fear, 26% felt isolated, 42% were homesick, and 42% were bored. While psychiatric symptomatology could lead to an abscond, patients often cited other rational reasons for leaving psychiatric settings (Bowers et al. 1999d; Bowers 2003; Carr 2006; Meehan et al. 1999; The Joanna Briggs Institute 2007a). Concern for home and/or property and household and family responsibilities were reasons given, with admission to a psychiatric hospital being experienced as a serious disruption to patients' everyday living and affairs (Bowers et al. 1999d; Bowers et al. 2000; Carr 2006; The Joanna Briggs Institute 2007a). This is supported by Meehan et al. (1999), who interviewed 100 repeat absconders who cited boredom, uninteresting activities, disturbing ward environment, lack of insight into the need for hospitalization, and concern about issues at home as reasons to abscond. Manchester et al. (1997) highlighted poor quality food and lack of privacy as additional causative factors of absconding.

Nurses

Three studies considered what absconding meant to nurses (Bowers et al. 1999b; Bowers 2003; Meehan et al. 1999). Nurses perceived that absconding caused disturbances in the ward, produced feelings of anger, guilt, concern, and anxiety that they did not predict, as well as prevent, the absconding event. The process of reporting and taking action after an abscond was felt to be time consuming, detracting time away from other activities such as providing direct care to other patients on the ward (Bowers 2003; Meehan et al. 1999). Agency nurses were also mentioned as impacting negatively on the unit, with nurses convinced that reducing the number of agency staff, whilst increasing staffing levels and stability would decrease absconding incidences (Bowers et al. 1999b). McMillan (2004) found that an absconding event created trust issues, with families losing confidence in both psychiatric services and the unit, whilst Quinsey and Coleman (1997) found that community confidence was eroded with the public perceiving hospital services as at fault.

Nurses responses and assessments

Nurses responded to absconding events by contacting the police in 47% of all abscond events according to Bowers et al. (1999c). Moreover, the police were contacted when nurses viewed the absconding patient to be at high risk of harm to self or others and/or were legally detained, with nurses overlooking short disappearances when patients were perceived as low risk. However Neilson

et al. (1996) and Shah and Ganesvaran (2000) suggest that when a patient was perceived as manipulative by nurses, threats of suicide were taken less seriously. In one study, 58% of patients who absconded had previously voiced their intent to nurses, suggesting that such verbalizations accurately reflect patients' intentions and ought to be taken seriously and assessed as such by nurses (Bowers et al. 1999a).

The Joanna Briggs Institute (2007a) recommend thorough abscond procedures that are directed mainly towards nursing staff, and involves the searching of the ward and the grounds, notification of appropriate staff members, and documentation requirements, but omit issues such as contacting relatives, risk assessment, and comprehensive documentation of precipitating events. Risk assessment was identified as problematic by Bowers et al. (1999b), with risk being perceived differently between psychiatrists and nurses (Neilson et al. 1996). However, accuracy of risk predictions by mental health clinicians is open to question with some estimates of accuracy reported as low as 30% (Bowers et al. 1999b).

Interventions and recommendations

Despite the links between absconding and risk of harm, there is sparse high-quality information available concerned with interventions to reduce its occurrence (Meehan et al. 1999). A common and increasing practice is to lock ward doors to prevent patients from leaving, yet there remains insufficient evidence that supports this intervention. Close observation, seclusion, chemical restraint, or other forms of containment have been cited in the literature as other management strategies to prevent an absconding event (Bowers et al. 2003a,b; Muir-Cochrane & Holmes 2001; Muralidharan & Fenton 2006), with little evidence of their utility, acceptability, or appropriateness. Bowers (2003) and Manchester et al. (1997) suggest that the link between absconding, physical containment, and surveillance is not well established and may not contribute towards an absconding event, with other as yet unidentifiable factors playing a more important role. Bowers et al. (1999a) and Bowers et al. (2000) support this, recognizing that there is no apparent relationship between the level of observation and number of exits available on the hospital ward. The consequence of locking ward doors and other forms of ward containment to prevent individuals leaving results in the restriction of movement of all inpatients, creating ethical issues about the inhibition of an individual's autonomy as a voluntary or involuntary inpatient (Dickens & Campbell 2001).

Recommendations to reduce absconding include nursing staff developing close therapeutic relationships with patients, particularly at the time immediately after admission (Bowers et al.

1999a). Engaging with relatives to encourage patients to return to the ward, telephoning the patient at home, having close contact with the local police, and engaging more with community mental health professionals are strategies cited to reducing the risk of harm to self or others for the absconder (Bowers et al. 1999c). Bowers (2003) also outlines strategies successfully implemented in the United Kingdom involving 15 psychiatric wards in total. In these trials, a number of measures were implemented, resulting in a decrease in the absconding rate of 25%. Interventions included: a book for patients to sign in and out; the identification of high risk patients; providing more time for patients to be with nursing staff; providing controlled home visits; encouraging contact with family and friends; the careful conveyance of bad news to patients; post incident debriefings after violent or noisy altercations; and multidisciplinary reviews.

Dickens and Campbell (2001) are more cautious about proposing set interventions, stipulating that efficacy should be evaluated before implementation occurs. However, they suggest that improved documentation that includes aspects such as previous circumstances, elements and, outcomes of absconding incidents may assist risk assessment and harm minimization regarding absconding. In the evidence summary included in The Joanna Briggs Institute's (2007a) Recommendations of Practice, evidence suggests that nurses should consider the meaning of an admission for a patient and the significant impact on his or her daily life experience. Meehan et al. (1999) suggest that staff need to be experienced and skilled to deal with people diagnosed with a mental illness; with activities in the ward being interesting and perceived as useful and with programs designed to meet different levels of patient functioning. Locked areas (as opposed to an entirely locked unit to ensure freedom of movement for other patients) can be useful and may help to alleviate forms of anxiety and subsequent fear (Meehan et al. 1999). Since absconding often occurs at or just after admission, the creation of a caring environment, together with the development of therapeutic relationships, may be useful. Quinsey and Coleman (1997) identify that factors such as adverse decisions from review boards or family crises may also precipitate an abscond, as other literature has previously identified. They also agree with previously outlined recommendations that environmental factors should be carefully considered if known to precipitate emotional reactions, formulation of appropriate patient, staff interactions should occur, together with treatment strategies designed to assist in the development of anger management, coping skills, and personal control. Whilst links between absconding and harm have been conclusively demonstrated, significant gaps in knowledge exist. There is also little known about ethnicity/ multicultural factors and absconding, the relationship between locked doors and absconding, or the use of other containment measures such as seclusion and their relationship with absconding within the same period of hospitalization. Farragher et al. (1996) assert that medication management, visit

facilitation, assessment of behaviours, and attention to personal problems may prevent absconding by 50%; however, there is little basis for this assertion. The use of behavioural management plans (Blass et al. 2001), token economy approaches (LePage 1999), and the use of humour (Higueras et al. 2006) have also been suggested as potential therapeutic tools in the reduction of absconding behaviour.

STUDY LIMITATIONS

Hand-searching of journal articles was not undertaken because of time and financial constraints, and similarly, only English language articles were sourced because of translation costs.

CONCLUSION

Absconding results in potential risk to patients, public safety issues, legal consequences, and media exposure (Tammelleo 2001, 2006). It is directly correlated with prolongation of inpatient psychiatric treatment, and as such, is costly for health services and deleterious for patients. The findings in this review have contributed to the development of a comprehensive absconder profile. It has extended the work of Bowers et al. (1998), Carr (2006), and Lockwood (2007), and by being systematic in its approach, it has developed a comprehensive absconder profile, widened the scope of the papers reviewed, and provided further insight into absconding that has not been apparent before. However, other extraneous factors need to be considered including the psychological profile and characteristics of the individual inpatient, the meaning of the admission, alienation, social structure of the unit, situational and environmental factors, and precipitating events. Further research into the dynamics of absconding is required. Given the emotional, social, and economic cost of absconding to society in general and individual patients in particular, sustained enquiry into the dynamics of this phenomenon is required.

ACKNOWLEDGEMENTS

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