A retrospective analysis of absconding
behaviours by acute care psychiatric inpatients in
one psychiatric hospital campus in Australia

Krista A. Mosel
BNurs RN
Flinders University
School of Nursing and Midwifery
Faculty of Health Sciences
November 2008

Submitted in partial fulfilment of the requirements of Bachelor of Nursing Honours degree
# Table of Contents

Declaration ................................................................................................................................. v  
Acknowledgements .................................................................................................................... vi  
Glossary ................................................................................................................................... vii  
Chapter 1: Introduction ......................................................................................................... 1  
  2.0 Introduction ..................................................................................................................... 5  
  2.1 Background ..................................................................................................................... 6  
  2.2 Aim ................................................................................................................................... 8  
  2.3 Design ................................................................................................................................ 9  
   2.3.1 Approach used .......................................................................................................... 9  
  2.4 Search Methodology ........................................................................................................ 10  
   2.4.1 Electronic Searching ............................................................................................... 10  
   2.4.2 Inclusion/Exclusion Criteria ................................................................................... 11  
  2.5 Search Outcome ............................................................................................................. 11  
   2.5.1 Included literature ................................................................................................. 11  
   2.5.2 Excluded literature ............................................................................................... 12  
  2.6 Quality Appraisal ............................................................................................................ 12  
   2.6.1 Assessment ........................................................................................................... 12  
   2.6.2 Methodological quality and rationale ................................................................. 13  
  2.7 Results ............................................................................................................................ 14  
  2.8 Emergent Themes .......................................................................................................... 15  
   2.8.1 Theme 1: Definitions ............................................................................................... 15  
   2.8.2 Theme 2: Profiles ................................................................................................... 16  
   2.8.3 Theme 3: Varying statistics .................................................................................... 18  
      2.8.3.1 Abscond rate ................................................................................................... 18  
      2.8.3.2 Abscond return rate ....................................................................................... 19  
      2.8.3.3 Harm rate ....................................................................................................... 21  
      2.8.3.4 How patients abscond ................................................................................... 22  
   2.8.4 Theme 4: Thoughts and Feelings ............................................................................ 23  
      2.8.4.1 Patients ............................................................................................................ 23  
      2.8.4.2 Nurses .............................................................................................................. 24  
      2.8.4.3 Outside consequences .................................................................................... 24  
   2.8.5 Theme 5: Actions ........................................................................................................ 25  
      2.8.5.1 When does absconding occur? ....................................................................... 25  
      2.8.5.2 Where do they go? ......................................................................................... 25  
      2.8.5.3 Nurses responses and assessments .................................................................. 26  
      2.8.5.4 Nurses interventions and recommendations .................................................. 27  
  2.9 Discussion ....................................................................................................................... 31  
  2.10 Review Limitations ....................................................................................................... 33  
   2.11 Bias ............................................................................................................................. 34  
   2.12 Robustness .................................................................................................................. 35  
   2.13 Conclusion ................................................................................................................... 35  
   2.14 Acknowledgement ...................................................................................................... 37  
Chapter 3: Methods .............................................................................................................. 38  
  3.0 Introduction ..................................................................................................................... 38  
  3.1 The research problem ..................................................................................................... 39  
  3.2 Aims of the research ...................................................................................................... 39  
  3.3 Justification ..................................................................................................................... 39
Abstract

Absconding (leaving without permission) has been identified as a significant problem within mental health settings and has the potential to create major health, economic and social issues as well as risks for the patient (Muir-Cochrane & Mosel 2008a). This research examined absconding behaviours on one Australian psychiatric campus over 12 months. Absconding is defined in this research study as a detained patient leaving without permission from a ward. 49 patients absconded 64 times. Descriptive statistics were used and determined the rate of absconding and profile of patients that abscond. The areas of analysis also included times of absconding, legal status and identification of patients that absconded more than once. Findings of this research provide data within an Australian setting that future studies may be compared against. The rate of absconding was 13.33%. Those who absconded were males diagnosed with schizophrenic disorders (57.14%) aged between 20-29 years (53.57%). Culturally and Linguistically Diverse (CALD) patients represented 20.24% of patients that absconded. 62.50% of absconding events occurred whilst the patient was on their first 21 day detention order. Nearly half of all absconding events were by patients that had absconded previously and the highest proportion of absconding events occurred during nursing hand over. The profile of patients that abscond has similarities to overseas research, although in this study, patients were slightly older and almost 25% were women. These findings also identify that a history of absconding increases the risk of this behaviour in the future, men are more likely to abscond than women and a patient on their first 21 day detention order is more likely to abscond than patients on other detention orders.
Declaration

Candidate Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Krista Ann Mosel
November 2008

Supervisor Declaration

I believe that this thesis is properly presented, conforms to the specifications for the thesis and is of sufficient standard to be, prima facie, worthy of examination.

Professor Eimear Muir-Cochrane
Principal Supervisor
November 2008
Acknowledgements

I would like to express my sincere gratitude and heartfelt thanks to my Principal Supervisor, Dr. Eimear Muir-Cochrane, Professor of Mental Health Nursing, Flinders University (formerly Associate Professor of Mental Health Nursing, University of South Australia). Over the past 2 years, you have provided guidance, support, compassion and sage advice. Thank you for leading me through this research process, and providing me with so many opportunities that would not have been available to me otherwise. Eimear, you inspire me!

To my Associate Supervisor, Dr. Pauline Guerin, Flinders University. Thank you for the time you have given to me this past year, in both your statistical expertise and the insight that you have shared regarding this research project. You have been a wealth of knowledge, and without you, my tables would be presented quite differently!

I would like to extend a special acknowledgement to Dr. Tahereh Ziaian, Senior Lecturer, University of South Australia. Thank you for the advice you have given in relation to Culturally and Linguistically Diverse population groups. Your kindness and compassion knows no bounds, and I feel that you are a wonderful role model for the university community. I would also like to thank the Director of Nursing and associated staff of the research site the data were collected from. Thank you for being so welcoming and putting up with all of the questions and emails. Without your input and provision of the data, this thesis would not exist!

Finally to my family, Richard, Taylor and Maddyson. There have been many days and nights that you have come second best to the wonderful world of computers and spreadsheets. Thank you for all of the support and love that you have given me over this time, without you all, I would be lost. I would also like to extend a special thank you to my parents, Pauline and Terry, who have supported me while I have been studying at university (some 6 years now!) and have always had unwavering faith in me to accomplish anything that I set my mind to. Thanks for buying me all the text books!!
Glossary

Aboriginal and Torres Strait Islanders: see ATSIs.

ABS: The abbreviation used for the Australian Bureau of Statistics (in-text and end of text references).

Abscond: Defined as a detained patient who leaves the premises (ward) without permission.

Absconding event: The incident of a patient leaving the premises (ward) without permission.

Absconding rate (event based): A measure of the number of absconding events per 100 patient hospital separations. This is calculated by using the number of absconding events divided by the number of patient separations; then multiplying this by a constant multiplier, being 100, to make a percentage. This rate can be expressed as per 100 or as a percentage.

Absconding rate (patient based): The rate which is adjusted to reflect only the number of patients that abscond as one patient may abscond more than once. It is a measure of the number of patients that abscond per 100 patient hospital separations. This rate is calculated using the number of patients that abscond (ignoring repeat incidents/events by the same patient) divided by the number of patient separations; then multiplying this
by a constant multiplier, being 100, to make a percentage. This rate can be expressed as per 100 or as a percentage.

**American Psychological Association**: see APA.

**ANMC**: The abbreviation used for the Australian Nursing and Midwifery Council (in-text and end of text references).

**APA**: The abbreviation used for the American Psychological Association (in-text and end of text references).

**ATSIs**: The abbreviation used for persons of Aboriginal and Torres Strait Islanders descent. The researcher acknowledges that this term can be contentious however this abbreviation is used for brevity and ease of reading.

**Australian Bureau of Statistics**: see ABS.

**Australian Nursing and Midwifery Council**: see ANMC.

**CALD**: The abbreviation used for Culturally and Linguistically Diverse. Defined as patients that are identified within the data as ATSIs and Other (non Caucasian or ATSIs).

**CALD Background**: The abbreviation for persons of a Culturally Linguistically Diverse background. Defined as categories of patient ethnicity. The categories of ethnicity are ATSIs and Other (non Caucasian or ATSIs). For the purposes of this thesis
and for the sake of clarity, ATSIs have been included in this section, as ethnicity refers to a sense of belonging or a person’s identity within a group (Crisp & Taylor 2001).

**Centre for Reviews and Dissemination:** see CRD.

**CRD:** The abbreviation used for the Centre for Reviews and Dissemination (in-text and end of text references).

**Culturally and Linguistically Diverse:** see CALD.

**Detained:** The patient is admitted and held against their own volition in the psychiatric hospital in the interest of their own health and safety or for the protection of others. *Mental Health Act 1993* (SA), s.2 (12).

**Diagnosis Related Group:** see DRG.

**Discharge:** The release of a person from the acute care wards of the psychiatric hospital campus.

**DRG:** The abbreviation used for the Diagnosis Related Group. This is defined as representing a class of patients that have similar clinical conditions. This class of patients require comparable hospital resources for their total treatment (ABS 2008c).

**Ethnicity:** A sense of belonging to a group.
**Hospital:** for the purposes of this thesis and for ease of reading, the three acute care wards of the psychiatric hospital campus that data were collected from, is referred to as ‘the hospital’.

**Involuntary:** A patient that is held (detained) against their will in the psychiatric hospital campus.

**JAN:** The abbreviation used for the Journal of Advanced Nursing (in-text and end of text references).

**JBI:** The abbreviation used for the Joanna Briggs Institute (in-text and end of text references).

**Joanna Briggs Institute:** see JBI.

**Journal of Advanced Nursing:** see JAN.

**National Health and Medical Research Council:** see NHMRC.

**NHMRC:** The abbreviation used for the National Health and Medical Research Council (in-text and end of text references).

**Patient:** A person who receives medical treatment either voluntarily or involuntarily within the psychiatric hospital campus. For the purposes of this thesis, the term patient as opposed to consumer is used, as the term consumer implies someone who is accessing services voluntarily. In this case, the patient data analysed refers to patients that are being held in this psychiatric hospital campus involuntarily.
Patients that abscond: Patients that leave the premises (ward) without permission that are detained.

Population groups: Defined as categories of patients. The categories are patients from a Culturally and Linguistically Diverse (CALD) background, Caucasian or Not Known.

Principal Diagnosis: The condition that is primarily responsible for the admission of the patient into a hospital for care (ABS 2008b).

Principal Diagnosis: Bipolar Affective Disorder: the patient is currently manic with or without psychiatric symptoms.

Principal Diagnosis: Mental & Behavioural Disorder: due to opioid use depressive syndrome.

Principal Diagnosis: Personality Disorders: and acute reactions.

Principal Diagnosis: Severe Depressive Disorder: the patient is without psychiatric symptoms and is not postnatal.

Schizophrenic disorders: a group of principal diagnoses that includes Residual Schizophrenia, Unspecified Schizophrenia, Paranoid Schizophrenia and Hebephrenic Schizophrenia.
**Separation:** Defined as a discharge.

**Site:** The psychiatric hospital campus that data were collected from. The data analysed for the purposes of this research was from the three acute care wards on this site.

**WHO:** The abbreviation used for the World Health Organisation (in-text and end of text references).

**World Health Organisation:** see WHO.
Chapter 1: Introduction

The World Health Organisation (WHO 2007) states that it is essential that new knowledge about mental health and illness be generated to facilitate greater understanding on both a multicultural and global level. From a broad perspective, 25 million people across the world suffer from Schizophrenia (WHO 2007); which has been identified as the largest cause of premature death in young, unemployed, single males. Broad mental disorders are responsible for increased mortality and social isolation; with significant economic and social costs incurred (Muir-Cochrane & Mosel 2008b). In addition, individuals suffering from mental health issues are more likely to have their freedom and rights infringed upon, with compulsory detention resulting in their right to liberty being taken away (WHO 2007).

On this basis, this researcher believes that there is an ethical requirement to explore the levels of harm or risk that face mental health sufferers, who encounter various stigmas and inequities as part of their everyday life. A nurse is charged to advocate for their consumer, and practice benevolence and non-maleficence (Crisp & Taylor 2001; Wallace 2001). In other words, do no harm and promote well being. Nurses have a therapeutic responsibility towards their patients (Crowe & Carlyle 2003), and ethically, mental health patients should receive care that is optimal, reduces risk and prevents a crisis (Paley & McGinnis 2003; ANMC 2007). Risk assessment and management are therefore important components of the mental health care delivery system; with the focus being to ensure the welfare of the patients is protected (Crowe & Carlyle 2003). These are implemented when there is uncertainty about possible outcomes and include assessment of the likelihood of different outcomes arising as well as balancing the
probability of benefit versus harm (Kumar & Simpson 2005; McConnell, Pasben & McLean 2007).

There are a number of negative consequences from the act of absconding which include self-neglect or exposure from the elements, violence, aggression, homicide, harm to self or others, loss of contact and confidence with psychiatric services and potential legal liability towards the hospital (Bowers, Jarrett & Clark 1998; Meehan, Morrison & McDougall 1999; Dickens & Campbell 2001). However, there is only one published study to date that has implemented nursing interventions designed to reduce incidences of absconding (Bowers 2003). There remains little evidence to support the efficacy of these and no gold standard research on absconding is available to date (Muralidharan & Fenton 2006). Research investigating patient ethnicity, multicultural factors and links to absconding have not been investigated, nor have correlations and implications of containment and absconding been conclusively established (Muir-Cochrane & Mosel 2008a).

There has been scant research within Australia investigating absconding behaviours of psychiatric inpatients (Meehan, Morrison & McDougall 1999; Muir-Cochrane & Mosel 2008b). The rate of absconding has not been established in different Australian psychiatric facilities, nor has the profile of patients that abscond in an Australian setting been accurately defined. These are critical from a risk assessment perspective. Furthermore, Bowers, Alexander & Gaskell (2003) and Bowers, Simpson and Alexander (2005) have identified the need for efficacious nursing interventions designed to reduce the incidences of absconding whilst at the same time providing (or maintaining) therapeutic and healing environments. Nursing interventions designed to
decrease absconding have been implemented with success, but only in one study, and, in Australia, none have been reported in the literature to date. This is at odds with current ANMC (2007) Registered Nurse competency standards which require that nursing practice be based on evidence; yet without current Australian research, the phenomenon of absconding within Australia can not be accurately assessed nor can practice standards be defined. This researcher’s intention was to investigate the phenomenon of absconding within an Australian setting. What is the rate of absconding in Australia? What is the profile of patients that abscond in an Australian setting and does this concur with recent literature? When patients abscond once, were they more likely to do so again? What were the overall population demographics of this setting? How did this compare to the patients that abscond; and were there any significant overrepresentations in the data? By seeking answers to these questions, it is the researcher’s desire that this study will provide evidence to influence current nursing practice and ensure that nursing practice is centred within an evidence based framework.

Based on this and the poor health outcomes previously identified by the WHO (2007) underpinning this study, an initial starting point was to explore the absconding behaviour of acute care psychiatric patients in one Australian psychiatric hospital campus. This empirical study gathered retrospective data about absconding by acute care detained patients over a 12 month period. The aims were

- To examine absconding behaviour over 12 months.
- To determine the rate of absconding (on three acute care inpatient wards) over 12 months.
• To determine the profile of patients that abscond from this setting, including the analysis of areas such as population demographics, diagnosis, time of absconding and identification of patients that abscond more than once during their admission.

This study was informed by a systematic literature review (Appendix 1) (Muir-Cochrane & Mosel 2008a), part of which is presented in Chapter 2. This served to establish what was currently known about the phenomenon of absconding on both a national and international level. To ensure rigour within this research study, the reliability and validity of the methods were carefully considered and these as well as the aims of the research are outlined in depth in Chapter 3. The research findings which are presented in Chapter 4 are discussed in Chapter 5. A comparison of these findings in relation to other research studies is also presented within this chapter. However, it became very clear that generalisability was difficult to establish due to absent or differing definitions of absconding and rates of absconding were reported variously using differing numerators and denominators. Hence comparative data does not currently exist to aid in interpretation about trends of absconding worldwide.

This research study presented here was undertaken as a partial fulfillment of the requirements to complete the degree Bachelor of Nursing (Honours).
Chapter 2: Literature Review

2.0 Introduction

The exponential growth of literature available to assist in developing best health practices has resulted in systematic literature reviews proving a useful tool for the nursing profession, with the rationale for use firmly established (Mulrow 1994; Schneider et al. 2004). It allows researchers to become familiar with the phenomenon of interest, creates a comprehensive understanding and awareness and serves to ascertain what gaps in knowledge exist (Roberts & Taylor 2002). A systematic review is also grounded in several premises, with numerous benefits apparent. It enables the reduction of large quantities of information to smaller, easily absorbable pieces, allows integration of critical pieces of information, is an efficient technique, can establish generalisability, assesses consistency of relationships, may explain data inconsistencies or conflicts and may increase power by pooling results (Mulrow 1994; Bowman 2007).

From this premise, a systematic literature review on absconding was completed and served to inform this current research study. This systematic literature review will be presented under the headings of Background, Aims and Objectives, Design, Search Methodology, Search Outcome, Quality Appraisal, Results, Discussion, Review Limitations, Bias, Robustness and Conclusion.
2.1 Background

In 1998, Professor Len Bowers and his team at City University, London, UK, conducted a literature review on patients that abscond from general psychiatric services, seeking to bring together available literature. A total of 37 descriptive and evaluative studies from 1962 to 1996 were examined. Their review sought to collate and synthesise studies in an attempt to discover what was known globally about the phenomenon. It identified the definition of absconding used in different settings, rates of absconding, the profile of patients that abscond, how, when and why patients abscond and examined evaluative studies concerning interventions that may be used and how they impact on the rate of absconding. Bowers, Jarrett and Clark (1998) found that a link between absconding and self-harm together with successful suicide was a recurrent theme.

Bowers, Jarrett and Clark (1998) also identified a number of negative consequences evident from the act of absconding within the literature in addition to suicide and self harm, which included self-neglect or exposure from the elements, violence, aggression, homicide, loss of contact and confidence with psychiatric services and potential legal liability towards the hospital. However, they could find little research that identified the reasons for these or effective nursing interventions available that may aid in reducing absconding events (Bowers, Jarrett & Clark 1998). Yet identification of reasons and creation of effective nursing interventions, by definition, may reduce the number of negative outcomes.

This review (Bowers, Jarrett & Clark 1998) stated that in some of the reviewed articles, definitions of absconding were omitted. Therefore, the question of the validity of the studies, and other variations were examined within the context of an unclear definition.
Despite the possibility of flawed data collection, which hinges upon the definition of absconding, a mean rate of absconding of 12.6 per 100 patients was established. The patient who absconds was identified as being most likely a young, disadvantaged, male diagnosed with Schizophrenia, who absconds after permission to leave the ward and does not return, or, attempts and succeeds in various means of escape, with locked ward doors proving no barrier. Seasonal variations influenced absconding, with absconding increasing during the warmer seasons, together with meal and evening times were predictors. Staffing levels were important, as it was demonstrated that an increase of absconding events occurs when the least experienced staff are present. There were also a number of triggers that were identified from a patient’s point of view, with three or four factors interacting. This included the initial level of therapeutic relationship that was established, being unclear of the nurses role, current symptoms, medications, responsibility to significant others in the home, or perhaps even lack of friends visiting. Other factors may also contribute to absconding such as a lack of comprehension towards hospitalisation, the stigma attached to hospitalisation and disliking the ward or staff, amongst many others factors. Nursing interventions were also considered, but little could be deduced due to the weakness of the studies analysed. Bowers, Jarrett and Clark (1998) hypothesised however, that locking ward doors might reduce absconding, but may have harmful consequences, with other suggestions being participation in group activities, letting the patients voice their opinions and thoughts, being involved in planning of treatment and using a sign out book.

The studies reviewed in Bowers, Jarrett and Clark (1998) consisted of relatively small sample numbers, and in addition, significant gaps in knowledge were still evident, despite the potential serious outcome of an absconding event. The review demonstrated
that official data related towards absconding events is inherently artificial and creates difficulty in identifying accurately the relationship between absconding and risk, nor those predominately at risk. Other gaps in knowledge identified were the impact an absconding event had on staff, organisation or patients, and significant others and the resultant trust issues that arise. The authors (Bowers, Jarrett & Clark 1998) suggested that an understanding towards the motivation of a patient that drives them to abscond, together with a clear profile of patients that abscond, using ideal statistical methods and data, would assist in identifying those at risk, and then necessary steps could be put into place to reduce the inherent negative outcomes. In order to do this however, devising and testing nursing interventions in the format of clinical trials is necessary, and by doing this, nursing interventions may then be able to be confidently developed and then implemented (Bowers, Jarrett & Clark 1998). The review by Bowers, Jarrett and Clark (1998) demonstrated there has been little published during the period examined, however certain links have been made, but not to the accepted gold standard view that is currently held (Schneider et al. 2004).

Further research in this topic is necessary. Since 1998, there have been no further literature reviews on absconding. It is timely therefore to examine literature about absconding from January 1996 to April 2008; extending the aforementioned review by Bowers, Jarrett and Clark (1998). These findings will now be discussed.

2.2 Aim

The aim of this systematic literature review is to analyse and synthesise quality literature on absconding in psychiatric wards, units or hospitals. The objectives within is
to discover further research developments and findings, identify gaps in knowledge and
to contribute key information to a growing body of evidence.

2.3 Design

A systematic literature review was utilised as this has been demonstrated as the most
useful and efficient way in which to allow the integration of critical pieces of
information in which to base current research (Mulrow 1994; Schneider et al. 2004).
This systematic literature review is based on the guidelines outlined in The Cochrane
Handbook for Systematic Reviews of Interventions (Higgins & Green eds 2006), CRD
(2007) and the JAN (2007).

2.3.1 Approach used

While most of the literature included in this systematic review contained some aspect of
quantitative data, the majority of findings were qualitative in nature. Hence, a thematic
synthesis of the data was utilised, using quality appraisal as a basis to judge findings
which is identified below. However, while thematic synthesis has the potential to
generate hypotheses in qualitative research, is more suited and has the potential to arrive
at conclusions among heterogeneous studies; therefore it has the potential to mask
shortcomings of the literature present in the review (Lucas et al. 2007). These
limitations were considered and this review attempts to address these aspects to
minimise this.

To ensure this review remain transparent and reproducible, the thematically synthesised
data will incorporate main elements such as the reporting of results, development of
preliminary synthesis, exploring the relationships contained within the data, explaining
how and why these interventions work as well as developing a theoretical model based on these, and assesses the robustness of the product synthesis (Popay et al. 2006, p. 12; Rodgers et al. 2007, p. 9).

2.4 Search Methodology

2.4.1 Electronic Searching

The literature review by Bowers, Jarrett and Clark (1998) used CINAHL (1982-1997), Cochrane Database of Clinical Trials (1997 issue 4) and PSYCLIT (1974-1997). This was expanded upon in this systematic literature review, which used Academic Search Elite, British Medical Journal, CINAHL, Cochrane Library, Health Source Academic Version, JBI, PsycInfo and Wiley Interscience.

The keywords used by Bowers, Jarrett and Clark (1998) were used, and appeared to cover absconding in its entirety. These keywords were 'abscond', 'AWOL', 'elope', 'escape', 'runaway' and variants.

Search results were limited in a number of ways.

1. Literature from January 1996 to April 2008, English language and peer reviewed limiters were set.

2. When results yielded 0-200 articles, all were examined in their entirety and inclusion/exclusion criteria applied.

3. When results yielded 201 - 500 articles, all abstracts were examined and inclusion/exclusion criteria applied, as well as refining words added to original
keywords. These refining words were 'mental' and 'psychiatric'. For example, if 'runaway' yielded this many results, then 'runaway' plus 'mental' and 'runaway' plus 'psychiatric' was used. This ensured completeness of search.

4. When results yielded over 500 results, then a refining search commenced, and the results of this refining search examined in its entirety.

2.4.2 Inclusion/Exclusion Criteria

Peer reviewed literature was used to enhance credibility of the reported research (Schneider et al. 2004) and included only literature that referred to absconding from the acute care psychiatric ward/unit or hospital. English language articles were sourced between January 1996 and April 2008. Literature was excluded when it included acute care general wards or required translation.

2.5 Search Outcome

2.5.1 Included literature

The results of the database searches and description of articles included in this review are tabled in Appendix 2. Of the potential 2790 citations, abstracts and articles viewed, 38 articles were included for review based on relevancy and quality. From an international perspective, 47.37% originated from the United Kingdom, 15.79% United States of America, 10.53% globally, 13.16% Australia, 5.26% Ireland, 2.63% India, 2.63% Canada and 2.63% Spain (Appendix 3).
2.5.2 Excluded literature

The number of excluded studies totaled 2725. Accordingly, it is not feasible to incorporate all of these in a concise form for the purposes of this review. In reference to the selection process and the search strategy, each title and citation of the literature from each database was reviewed, and the inclusion/exclusion criteria applied. If the title or citation was unclear, then the entire article was retrieved and read in entirety and the inclusion/exclusion criteria applied.

2.6 Quality Appraisal

2.6.1 Assessment

Given the literature to be reviewed was quantitative, qualitative and triangulated, the literature was analysed using a mixed method approach. This was adapted from the Cochrane Handbook (Higgins & Green eds 2006) and JBI (2007b), in conjunction with Graneheim and Lundman (2004) and Schneider et al. (2004).

Each article was judged for trustworthiness, encompassing credibility, dependability and transferability (Graneheim & Lundman 2004). The credibility of each article was then assessed as unequivocal, credible or unsupported (JBI 2007b). The articles that contained quantitative data were ranked in terms of levels of evidence, with Level 1 being evidence obtained from review of all Randomised Control Trials (RCTs), Level 2 evidence from at least one properly designed RCT, Level 3 (1) well designed control trial without randomisation, Level 3 (2) comparative study without randomisation but with control and allocation, Level 3 (3) comparative study with the control being
historical and Level 4, being evidence obtained from case series (Schneider et al. 2004, p. 99; JBI 2007b).

2.6.2 Methodological quality and rationale

Of the 38 studies included in this review, only one (Muralidharan & Fenton 2006) met the Level 1 criteria. The outcome of this systematic literature review was that there existed no relevant gold standard trials with which to base current practices on, and consequently, no solid, undisputable evidence exists to formulate an opinion.

However, for the purposes of this current systematic review, conducting a RCT for the purposes of testing various hypotheses relating to the area of absconding is impractical and unethical, given that the interventions or treatment received would be highly experimental, and the patient may be unable to give informed consent. By testing cause and effect, significant harm for the individual may result, should an abscond event occur as a result of the experimental treatment or intervention. Furthermore, an experiment relies on the identification of relevant variables, and even if they were identified, in this area of interest, manipulation of the variables may not be possible, or, ethically appropriate (Schneider et al. 2004; Horsfall et al. 2007).

Accordingly, Graneheim and Lundman (2004) and the JBI (2007b) argue that the systematic review process should include other findings in addition to RCTs, provided they adhere to the rigorous standards as previously mentioned. They suggest that qualitative research findings not only enhance the findings of quantitative studies, but are capable of generating evidence in their own right. Thus, the studies included in this
review were subjected to the aforementioned quality appraisal, to ensure high quality results were included.

With the above rationale identified, the other included quantitative articles were Level 3 (1) \(n=1\), Level 3 (2) \(n=10\), Level 3 (3) \(n=7\) and Level 4 \(n=19\). A summary of the evidence rankings and results are provided in Appendix 4. When relevant, included articles were ranked as unequivocal \(n=2\), credible \(n=31\) and unsupported for the qualitative content. However transferability of the articles was questionable, due to the diverse and individual nature of the patients themselves, their world view and the uniqueness of the setting. There were also a myriad of other variables that may not be able to be manipulated and subsequently reproduced (CRD 2007).

In general however, all of the included studies were judged generalisable, as the emergent themes were broadly ones of concurrence and agreement. Thus, when combined, each added significant weight to the findings, with individual voices emerging as a collective whole (Schneider et al. 2004).

### 2.7 Results

The emergent categories identified were statistics of study, definitions of absconding, profile of patients that abscond, harm and risk, absconding procedure, actions, experiences, thoughts and feelings, correlations and background information. Themes included; Definitions of absconding, The profile of patients that abscond, Varying statistics (absconding rates, return rates, harm rates and how patients abscond). The Thoughts and Feelings theme explored areas such as reasons and commonalities of why patients abscond, nurses feelings and outside consequences. The Action theme included
how patients abscond, where they went, nurses actions and responses to absconding and nursing interventions including recommendations for future practice.

2.8 Emergent Themes

2.8.1 Theme 1: Definitions

From the literature reviewed, eleven defined absconding (Farragher, Gannon and Ahmad 1996; Manchester et al. 1997; Walsh et al. 1998; Andoh 1999; Bowers et al. 1999a, c, d; Meehan, Morrison & McDougall 1999; Bowers et al. 2000; Moore 2000; Dickens & Campbell 2001; Khisty et al. 2008). There was consensus that the absence of the patient was without sanction, however, the length of time ranged from absence for more than one hour to only when noticed. Farragher, Gannon and Ahmad (1996) and Meehan, Morrison and McDougall (1999) defined absconding as once the patient physically left the hospital grounds. Andoh (1999) defined absconding as patients leaving the hospital grounds who failed to return by midnight, whilst the others viewed it occurring once the patient left the ward without permission.

Of concern is the number of papers that did not define absconding, and as a consequence, transferability is hard to establish. This was similar to the finding made in Bowers, Jarrett and Clark (1998) and indicates that the definition of absconding is inherently fraught with obscurity and may have different meanings to different people. It may also be hypothesised that data in various institutions is not recorded appropriately, accurately, with enough detail, or with a definition in mind. Therefore it may be difficult to quantify an absconding event if the study is relying on its implicit meaning rather than explicitly stating this. As a result, it becomes difficult to compare
studies when the essential meaning of the issue in question is undefined. As a consequence, this review juxtaposes absconding literature that may mean different things to different people. The result may therefore be one that is inherently based on ambiguity, even though clarity is the desired result.

2.8.2 Theme 2: Profiles

It has been conclusively demonstrated in this literature search that the profile of the patient who absconds is a young male, diagnosed with Schizophrenia and legally detained (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; JBI 2007a). However, Walsh et al. (1998) and Dickens and Campbell (2001) suggest that while patients that abscond are more likely to be single, formally admitted patients, who are diagnosed with Schizophrenia, there appears to be no gender effect. The absence of the gender effect was also found by Khisty et al. (2008). In addition Khisty et al. (2008) found that the most frequent diagnosis was Bipolar disorders; however attribute this difference to how Indian psychiatrists diagnose patients as opposed to their counterparts in developed countries. Carr (2006) found on behalf of the JBI that the majority of patients that abscond were middle-aged men, which was an aberration.

Moore and Hammond (2000) state that assessment of absconding risk is possible, with Brook et al. (2006) supporting this, saying prediction of absconding is possible using a number of variables. This is confirmed by Brook, Dolan and Coorey (1999) who found the patients that abscond to have a history of multiple absconding episodes, were
younger than the controls and the majority was diagnosed with Schizophrenia or Personality Disorders.

The person who has absconded is likely to have a history of substance abuse, previous admissions to hospital and has a history of absconds, with most absconding events occurring within seven 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, Alexander & Gaskell 2003). There was only minor evidence demonstrating patients that abscond as having a history of self-harm, however links to compulsory detention and police referral have been demonstrated (Andoh 1999; Bowers et al. 1999c; Bowers et al. 2000; Carr 2006; JBI 2007a). A link to alcoholism and absconding was also found (Andoh 1999).

Contributing factors identified within the literature was refusal of medication and lack of insight into illness (Manchester et al. 1997; Bowers et al. 1999d; Bowers et al. 2000). Only two articles mentioned ethnicity, with Dickens and Campbell (2001) finding ethnicity was not a contributing factor, while Pages et al. (1998) stated that against medical advice (AMA) discharges were most likely to be non-Caucasians. An interesting finding in one study (Andoh 1999) was that patients that abscond were most likely to have less weekly visitors than patients that did not abscond; hence feelings of isolation or missing friends may be a contributing factor that may precipitate absconding.

Meehan, Morrison & McDougall’s (1999) article argues that young male patients diagnosed with Schizophrenia are more likely to be admitted to inpatient facilities,
which leads to an overrepresentation when constructing a statistical profile. Regardless of this overrepresentation, the fact remains that they are significantly represented in most psychiatric facilities. Therefore, because of this overrepresentation and proven predilection to abscond, they contribute significantly towards the profile of patients that abscond, and therefore should be considered in a profile construction.

2.8.3 Theme 3: Varying statistics

2.8.3.1 Abscond rate

Meehan, Morrison & McDougall (1999) state that literature has reported rates of absconding from 2.5 to 34% of all admissions, however, only ten articles in this review attempted to quantify rates of absconding. In the study by Pages et al. (1998) found 16% (n=2230) of discharged patients were discharged against medical advice (which included absconding patients), while Meehan, Morrison & McDougall (1999) found the absconding rate of acute psychiatric admissions was 13% (n=390). Dickens and Campbell (2001) state an overall absconding rate was 16.7% (n=88 patients that abscond; n=1378 control group); however the rate was calculated by including ‘the number of in-patients in the study setting at the beginning of the study period plus all those admitted during the period of the study’ (p. 547). Bowers, Simpson and Alexander (2003) state two different rates. 10.9% of all admissions went missing without permission, whilst the official hospital absconding rate per 100 admissions was 14.7% (n=238). Khisty et al. (2008) found the absconding rate per 100 admissions was 14.28% (n=231) while Carr et al. (2008) found the absconding rate per admissions was 15.7% (n=3242).
Other ways of expressing absconding rates were also used. Bowers, Alexander and Gaskell (2003) found an absconding rate of 1.68 per 100 bed days \((n=5\) acute care wards); conversely Bowers, Simpson & Alexander (2005) found the mean rate of absconding was 0.57 per 100 bed days \((n=15\) adult acute care wards). Williams et al. (1999) found that there was 66 absconds in 13 years and Bowers (2003) states that an average 20 bed acute care ward has approximately 120 absconds per year. However, these absconding rates may be higher should one consider the assertion by Bowers, Simpson and Alexander (2005) who state that approximately 50% of absconds are not reported.

Making clear comparisons or obtaining meaningful data is difficult from the above, as some studies do not compare absconding to overall patients admitted, and in some cases absconding patients are included with patients who are discharged against medical advice. In addition, absconding rates are calculated differently, for example, per admission, per 100 bed days or per 100 discharges. Therefore, the true rate of absconding is masked and comparisons between studies can not be done. It would be fair to assume however, that given the large samples and the reported figures of 2.5% to 34%, taking the mid point percentage of 12%, may be an accurate estimate of the rate of absconding.

**2.8.3.2 Abscond return rate**

The literature did not succinctly identify the percentage of patients who absconded and returned. The articles concentrated on where they were found, or, who returned the patient. There was significant variation on the figures, with small samples provided. Williams et al. (1999) was the only article claiming that all patients who absconded
were returned \((n=66)\), with 69% caught in the first 24 hours, while 11% were absent for more than a month. However, this study was confined to special hospitals (forensic), hence a 100% return would be expected (Butwell & Jamieson 2000).

Bowers et al. (1999c) found 63% of patients returned on their own (pressured by others), 2% were returned by ward staff, 8% by relative or friends and 13% by police \((n=175)\); whereas Dickens and Campbell (2001) state 35.1% of patients were returned whilst on hospital grounds with police returning 23.6% \((n=148)\). Meehan, Morrison & McDougall’s (1999) definition of absconding was different to the others, and was when the patient physically left hospital grounds. In their study, they found 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 \((n=51)\). Walsh et al. (1998) state that patients returned 91% of the time, 62% returned on their own, 19% were accompanied by family or friends, 6% by police and 5% by hospital staff; with 80% returning within 24 hours \((n=1237)\). They also state that this is the highest return rate cited in the literature so far, yet Williams et al. (1999) found a 100% return rate. Nevertheless, it is clear from the above that families and friends, ward staff and police have all returned a patient at some point, with the patient themselves returning of their own volition.

The above rates comparison demonstrates that data depends on the definition of absconding and the setting of the study. The comparison of the absconding rates and abscond return rates hinges solely on this, and as such, comparison between the above is difficult. Bowers (2000) recommends ways to express absconding rates, highlighting this disparity that is evident and attempting to establish generalisability of research studies. His recommendations include using patient and event based figures,
standardised expression of rates, detail the duration of data collection as well as sample numbers, and, the expression of rates in many forms to allow comparisons to other studies (Bowers 2000).

2.8.3.3 Harm rate

This review located considerable literature regarding the incidences of harm in relation to absconding with reasonable sample numbers evident \( n=48 \) Farragher, Gannon & Ahmad 1996; \( n=95 \) Walsh et al. 1998; \( n=35 \) Bowers et al. 1999b; \( n=22 \) Shah & Ganesvaran 2000; \( n=88 \) Dickens & Campbell 2001; \( n=59 \) King et al. 2001; \( n=62 \) Bowers 2003; \( n=175 \) Bowers, Alexander & Gaskell 2003). There was concurrence in these studies that an absconding event may eventuate in significant harm to both the patient and others. Of note was Shah and Ganesvaran’s (2000) study, in which they found 21% of suicides occurred after the patient absconded from hospital.

There was variation to rates of harm to self and others, however these were difficult to compare, with Bowers et al. (1999c) finding 2.4% harmed themselves and 1.6% harmed others, while Bowers (2003) stated 4% of patients that abscond harmed themselves or others. Dickens and Campbell (2001) however found incidences of harm being 16.2% of all absconds, but this included both suicide and serious adverse outcomes. Farragher, Gannon and Ahmad (1996) found suicidal behavior and criminal activity was evident, rape occurred in one instance (Tammelleo 1999), while offenses such as theft, affray, threatening behaviour and assault occurred in a study by Brook, Dolan and Coorey (1999) with patients that abscond having no history of sexual offences or serious violence prior to the abscond event. Other risks associated with absconding were
identified as medication non-compliance, alcohol consumption and aggression or violence (Dickens & Campbell 2001; Bowers 2003; Carr 2006; JBI 2007a).

2.8.3.4 How patients abscond

Only four articles provided data on how patients absconded. Bowers et al. (1999a) identified that over half of the patients that 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. The JBI (2007a) identify also that over half of absconds occur while the patient is on leave with permission, and Brook, Dolan and Coorey (1999) state that absconds occurred during either community outings (61%) or running from the hospital site (38.8%), with most patients that abscond appearing to be impulsive or opportunistic. Dickens and Campbell (2001) stated 80% of patients on an unlocked ward walked out, while 29% of those in locked wards used agreed leave inside or outside grounds and failed to return. Breaching a locked environment occurred in 6.1% of cases. Others escaped by means of stealing keys, 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 patients that abscond. This is supported by Bowers et al. (2000) who found that ward observation had no significant relationship to absconding. It is clear in this instance that a locked door may be a deterrent, with leaving directly from a ward a common event. Granting leave with permission may also catalyse an absconding event; reinforcing the fact that physical
barriers may deter absconding for opportunists, but do not significantly prevent it (Dickens & Campbell 2001).

2.8.4 Theme 4: Thoughts and Feelings

2.8.4.1 Patients

There appears to be a number of reasons that may precipitate absconding (Meehan, Morrison & McDougall 1999; Bowers 2003). Bowers et al. (1999d) interviewed 52 patients, finding that 42% of patients felt fear, 26% felt isolated, 42% were homesick and 42% were bored. Treatment failure was another causative factor in absconding, with no single trigger, however psychiatric symptoms, or, mental state, could lead to absconding. However in this study and others, further reasons were provided in addition (Bowers et al. 1999d; Meehan, Morrison & McDougall 1999; Bowers 2003; Carr 2006; JBI 2007a). Concern for home and/or property and household and family responsibilities were other reasons voiced, with admission being a serious disruption to the patient’s life and a prison sentence to others (Bowers et al. 1999d; Bowers et al. 2000; Carr 2006; JBI 2007a). This is supported by Meehan, Morrison and McDougall (1999), who interviewed 100 consecutive people that absconded finding the emergent issues were boredom, uninteresting activities, disturbing ward environment, lack of insight into need for hospitalisation, concern about issues at home and rewards from absconding, for example greater attention and access to staff. Manchester et al. (1997) highlight food and lack of privacy as a causative factor of absconding along with the feeling that they are in a constant state of punishment.
In order for nursing interventions and other recommendations to have any sense of meaning, they should be considered within the context of the voices of patients, identifying common experiences and reasons. The picture that emerges from this can be applied, and nursing interventions can be created to meet patients’ needs and expectations.

2.8.4.2 Nurses

Three articles considered what absconding meant to nurses (Bowers et al. 1999b; Meehan, Morrison & McDougall 1999; Bowers 2003). It was found that the absconding behaviours caused disturbances in the ward, producing feelings of anger, guilt, concern, and anxiety, combined with a sense of failure that they did not predict, thus prevent, an abscond event. Nurses also felt that there was considerable effort spent in the implementation of the abscond procedure in combination with the paperwork involved, which essentially detracted treatment and care from other patients (Meehan, Morrison & McDougall 1999; Bowers 2003). Feelings of blame occurred, which resulted in job insecurity. Agency nurses were also mentioned as impacting negatively on the unit, with nurses convinced that eliminating agency staff, whilst increasing staffing levels and stability would decrease absconding incidences (Bowers et al. 1999b).

2.8.4.3 Outside consequences

Walsh et al. (1998) found that an absconding event creates trust issues, with families losing confidence in both psychiatric services and the unit; whilst Quinsey and Coleman (1997) found that the community confidence of mental health services is eroded and the public view the hospital as negligent.
2.8.5 Theme 5: Actions

2.8.5.1 When does absconding occur?

Bowers et al. (1999a) suggest that nursing handover times are the peak times for an absconding event to occur, implying the lack of supervision is exploited by patients determined to abscond; with most absconding events occurring during the first three weeks of admission. Carr (2006) supports this and suggests that the reduction of nursing surveillance during this time may provide opportunities that may not be available at other times. However this is disputed by Walsh et al. (1998), Bowers et al. (1999a) and Bowers et al. (2000), who found that ward observation had no significant relationship to absconding. Dickens and Campbell (2001) indicate that nearly half of all absconds occur between 1200 to 1600, with seasonal influences (warmer weather) a contributing factor; with Walsh et al. (1998) stating that 70% of all absconds occurred between the hours of 1330 to 2100, being most likely to occur in the earliest part of the week, and summer time was the peak period. Of note is Manchester et al. (1997) and Bowers (2003) assertion that the link between physical containment measures and surveillance is not well established, and may not be crucial to precipitating an absconding event, with other as yet unidentifiable factors playing a more important role.

2.8.5.2 Where do they go?

Farragher, Gannon and Ahmad (1996), Bowers et al. (1999c), Bowers (2003), Carr (2006) and JBI (2007a) found that most patients that abscond simply went home and engaged in normal day to day activities, while some visited or stayed with relatives or friends.
2.8.5.3 Nurses responses and assessments

Bowers et al. (1999c) indicate that nurses contact the police 47% when it is noticed that a patient has absconded and the ward is searched, however contacting relatives is rarely done. The police were contacted when nurses viewed the patient to be at high risk to harm self or others and/or were legally detained, with nurses overlooking short disappearances when patients were perceived as low risk.

The JBI (2007a) recommend in the abscond procedures aspects such as thorough searching of ward and grounds, notification of appropriate staff members and documentation requirements, yet fail to include such aspects such as contacting relatives, documentation of precipitating events that may have lead to the action, nor risk assessment processes. However, previously in the same article the evidence summary of the research shows that relatives can play a vital role in returning or persuading the patient to return the unit.

Neilson et al. (1996) and Shah and Ganesvaran (2000) suggest that when a patient is perceived as manipulative, threats of suicide are taken less seriously (yet do occur). By default, this perception could be applied to patients who voice abscond intent, which occurs in 58% of absconds, hence the voicing of intent should be taken seriously (Bowers 1999a). However there was no information in the articles reviewed ascertaining or quantifying how nursing staff made judgements in relation to identifying patients that may engage in high risk behaviours, nor why they judge some patients to be manipulative. This is highlighted in Bowers et al. (1999b), who identifies that risk assessment is problematic; with risks being perceived differently between physicians and nurses, and nurses are certain of their risk assessment. Neilson et al. (1996) support
this and suggest that nurses’ judgement of risk and subsequent management was as valid as that of physicians, with nurses paying little regard to recommendations made by physicians. Bowers et al. (1999b) state however, that risk predictions by psychiatric professionals are correct only one out of three times. From this premise therefore, nurses’ confidence in their risk assessment predictions may also be flawed. Dickens and Campbell (2001) suggest that that the efficacy of management of patients that abscond be established, with risk predictors playing an vital role, and Bowers et al. (1999b) state accuracy may be heightened by using only short term predictors of risk. Neilson et al. (1996) state that nursing care plans may be a useful tool in risk assessment, and be a useful aid to instigate nursing interventions designed to reduce absconding and/or harmful events. They also draw attention to nursing care plans as potentially legal documents, and hence it is necessary to have a full risk assessment and levels of supervision documented for all patients.

2.8.5.4 Nurses interventions and recommendations

Despite the links between absconding and harm and the inherent risks, there is sparse high quality information to assist in identifying interventions and strategies that may reduce the incidences of absconding (Meehan, Morrison & McDougall 1999). Manchester et al. (1997) further suggests that the role the therapeutic environment has, is uncertain and veiled in ambiguity.

Structural

Currently, in the literature reviewed, one particular common intervention is to lock the doors to the ward, although, as Bowers et al. (1999b) and Bowers (2003) points out, effectiveness has not been established, and nurses may be reluctant to participate. The
consequence of this is over-restriction of all inpatients, due to the actions of few, and captivity induced trauma may result (Dickens & Campbell 2001; Cohen 2004). Seclusion or containment is another management strategy to reduce problematic (conflict) behaviours, of which absconding is one (Muir-Cochrane & Holmes 2001; Bowers, Simpson & Alexander 2003; Muralidharan & Fenton 2006), with nurses claiming unknown efficacies when required to observe patients more closely in an attempt to prevent an absconding event (Bowers et al. 1999b).

Care received

One study found when patients who had absconded returned to the unit, one fifth were transferred to a high dependency unit, for closer observation and containment (Meehan Morrison & McDougall 1999). Most of the patients in this study were positive about this experience, claiming to receive more attention and greater access to nursing staff. This finding indicates that patients require closer attention to their personal needs, view absconding as an effective strategy for meeting those needs, and therefore feel a greater sense of security when these are met. Meanwhile, Bowers et al. (1999c) found that in 73% of cases no change of care for the patient occurred. Dickens and Campbell (2001) demonstrated that single event patients that abscond and multiple event patients that abscond were treated similarly, with no distinction made between the two; yet a history of absconding has been shown to increase the risk of absconding in the future (Meehan, Morrison & McDougall 1999). Walsh et al. (1998) found that only 2% were transferred to a general ward, 15% were transferred to a secure ward, 16% had their medication changed and 7% had their status changed from informal to formal. Nevertheless, the impact and subsequent implication of these strategies on staff and patients is unknown, with current clinical practice on the whole based on evidence that is derived from past
practices as opposed to practice based on RCTs or rigorously designed studies (Bowers 2003; Muralidharan & Fenton 2006).

Current strategies

Physical containment measures are not enough to reduce absconding and may result in trauma. Manchester et al. (1997) demonstrated that there are precipitating factors that include both environmental factors interacting with organic variables and psychological traits that contribute to absconding as a whole. This notion is reinforced throughout the literature included in this review. Bowers et al. (1999a) recommend that nurses develop therapeutic relationships with patients, locking doors to deter absconding, increased supervision to decrease exploitation, and targeting nursing interventions to those recently admitted. Bowers et al. (1999c) suggest alternative ways to encourage the patient that had absconded return to the ward and includes the following; utilising relatives, developing the role of community mental health members and to telephone the patient at home. Walsh et al. (1998) further support this and add that looking for the patient at a public house is a useful initial starting point.

Bowers (2003) and Bowers, Simpson and Alexander (2005) outline the strategies that were implemented in the United Kingdom encompassing five psychiatric wards initially, and then fifteen subsequently. In these trials, a number of measures were tested, which resulted in a 25% decrease of the absconding rate. These were: a book for signing in and out, identifying high risk patients and providing more time with nursing staff, providing controlled access to their home, encouraging contact with family and friends, careful conveyance of bad news to patients, post incident debriefings after violent or noisy altercations, and multidisciplinary reviews. From the decreased
absconding rates quoted, these interventions appear efficacious and are aimed at improving care in order to decrease absconding incidents (Bowers, Alexander & Gaskell 2003). In the wards where the interventions took place, decreases in locked doors were evident, however, violent incidences did not decrease (Bowers, Alexander & Gaskell 2003). It would be useful to trial this elsewhere to establish generalisability.

**Suggested strategies**

Dickens and Campbell (2001) are cautious about proposing set interventions, stipulating that efficacy should be evaluated before implementation occurs. However, they suggest that development of improved documentation that includes aspects such as previous circumstances and elements and outcomes of absconding incidents. Debriefing of patients should also occur, with locking of doors also a priority; noting however that this reduces opportunistic absconds versus those more determined. Shah and Ganesvaran (2000) recommend that nurses should be vigilant towards patients who demonstrate suicidal intent or ideation, and take special measures to engage patients at risk. Closer evaluation before the patient is granted leave should also occur. Carr (2006) suggests that on a personal level, nurses should consider the meaning of an admission for a patient and the significant impact on daily life experienced. Meehan, Morrison and McDougall (1999) suggest that staff ought to be experienced and skilled to deal with mentally ill patients; with activities in the ward being interesting and perceived as useful, with programs designed to meet different levels of patients 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, Morrison & McDougall 1999).
It has been noted that as absconding occurs at or just after admission, the creation of a caring environment, together with the development of therapeutic relationships may also reduce absconding. 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 recommendation that environmental factors should be carefully considered if known to precipitate emotional reactions. In addition, 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. Farragher, Gannon and Ahmad (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. Blass et al. (2001) suggest behaviour modifications plans were useful, while Higuera et al. (2006) demonstrate the use of humour on the ward can be a useful tool and LePage (1999) found that the use of a token economy was useful to target behaviours that may lead to negative incidents.

2.9 Discussion

The mental health of all populations is of prime concern globally. As identified in this literature review, absconding results in potential risk to patients, public safety issues, legal consequences and media exposure (Walsh et al. 1998; Andoh 1999; Brook, Dolan & Coorey 1999; Moore 2000; Tammelleo 2001, 2006). It is directly correlated with prolongation of inpatient psychiatric treatment, and as such, is costly for health services and deleterious for the patient. Over the last 42 years, 75 high quality articles have investigated this topic, but additional research will enable further strategies to be developed to decrease incidences of absconding.
As outlined in the above thematic analysis of the literature, there are extensive gaps in knowledge evident. There are varying absconding rates that serve to mask meaningful data, many do not define absconding, nor do many identify that absconding return rate. The impact the absconding event has on staff, organisations, patients and significant others was also not fully investigated, nor was the resultant trust issues that may arise. Ethnicity as a contributing factor is not explored, nor is the relationship between restraint and containment. In addition there are no proven nursing interventions and strategies that examine efficacies of management, risk assessment, nursing care plans or staffing levels; although interventions are being trialled in the United Kingdom. Some articles attempt to address these, however many fall short, and there is neither consensus on nursing best practice nor are current interventions based upon the principles of evidence based practice.

This literature review failed to accurately identify the prevalence of absconding in different settings. This creates difficulty to make any meaningful understanding either globally or locally. Thus, absconding policies within mental health services are based on assumptions and past practice. The few statistics that exist indicate that absconding results in negative outcomes, demonstrating a critical need for data recording and collection to be of high quality enabling accurate data capturing to ascertain true rates.

The findings in this review have identified the current state of play in relation to the phenomenon of absconding and have contributed towards the development of a potential profile of patients that abscond. However, whilst constructing such a profile is important, there is a risk of extraneous factors remaining unrecognised. Other factors
that need to be considered include; the psychological profile and characteristics of the individual patient, the meaning of the admission, alienation, social structure of the unit, situational and environmental factors and precipitating events. Similarly, it is clear that police are used frequently in patient retrieval returning to hospital, however studies have shown that family members, friends and community mental health teams may be untapped resources.

Interventions developed should be flexible enough to cover patients that may not meet this identified profile, but possess a number of the other risk factors. Interventions should also address interactive events that may precipitate an abscondion. Therefore nurses should be mindful to treat each patient as an individual and aim to predict and prevent absconding, being aware of the negative outcomes that may eventuate. To do this, nurses should strive to promote optimal care that is therapeutically meaningful, by utilising the absconding profile and aforementioned identified issues as warning signals and potential predictors, rather than absolutes (Lake 2006). Containment is used as an intervention to control a variety of problem behaviours, one of which is absconding (Muir-Cochrane & Holmes 2001). There is little evidence to support its efficacy and no gold standard research is available to date (Muralidharan & Fenton 2006). Containment measures should be considered as an individual aspect of a nursing intervention, and is one that is of concern. Containment therefore ought be considered within the context of the least restrictive environment principle (WHO 1996, p. 4).

2.10 Review Limitations

There are a number of limitations in this systematic review. Decision-making was crucial as each decision may enhance or detract from the review validity. Being a
novice researcher, decision making was difficult, however, attempts were made to ensure the decision for inclusion was correct. The search strategy may have also been flawed. Seven databases were used, however other databases may have yielded greater results. Other databases were attempted to be utilised, however it was unclear whether they included peer reviewed journals, and the advanced search option did not have a peer review limiter. For the purposes of validity and quality, these databases were excluded. Another important limitation was time period and funding. Hand searching was not done given the time restrictions and lack of funds. The result of which may have been the omission of pertinent articles. English language articles were also chosen due to funding limitations pertaining to translation. Missing articles may also limit the findings of the review as omission of too many articles can make the conclusions made unreliable (Bowman 2007). However there is no way to ascertain if there were other articles that could have been included.

2.11 Bias

Selection and performance bias was reduced by a critical synthesis of the literature and adhered to standards as outlined by Higgins and Green (eds 2006). However, only one study formally trialed intervention efficacies, and as such, it would be unwise to base nursing interventions on this alone. Publication bias may be evident in this review as outlined in the limitations; as the results of the studies is limited to finding relevant studies. This was reduced by showing overall consistency with the findings as a whole. Duplication of results is also concerning in this review, as included articles refer in their article to other included articles. This was attempted to be minimised by highlighting or excluding duplicates throughout the review.
2.12 Robustness

A vast amount of information was analysed within the data gathered and subsequently synthesised. Each article was reviewed in its entirety and key phrases were pasted into the codebook to ensure context of meaning was intact. The number of issues that were addressed in these articles created issues for transparency, with the author attempting to maintain simplicity, although it was difficult to do, given the threads of meaning that were interspersed, with numerous factors interacting with each other. Replication of review was a key consideration to ensure transparency and this is outlined clearly.

Transferability was difficult to establish, however given the repetitive nature of findings, it became clear that transferability was established by the collective whole. Guest, Bunce and Johnson (2006) state that 12 interviews are enough to achieve theoretical saturation, with larger samples required to find correlation between variables. To further support this, Roberts and Taylor (2002) suggest that 10 years is a reasonable period of time in which to search. Theoretical saturation therefore occurred in this instance, and correlations were found in existing literature, however gaps in knowledge were still evident and are individually identified before the discussion begins. Other aspects of critical reflection of synthesis are interspersed within this review.

2.13 Conclusion

Further research in absconding is required. Whilst links between absconding and harm have been conclusively demonstrated, significant gaps in knowledge exist. The profile of patients that abscond has been somewhat established, however ambiguity remains.
There is little known about ethnicity and multicultural factors and links to absconding, nor have correlations and implications of containment and absconding been established. The prevalence rates of absconding hinges upon definitions and quality data recording, yet it is evident that throughout the literature it is either not occurring or, the information is unavailable; the result of which is the prevalence of absconding is hard to establish. The papers are clustered around aspects of harm and risk, profiles and absconding rates, with few exploring other areas. Nursing interventions have also been trialed in order to decrease absconding events. These have been met with success, however further research to demonstrate efficacy is needed.

While Muralidharan and Fenton (2006) concluded in their study that in the absence of RCTs, the benefits or evident harm could not be established, they argue therefore that current practice should not continue until such trials commenced, and efficacy be recognised. For the purposes of both absconding and containment, it is unethical to conduct RCTs in this area. Hence, the collection of evidence should be of prime concern, with studies seeking to quantify the aforementioned discrepancies and justify with evidence the use of current interventions, and, to investigate and implement others in attempts to prove efficacy.

Nurses should reflect upon their current practices in conjunction with the findings of this review and investigate new ways of practice that encompass aspects such as risk assessment, abscond procedures, untapped resources, multidisciplinary cooperation and ward unity. By treating patients as individuals and attempting to alleviate or address their feelings upon admission, creation of therapeutically caring relationships occurs. Nurses are also charged to contribute to bodies of evidence; there is considerable scope
to contribute to this area of nursing, and nurses should be encouraged to develop ways
to add to this.

2.14 Acknowledgement

The researcher would like to acknowledge Professor Len Bowers for his reflections on
this literature review and resulting journal publication (Muir-Cochrane & Mosel 2008a).
Chapter 3: Methods

3.0 Introduction

This chapter will identify the research problem, aims of the research and justification for this research, together with the methods used. The research design, tools and measures, procedural and instrumentation measures employed will be identified, and the reliability and validity aspects of this research will be discussed; which ensures that the research undertaken is rigorous, accurate, credible and meaningful (Walliman 2001; Schneider et al. 2004). The data analysis methods employed as well as the ethical issues that may arise when embarking upon research of vulnerable population groups will also be examined (Liamputtong & Ezzy 2006; Liamputtong 2007).

The researcher is mindful that there has been minimal research within Australia seeking to investigate the absconding behaviours of psychiatric patients. The rate of absconding has not been established in different Australian psychiatric facilities, and little has been done to define the profile of patients that abscond in an Australian setting. Nursing interventions and current practices to reduce incidences of absconding have not been investigated substantially in Australia; yet have been trialled in the UK. It is clear however, that current nursing interventions are not based on evidence, but on widely held beliefs (Bowers et al. 2002; Melvin, Hall & Bienek 2005; Muralidharan & Fenton 2006; Haglund, Von Knorring & Von Essen 2006). A retrospective data analysis of absconding behaviours allows the exploration of this phenomenon in detail and may provide an in depth understanding of absconding, serving as an impetus to facilitate evidence based nursing interventions (Gamel et al. 2001; Foss & Ellefsen 2002).
3.1 The research problem

As has been demonstrated in Chapter 2, the phenomenon of absconding has been under investigated, both globally and in Australia. There exists a lack of high quality evidence and significant gaps in knowledge remain. This research will identify the profile of patients that abscond in an Australian setting, which may then lead to conclusively identifying causative factors as well as attempting to establish efficacies of treatment.

3.2 Aims of the research

An initial starting point was a 12 month data analysis of acute care detained patients admitted to a large metropolitan psychiatric hospital campus in Australia that abscond. The data analysis was completed to meet the below aims.

**Overall Aim**

To examine absconding behaviour over 12 months.

**Aim 1**

To determine the rate of absconding on three acute care inpatient wards over 12 months.

**Aim 2**

Determine the profile of patients that abscond from this setting, including the analysis of areas such as population demographics, diagnosis, time of absconding, legal status and identification of patients that abscond more than once.

3.3 Justification

An explanation of the rate of absconding across one hospital campus will generate sophisticated and complete data which will allow meaningful interpretation, generate
further research questions and suggest implications for practice (Barbour 2000; Barbour & Barbour 2003).

### 3.4 Method

#### 3.4.1 Research design

This is an empirical study gathering data about absconding that can be useful to generate knowledge about this phenomenon (Polit & Hungler 1999; Denzin & Lincoln eds 2000; Schmitz 2001; Rowbottom & Aiston 2006). A retrospective descriptive survey was designed to examine absconding behaviour over 12 months. By using descriptive statistics and summarising and quantifying the characteristics of the numerical data, the information obtained can aid prediction of future absconding and serves to stimulate causal hypotheses (Polit & Hungler 1999; Schneider et al. 2004; Walliman 2001; Eakin & Mykhalovskiy 2003; Leedy & Ormrod 2005; Mitchell & Jolley 2007).

Literature suggests that this is the best approach to be used, with Bowers (2000) stating that the ideal way to examine incident rates is by using patient and event based figures. This is advantageous as these rates are less likely to fluctuate over time, thereby reducing the period of time the data need be collected. This further allows the multiple event patients to be identified, the rigorous expression of rates will be produced and the precision will be achieved. To further support the approach used in this current study, a number of studies included in Chapter 2 utilised retrospective data analysis and descriptive statistics. These studies were; Meehan, Morrison, & McDougall (1999), who analysed consecutive AWOL events in order to develop a profile of the patient and their
characteristics; and Dickens and Campbell (2001) examined retrospectively case notes over three years to obtain absconding patient characteristics. Walsh et al. (1998) identified all absconding incidents over a 12 month period and compared the patient characteristics to the hospital population at large, while other studies retrospectively analysed absconding patients or events, using random sampling or control groups to compare overall patient characteristics, outcome variables, risk assessment or, to predict absconding behaviours (Farragher, Gannon & Ahmad 1996; Quinsey & Coleman 1997; Pages et al. 1998; Brook, Dolan & Coorey 1999; Moore & Hammond 2000; Shah & Ganesvaran 2000).

3.4.2 Tools and measures

This is a retrospective analysis of data that is a normal function of organisational audit within a large metropolitan psychiatric hospital in Australia. Data of all acute care absconding events was provided by this campus in the form of Excel spreadsheets and included areas such as time and date of absconding, non-identifiable patient number (to allow for the same patient who absconds more than once to be identified), admission data, detention status, gender, CALD patients, DRG and principal diagnosis, number of occupied beds and separations for all acute care wards (voluntary and detained patients).

3.5 Procedures

Descriptive research has the capacity to be strong and meaningful when seeking to provide essential information that then requires understanding (Gross Portney & Watkins 2000). To demonstrate rigour, the following critical components will now be discussed (Aroni et al. 1999; Tobin & Begley 2004).
3.5.1 Instrumentation

Data were provided by this campus as a normal function of organisational audit. The analysis was undertaken by the researcher using components of Microsoft Office 2003 Excel software package.

3.5.2 Reliability

The site was chosen because this psychiatric hospital campus has a comprehensive and complete data as the accuracy and credibility of the data source is an important consideration (Gross Portney & Watkins 2000).

3.5.2.1 Internal Reliability

As non-identifiable data is provided by an outside source, there may be measurement errors within this area. The researcher in this instance is powerless to audit these processes and must rely on the collection of the data internally to be accurate. In order to ensure credible findings, the data analysed was compared to other studies to assess for congruence (Gross Portney & Watkins 2000; Schneider et al. 2004). In addition, the data collected was analysed by a statistician to ensure accuracy of calculations.

Selection bias did occur in this setting, as the phenomenon of interest dictates that absconding data were retrospectively analysed, and all acute care absconding events within this 12 month period were identified and included in the analysis (Schneider et al. 2004).

3.5.2.2 External Reliability

Currently, there are no published studies concerned with the profile of patients that abscond in Australia. The information generated by this research study may therefore
serve to establish generalisability of other previous studies indicated in the literature review and will provide initial data that will allow comparisons to future Australian studies (Gross Portney & Watkins 2000; Muir-Cochrane & Mosel 2008a).

### 3.5.3 Validity

Validity is the most appropriate and meaningful interpretation of results in relation to the study (Schneider et al. 2004). How the data were analysed and the methods of measure were the most appropriate and feasible way to attempt to generate information related to the phenomenon of absconding (Walliman 2001; Schneider et al. 2004). Validity refers to variables and the relationship between (Walliman 2001; Schneider et al. 2004). This study did not seek to implement variables, nor did it attempt to discover these. Nevertheless, it is anticipated that this exploratory research will inform future studies to reduce the incidence of absconding. The results generated were compared with other existing studies, in particular the work of Bowers et al. (2000) and Carr et al. (2008), expanding understanding of the phenomenon of absconding.

### 3.5.4 Data Analysis

Descriptive statistics were used and measured variability by way of central tendency. This study utilised statistical measures that includes mean, mode and proportion, aiming to describe the demographics of detained absconding patients and their central tendencies (Corty 2007; University of Calgary 2007). Descriptive statistical methods were individually applied to other variables available in the data provided by this hospital and included diagnosis, gender and age. These statistical methods included calculation of the rate of absconding, a description of the demographics of patients that abscond and time of absconsion within the Microsoft Excel software package. To
achieve this, formulas were keyed into the software spreadsheets, which enabled the calculation of mean, mode and proportion.

Admission data or separation (discharge) data may be used for calculations of rates. If admission data is used, then the absconding rate is an expression of episode against the number of admissions by 100 to get a percentage. Patients may have several admissions in this hospital however will only have one separation (discharge). Therefore separation data were used to ensure accuracy of absconding rates. For the purposes of this research, these absconding rates are an expression of episodes against the number of separations. In addition, by using separation data, a complete and accurate profile of detained patients that abscond was determined.

3.6 Ethical Aspects

Researching vulnerable individuals or population groups is required to be ethically appropriate, with informed consent and confidentiality of significant concern for any research project (Liamputtong & Ezzy 2006; Liamputtong 2007). Therefore the ethical component of this research should be given utmost consideration and conducted with the greatest amount of sensitivity (Liamputtong & Ezzy 2006; Liamputtong 2007). This research studied data obtained from a large metropolitan psychiatric hospital campus in Australia; an organisation that contains vulnerable population groups. However, this study did not involve contact with human participants, but did require analysis of patient information.

As it sought to retrospectively analyse data collected from this site of interest, this researcher was mindful that an individuals right to privacy is fundamental, however it is
recognised that ‘research, and the compilation or analysis of statistics, are important for providing information to help the community make decisions that impact on the health of individuals and the community’ (NHMRC 2001, p. 1). Nevertheless the privacy of the individual should be protected. For this particular research purpose there was no need for the identification of the patients to occur. In this instance, in accordance with guidelines approved under Section 95A of the Privacy Act 1988 (NHMRC 2001, p. 44), an organisation may provide information to the researcher, provided that de-identification occurs prior to the organisation providing the information. Within this context, the NHMRC (2007) define this as non-identifiable data; meaning the person's identity remains unknown, however can be linked with other data.

The National Statement on Ethical Conduct in Human Research (NHMRC 2007) provides further guidelines in relation to the identification of data. Data may be collected, stored and disclosed in three ways, individually identifiable data, re-identifiable data and non-identifiable data. For the purposes of this research, whilst data will be termed non-identifiable, the organisation that the data were collected from has the capacity to re-identify the data if need be, hence the data may be potentially re-identifiable. The ability to de-identify and re-identify data has been acknowledged within this statement as enhancing the contribution that research can make. This serves this researcher well, should any information become available that may affect the well-being and safety of the psychiatric patient being analysed. However, it was anticipated that the information that was collected would not have any bearing on the well-being and safety of the patients being analysed. The data analysed in this instance included, but was not limited to, age, gender, patients from a CALD background, principal diagnosis, and, time, date and ward of the admission and separation. This researcher
understands the implications within The National Statement on Ethical Conduct in Human Research (NHMRC 2007) and did not attempt to re-identify the collected data. Potential conflicts of interest within the organisation, institution and researcher have been considered within this framework, with none being identified (NHMRC 2007).

This researcher adhered to the Flinders University’s ethical research requirements (Flinders University 2007). In accordance with these ethical research requirements an Ethics Protocol form has been lodged and ethics approval for this research has been granted. This is provided in Appendix 5 and 6 as evidence.

3.7 Dissemination of findings

Dissemination of findings is an extremely important component of the research process in order to communicate the findings, as it is of little utility or value to the scientific community if the findings remain unknown (Polit & Hungler 1999; Schneider et al. 2004). Therefore the research findings were disseminated in the following ways:

- Presentation of findings at the Australian College of Mental Health Nurses (ACMHN), Branch International Conference Melbourne 2008.
- Presentation of findings at Glenside Campus 2008.
- Two journal articles submitted and accepted for publication in the International Journal of Mental Health Nursing and the Journal of Psychiatric and Mental Health Nursing (Appendix 1, 7, 8).
3.8 Conclusion

The aims of this research, and the justification of the methods used have been presented in this chapter. A comprehensive discussion on the issues of rigour, inclusive of validity and reliability, together with ethical components has been addressed. The research methods identified in this chapter have been identified as the most appropriate way to meet the stated aims of this research. The next chapter will present the findings of this research into the phenomenon of absconding. This will include descriptive statistics of the data analysed, which has been shown in this chapter as the most ideal way to present such data, with the result therefore allowing a meaningful interpretation.
Chapter 4: Findings

4.0 Introduction

The findings of this research will be presented in this chapter, and will show the patient demographics of the acute care hospital population and the findings of the absconding data analysis. The data were collected between the periods of 1st September 2006 to 31st August 2007 and analysed retrospectively. Absconding was defined as a detained patient who leaves the premises (ward) without permission. The absconding rates calculated are expressed as a percentage or per 100 separations; with separations being defined as a patient discharged from hospital. The structures of the tables presented within this chapter were adapted from the Publication Manual of the American Psychological Association (APA 2001).

The expression of absconding incident rates in past research has been identified by Bowers (2000, p. 365) as problematic; ‘resulting in incomparability of information between studies and a lack of precision’. This has arisen by inconsistency of calculations as has been outlined in Chapter 2 (Section 2.8.3). Bowers (2000) suggests that to maintain uniformity in research (dependant upon the research question) clear identification of event based or patient based incidents should occur. When using event based data, repeat incidents by patients are distributed across the total number of patients; resulting in higher rates. Alternatively, patient based calculations ignore repeat incidents by patients and results in lower figures than the corresponding event based method. There are a number of advantages in using patient based calculations. These include the ability to identify artefacts within the data, rules out the effect of one patient
who creates multiple incidents, is less likely to fluctuate over time and has the potential to identify underlying trends (Bowers 2000). By using a patient based method, the time over which data needs to be collected decreases, with Bowers (2000) suggesting 12 months being ideal to calculate meaningful and comparable rates. Event based and patient based data are clearly identified throughout this chapter.

Descriptive statistics were used in this research and measured variability by way of central tendency. These statistical measures used mean, mode and proportion to describe the demographics of patients that abscond and their central tendencies. Raw data were provided in Microsoft Excel spreadsheets from the site. Descriptive statistical methods were also applied to other variables (diagnosis, gender and age). The absconding rate, identification of patients that abscond, absconding events, the profile of patients that abscond (including the average age, gender, diagnosis), population groups, patients that abscond more than once, legal status and time of absconsion will be described in this chapter.

4.1 Site

The site of the research is a major metropolitan psychiatric hospital campus located in Australia. Data were collected from the three acute care wards (one of which was closed/locked).

4.2 Patients that abscond and absconding events

Over a period of 12 months, there were 49 patients who left without permission a total of 64 times. Only absconding events by detained patients were recorded in this hospital,
so there are no records of voluntary patients leaving without permission. Each absconding event was analysed and patients were identified via their de identifiable patient number. By identifying patients that abscond as opposed to absconding events, a meaningful comparison of event based or patient based data occurs (Bowers 2000). For the purposes of this research, the absconding rates will be determined for the detained sector of the hospital population as absconsions by voluntary patients is unknown.

### 4.3 Absconding rates

<table>
<thead>
<tr>
<th>Table 1. The absconding rates of the detained hospital population: event based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absconding events</strong></td>
</tr>
<tr>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

As shown above in Table 1, there were 480 detained patients and 64 absconding events. Therefore the absconding rate for the detained sector of the hospital was 13.33% and was calculated by using the number of absconding events, dividing this by the number of separations and then using a constant multiplier, being 100, to make a percentage (Schneider et al. 2004, pp. 310-311). This rate therefore can also be expressed as 13.33 absconding events per 100 detained separations.

The gender of detained patients was then analysed. There were 50 absconding events by men, and 337 detained males. The absconding rate of detained males was 14.84% \((n=50/337)\), or 14.84 absconding events by males per 100 detained male separations. There were 143 detained females, and 14 absconding events by females. The
absconding rate of detained females was 9.79% \((n=14/143)\), or 9.79 absconding events by females per 100 detained female separations.

### 4.4 Demographic data of the acute care hospital population: 1\(^{st}\) September 2006 to 31\(^{st}\) August 2007

#### 4.4.1 Gender and Age

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total separations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n) Voluntary and detained</td>
<td>410</td>
<td>210</td>
<td>620</td>
</tr>
<tr>
<td>% overall</td>
<td>66.13</td>
<td>33.87</td>
<td>100</td>
</tr>
<tr>
<td>(n) Detained only</td>
<td>337</td>
<td>143</td>
<td>480</td>
</tr>
<tr>
<td>% of total detained</td>
<td>70.21</td>
<td>29.79</td>
<td>100</td>
</tr>
<tr>
<td>% of separations (per sex)</td>
<td>82.20</td>
<td>68.10</td>
<td></td>
</tr>
<tr>
<td>% overall</td>
<td>54.36</td>
<td>23.07</td>
<td>77.42</td>
</tr>
</tbody>
</table>

As expressed in Table 2, the hospital population was comprised of 66.13\% \((n=410/620)\) males and 33.87\% \((n=210/620)\) females. Out of all detained patients, 70.21\% \((n=337/480)\) were male, whilst 29.79\% \((n=143/480)\) were female. 82.20\% \((n=337/410)\) of male patients were detained, whilst 68.10\% \((n=143/210)\) of female patients were detained.

The mean age of all patients was 33.37 years with a median age of 36 years. The mean age of male patients was 35.92 years and median age was 35 years. The mean age of female patients was 40.2 years and median age 40.
The histogram below, Figure 1, demonstrates the age range of all separated patients and confirms the mean and median age findings; showing the frequency of ages, with the highest being between the ages of 30 to 39 years.

**Figure 1. The age spread of the hospital population demonstrating the most frequent score and mode: patient based**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No. Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19 years</td>
<td>16</td>
</tr>
<tr>
<td>20-29 years</td>
<td>162</td>
</tr>
<tr>
<td>30-39 years</td>
<td>195</td>
</tr>
<tr>
<td>40-49 years</td>
<td>144</td>
</tr>
<tr>
<td>50-59 years</td>
<td>75</td>
</tr>
<tr>
<td>60-69 years</td>
<td>28</td>
</tr>
</tbody>
</table>

**4.4.2 Population groups**

In the data supplied by this hospital campus, the ethnicity of each patient (known as Cultural and Linguistically Diverse, or, CALD) was identified. For the purposes of this research CALD patients were defined as patients, that were identified within data supplied by the hospital, as Aboriginal and Torres Strait Islanders (ATSIs) and Other (non Caucasian or ATSIs). The patient’s ethnicity within this research project is known as the CALD background and when patients from a CALD background are compared to Caucasian patients, then the term ‘population groups’ are used.

Of particular importance is that the hospital did not identify within the data collected the ethnicity of a number of patients within the hospital population. These patients appeared
within the data under the heading ‘Not Known’. This heading used by the hospital has been adopted within this thesis as a population group to reflect that the CALD background of these patients in not known.

**Table 3: The population groups of the hospital**

<table>
<thead>
<tr>
<th>Population groups</th>
<th>Hospital separations: voluntary and detained ( n (%) )</th>
<th>Hospital separations: detained only ( n (%) )</th>
<th>Detention rate of each population group ( % )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>405 (65.32)</td>
<td>318 (66.25)</td>
<td>78.52</td>
</tr>
<tr>
<td>CALD</td>
<td>71 (11.45)</td>
<td>60 (12.50)</td>
<td>84.51</td>
</tr>
<tr>
<td>Not Known</td>
<td>144 (23.23)</td>
<td>102 (21.25)</td>
<td>70.83</td>
</tr>
<tr>
<td>Total patients</td>
<td>620 (100)</td>
<td>480 (100)</td>
<td>77.42</td>
</tr>
</tbody>
</table>

As expressed above in Table 3, the total percentage of patients that were identified as Caucasian was 65.32\( (n=405/620) \), 11.45\( (n=71/620) \) were CALD, while the ethnicity of 23.23\( (n=144/620) \) is unknown. 84.51\( (n=60/71) \) of CALD patients were detained, while 78.52\( \% \) of Caucasians were detained.

The population groups as a proportion are shown below in Figures 2 and 3. Note in both figures the large number of patients whose ethnicity is unknown and slight increase of CALD patients that are detained.
Figure 2. Population groups of the hospital

Patient population groups: all acute care hospital separations

- Caucasian, 405, 65.32%
- CALD, 71, 11.45%
- Not known, 144, 23.23%

Figure 3. Population groups of the detained hospital patient population

Patient population groups: all detained acute care hospital separations

- Caucasian, 318, 66.25%
- CALD, 60, 12.50%
- Not known, 102, 21.25%
4.4.3 CALD Background

4.4.3.1 CALD patients from a CALD background

Table 4. Patients from a CALD background and the hospital population

<table>
<thead>
<tr>
<th>CALD patients</th>
<th>Hospital separations: voluntary and detained</th>
<th>Hospital separations: detained only</th>
<th>Detention rate of each population group %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>voluntary n (%)</td>
<td>detained n (%)</td>
<td></td>
</tr>
<tr>
<td>ATSIs (% of total hospital separations)</td>
<td>46 (64.79)</td>
<td>39 (65)</td>
<td>84.78</td>
</tr>
<tr>
<td>Other (% of total hospital separations)</td>
<td>25 (35.21)</td>
<td>21 (35)</td>
<td>84.00</td>
</tr>
<tr>
<td>Total patients from a CALD background</td>
<td>71 (100)</td>
<td>60 (100)</td>
<td>84.51</td>
</tr>
<tr>
<td>Total hospital separations</td>
<td>620 (11.45)</td>
<td>480 (12.50)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows the CALD background of the CALD population. Overall 84.51% \((n=60/71)\) of CALD separations were detained. While there were 64.79% \((n=46/71)\) of ATSIs within this population group, 84.78% \((n=39/46)\) were detained. There were 35.21% \((n=25/71)\) of Other CALD patients, 84% \((n=21/25)\) were detained.

4.4.3.2 Population groups: a comparison

Figure 4 (shown below) demonstrates the proportion of voluntary hospital separations voluntary to detained hospital separations for each population group. When compared to the Caucasian population group (Table 3, Section 4.4.2), the Caucasian detention rate is 78.52% \((n=318/405)\) and this histogram demonstrates that patients from a CALD background are detained in a higher proportion to Caucasian patients. Comparisons to the category Not Known cannot be made.
Figure 4. Population groups: a comparison of detained and voluntary hospital separations

4.4.4 Principal Diagnosis

For the purposes of this research, only the major three principal diagnoses of the patient hospital population are included here as there are over 17 principal diagnoses for patients used over this time.
As shown in Table 5, the most frequent three principal diagnoses are: 57.74% schizophrenic disorders (n=358/620), 23.23% Major affective disorders (n=144/620) and 8.23% Personality disorders (n=51/620). The average length of stay for acute care patients was 33.44 days. A full description of principal diagnoses used in this thesis are described in the glossary.

The most frequent diagnosis (schizophrenic disorders) was then compared to the gender composition of patients diagnosed with schizophrenic disorders and is expressed in this table as well. There was a total of 410 separated males in the hospital population and 251 (61.22%) were diagnosed with schizophrenic disorders. There were 210 separated females in the acute care hospital population and 107 (50.95%) were diagnosed with schizophrenic disorders.

### 4.5 Demographic data of patients that abscond

The demographic data of patients that abscond will now be shown and comparisons will be made to the hospital population that was presented previously in Section 4.4.
4.5.1 Gender and Age

By adjusting the data and identifying patients that abscond more than once, it allows for a more meaningful analysis. For example, by including all absconding events, the average age of the patient that absconds will not be true, as the patient may abscond a number of times. Similarly, by comparing the gender of patients that abscond, patient based calculations are required as the above also holds true. Adjusting data for patients that abscond more than once and identifying whether it is event or patient based is therefore necessary.

4.5.1.1 Gender

<table>
<thead>
<tr>
<th>Patients</th>
<th>Male</th>
<th>Female</th>
<th>Total patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Patients that abscond</td>
<td>37 (75.51)</td>
<td>12 (24.49)</td>
<td>49 (100)</td>
</tr>
<tr>
<td>Absconding events</td>
<td>50 (78.13)</td>
<td>14 (21.88)</td>
<td>64 (100)</td>
</tr>
<tr>
<td>Detained hospital separations</td>
<td>337 (70.21)</td>
<td>143 (29.79)</td>
<td>480 (100)</td>
</tr>
<tr>
<td>(% of patients that abscond to separations)</td>
<td>(10.98)</td>
<td>(8.39)</td>
<td>(10.21)</td>
</tr>
<tr>
<td>(% of absconding events to separations)</td>
<td>(14.84)</td>
<td>(9.79)</td>
<td>(13.33)</td>
</tr>
</tbody>
</table>

Table 6. A comparison of gender to patients that abscond, absconding events and detached hospital separations: patient and event based

Out of the 64 absconding events, 78.13% of males (n=50) and 21.88% of females (n=14) were responsible. However, when adjusted for patients that abscond more than once (ignoring repeat incidents/events by the same patient), 75.51% (n=37/49) were male and 24.49% (n=12/49) were female. This is expressed above in Table 6.

As also shown above in Table 6; the gender of patients that abscond was then compared to the detached hospital population. 10.98% (n=37/337) of the male detached patient
population abscond, while 8.39% \( (n=12/143) \) of the female detained patient population abscond.

To aid in interpretation, the gender of patients that abscond were compared to the overall hospital population and the detained population within and is shown below in Figure 5. This figure demonstrates that a higher proportion of male patients abscond in relation to the hospital male population when compared to females that abscond and the hospital female population.

**Figure 5. The proportions of gender: a patient based comparison**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients that abscond</td>
<td>24.49%</td>
</tr>
<tr>
<td>Acute care detained hospital population</td>
<td>75.51%</td>
</tr>
<tr>
<td>Acute care hospital population (voluntary and detained)</td>
<td>33.87%</td>
</tr>
</tbody>
</table>

4.5.1.2 Age

The average age of patients that abscond was 33.33 years. The age range of patients that abscond was also analysed as the mean is affected by all scores in the distribution. This ensures that the findings are accurate and are not affected by an extreme score or by using a small sample size. In addition, by using the mode, it then allows for the most frequent score to be determined and aids in the interpretation of the data.
As shown below in Figure 6, the most frequent age range of patients that abscond is between 20-29 years and demonstrates that the interpretation of the data may be affected when using only one statistical measure.

**Figure 6. Age spread comparison of patients that abscond to the hospital population: patient based**
4.5.2 CALD patients

4.5.2.1 CALD Background

Table 7. The demographics of patients that absconds by population group and CALD background: patient based

<table>
<thead>
<tr>
<th>Population groups</th>
<th>Total patients that abscond n</th>
<th>% per CALD background</th>
<th>% overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>33</td>
<td>67.35</td>
<td></td>
</tr>
<tr>
<td>ATSIs</td>
<td>6</td>
<td>12.24</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>8.16</td>
<td></td>
</tr>
<tr>
<td>Not Known</td>
<td>6</td>
<td>12.24</td>
<td></td>
</tr>
<tr>
<td>Total overall</td>
<td>49</td>
<td>100</td>
<td>20.41</td>
</tr>
</tbody>
</table>

The CALD status of all patients that abscond was also analysed, and serves to provide further information. As expressed above in Table 7, 67.35% (n=33/49) of patients that abscond were identified as Caucasians, 12.24% (n=6/49) as ATSIs, 8.16% (n=4/49) Other (not Caucasian or ATSIs) and 12.24% (n=6/49) were Not Known. When CALD patients that abscond were considered as a whole, 60% (n=6/10) were ATSIs. The percentage of patients that abscond that were from a CALD background was 20.24% (n=10/49). Figure 7 below demonstrates the demographics of the population groups while Figure 8 demonstrates the demographics of the patients that abscond by ethnicity.
4.5.2.2 Population group comparison

To aid in interpretation, each population group of patients that abscond were compared to the detained hospital population. As shown below in Figure 9, 78.52% (\(n=318/405\)) of Caucasians patients were detained and 8.15% (\(n=33/405\)) abscond; while 84.51% (\(n=60/71\)) of CALD patients were detained and 14.08% (\(n=10/71\)) abscond. The
percentages of CALD patients that are detained and abscond are higher proportionately to that of Caucasians; however there were 4.17% \( (n=6/144) \) of patients that abscond and their CALD background is unknown.

**Figure 9. Patients that abscond as a proportion to the detained hospital population (per population group): patient based**

![Population group comparison chart](chart.png)

<table>
<thead>
<tr>
<th>Population group</th>
<th>Percentage of this population group that are detained</th>
<th>Percentage of this population group that abscond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>8.15%</td>
<td>0.00%</td>
</tr>
<tr>
<td>CALD</td>
<td>14.08%</td>
<td>70.83%</td>
</tr>
<tr>
<td>Not Known</td>
<td>78.52%</td>
<td>94.51%</td>
</tr>
</tbody>
</table>

Figure 10 (shown below) compares the total hospital separations for each population group to that of patients that abscond. Out of 620 separations, 7.42% \( (n=46) \) were ATSIs patients. From the ATSIs inpatient population of 46, 13.04% \( (n=6/46) \) absconded. Patients from an Other CALD background made up 4.03% \( (n=25/620) \) of the hospital inpatient population. From this patient population of 25, 16% \( (n=4/25) \) absconded. Conversely, Caucasians made up 65.32% \( (n=405/620) \) of the hospital inpatient population, and 8.15% \( (n=33/405) \) of patients from this population group absconded.
Figure 10. A comparison of the hospital demographics of each population group compared to patients that abscond (per population group): patient based
4.5.3 Principal Diagnoses and Gender

4.5.3.1 Principal Diagnosis: patients that abscond

Table 8. Principal Diagnoses and patients that abscond: patient based

<table>
<thead>
<tr>
<th>Principal Diagnoses</th>
<th>Male n (%)</th>
<th>Female n (%)</th>
<th>Total patients that abscond n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic disorders</td>
<td>28 (57.14)</td>
<td>6 (12.25)</td>
<td>34 (69.39)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td>(75.68)</td>
<td>(50.00)</td>
<td></td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>5 (10.20)</td>
<td>1 (2.04)</td>
<td>6 (12.25)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td>(13.51)</td>
<td>(8.33)</td>
<td></td>
</tr>
<tr>
<td>Severe depressive episode</td>
<td>-</td>
<td>1 (2.04)</td>
<td>1 (2.04)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td></td>
<td>(8.33)</td>
<td></td>
</tr>
<tr>
<td>Mental &amp; behavioural disorder</td>
<td>-</td>
<td>1 (2.04)</td>
<td>1 (2.04)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td></td>
<td>(8.33)</td>
<td></td>
</tr>
<tr>
<td>Unspecified nonorganic psychosis</td>
<td>1 (2.04)</td>
<td>2 (4.08)</td>
<td>3 (6.12)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td>(2.70)</td>
<td>(16.67)</td>
<td></td>
</tr>
<tr>
<td>Not stated in data</td>
<td>3 (6.12)</td>
<td>1 (2.04)</td>
<td>4 (8.16)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td>(8.11)</td>
<td>(8.33)</td>
<td></td>
</tr>
<tr>
<td>Total patients that abscond</td>
<td>37 (75.51)</td>
<td>12 (24.49)</td>
<td>49 (100)</td>
</tr>
<tr>
<td>(% of patients that abscond per sex)</td>
<td>(100)</td>
<td>(100)</td>
<td></td>
</tr>
</tbody>
</table>

The principal diagnoses of patients that abscond were then examined so that the profile of patients that abscond could be further developed. As shown above in Table 8, the majority (mode) of patients that abscond (69.39%, n=34/49) were diagnosed with some form of Schizophrenia. A full description of the principal diagnoses used in this thesis is described in the glossary.

The gender of each patient who absconds was then compared to their diagnosis. As is shown above in Table 8, the highest group of patients that abscond were males diagnosed with schizophrenic disorders (57.14%, n=28/49). If patients that abscond were to be considered within each gender grouping only, then 75.68% (n=28/37) of male patients that abscond were diagnosed with schizophrenic disorders.
Females diagnosed with schizophrenic disorders (12.25%, \( n = 6/49 \)) are also considered here; as they are the next highest group of patients that abscond in relation to gender, and is expressed above in Table 8. Female patients that abscond were considered within this gender grouping only, and 50% (\( n = 6/12 \)) of female patients that abscond were diagnosed with schizophrenic disorders.

### 4.5.3.2 Comparison

A comparison in the below histogram (Figure 11) shows clearly that when the genders of patients that abscond are compared to the principal diagnoses, the most frequent principal diagnosis by far for both male and female patients that abscond is schizophrenic disorders. This figure also shows the spread of principal disorders amongst male and female patients that abscond.

**Figure 11. Gender and Principal Diagnoses comparison: patient based**
4.5.4 Age: a comparison to Principal Diagnoses and Gender

4.5.4.1 Average age by Principal Diagnoses and Gender

Table 9. The average age of patients that abscond: patient based

<table>
<thead>
<tr>
<th>Patients</th>
<th>Male Average age</th>
<th>Female Average age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic disorders</td>
<td>32.17</td>
<td>30.67</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>39.60</td>
<td>40</td>
</tr>
<tr>
<td>Severe depressive episode</td>
<td>-</td>
<td>41</td>
</tr>
<tr>
<td>Mental &amp; behavioural disorder</td>
<td>-</td>
<td>38</td>
</tr>
<tr>
<td>Unspecified nonorganic psychosis</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Not stated in data</td>
<td>46.67</td>
<td>26</td>
</tr>
<tr>
<td>Total patients that abscond</td>
<td>34.82</td>
<td>32.42</td>
</tr>
<tr>
<td>Comparison: Total hospital population</td>
<td>35.92</td>
<td>40.2</td>
</tr>
<tr>
<td>Comparison: Total hospital detained population</td>
<td>35.56</td>
<td>39.67</td>
</tr>
</tbody>
</table>

The average age of all patients that abscond was analysed previously in this chapter. However a more in depth analysis is now presented here and is expressed above in Table 9, reflective of the principal diagnosis, gender and average age of patients that abscond, with a comparison to the hospital population provided. By doing so, it will allow the profile of patients that abscond to become clearer.

4.5.4.2 Male

The average age of males diagnosed with schizophrenic disorders that abscond (being the most frequent in relation to principal diagnosis; 57.14% overall or 75.68% of male patients that abscond), is 32.90 years and is expressed above in Table 9. However, the age spread of this group; shown below in Figure 12, Section 4.5.4.4, demonstrates that 53.57% (n=15/28) of male patients that abscond diagnosed with schizophrenic disorders were aged between 20-29 years.
4.5.4.3 Female

The second highest group of patients that abscond in relation to principal diagnosis and gender, were females diagnosed with schizophrenic disorders (12.25% overall, or, 50% of female patients that abscond). As expressed above in Table 9, their average age was 30.67 years. However, the age spread of this group, shown below in Figure 12, Section 4.5.4.4, illustrates that 66.67% \( (n=4/6) \) of female patients that abscond diagnosed with schizophrenic disorders were aged between 20-29 years.

4.5.4.4 Comparison

Figure 12 (below) shows the spread of the hospital population of male and female patients diagnosed with schizophrenic disorders and their age range as a comparison to male and female patients diagnosed with schizophrenic disorders that abscond and their age range.

While 36.65% \( (n=92/251) \) of all separated male patients diagnosed with schizophrenic disorders were aged between 30-39 years, 53.57% \( (n=15/28) \) of all male patients that abscond that were diagnosed with schizophrenic disorders were aged between 20-29 years.

This histogram below also demonstrates that 33.65% \( (n=36/107) \) of all separated female patients diagnosed with schizophrenic disorders were aged between 40-49 years, however, 66.67% \( (n=4/6) \) of female patients that abscond diagnosed with schizophrenic disorders were aged between 20-29 years. While 33.64% \( (n=36/107) \) of separated females diagnosed with schizophrenic disorders were aged between 40-49 years (the most frequent score), there are no female patients that abscond aged within this range.
Figure 12. A comparison of the age ranges and gender of patients: patient based

<table>
<thead>
<tr>
<th>Patients diagnosed with Schizophrenic disorders: a gender and age range comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Graph</strong></td>
</tr>
<tr>
<td><strong>Legend</strong></td>
</tr>
<tr>
<td>All male acute care hospital patients diagnosed with Schizophrenia (n= 251; expressed as a percentage)</td>
</tr>
<tr>
<td>All male patients that abscond diagnosed with Schizophrenic disorders (n= 28; expressed as a percentage)</td>
</tr>
<tr>
<td>All female acute care hospital patients diagnosed with Schizophrenic disorders (n= 107; expressed as a percentage)</td>
</tr>
<tr>
<td>All female patients that abscond diagnosed with Schizophrenic disorders (n= 6; expressed as a percentage)</td>
</tr>
</tbody>
</table>

4.6 Legal Status

Table 10. The legal status of the patients that abscond and events: patient and event based

<table>
<thead>
<tr>
<th></th>
<th>3 day detention n (%)</th>
<th>First 21 day detention n (%)</th>
<th>Second 21 day detention n (%)</th>
<th>Continued detention n (%)</th>
<th>Forensic Patient Order n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients that abscond</td>
<td>2 (4.08)</td>
<td>29 (59.18)</td>
<td>10 (20.41)</td>
<td>7 (14.29)</td>
<td>1 (2.04)</td>
<td>49 (100)</td>
</tr>
<tr>
<td>Absconding events</td>
<td>2 (3.13)</td>
<td>40 (62.50)</td>
<td>12 (18.75)</td>
<td>9 (14.06)</td>
<td>1 (1.56)</td>
<td>64 (100)</td>
</tr>
</tbody>
</table>
4.6.1 Patients that abscond

The legal status of patients that abscond was then analysed and is expressed above in Table 10. 59.18% (n=29/49) of patients that abscond left whilst on their first 21 day detention order; whilst 20.41% (n=10/49) left when on their second 21 day detention order.

4.6.2 Absconding events

As expressed in Table 10, 62.50% (n=40/64) of all absconding events occurred during the patients first 21 day detention order. Then, 18.75% (n=12/64) of all absconding events occurred while patients were on their second 21 day detention order.

4.7 Patients that abscond more than once

4.7.1 Identification

<table>
<thead>
<tr>
<th>Patients that abscond once n (%)</th>
<th>Patients that abscond more than once n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absconding events by patients that abscond twice (n %)</td>
<td>5 (10.20)</td>
<td>(50)</td>
</tr>
<tr>
<td>(n %) of patients who abscond more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absconding events by patients that abscond 3 times (n %)</td>
<td>5 (10.20)</td>
<td>(50)</td>
</tr>
<tr>
<td>(n %) of patients who abscond more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total no. of patients that abscond (n %)</td>
<td>39 (79.59)</td>
<td>10 (20.41)</td>
</tr>
<tr>
<td>(n %) of patients who abscond more than once</td>
<td></td>
<td>(100)</td>
</tr>
<tr>
<td>Total absconding events</td>
<td>39 (60.94)</td>
<td>25 (39.06)</td>
</tr>
</tbody>
</table>
As expressed above in Table 11, ten patients (20.41%, \(n=10/49\)) absconded more than once. However, of the 64 absconding events, 25 events (39.06%, \(n=25/64\)) were by patients that abscond more than once.

Overall, 79.59% of all patients who absconded did so only once. Then, 10.20% (\(n=5/49\)) of patients absconded twice and 10.20% (\(n=5/49\)) of patients absconded three times within this 12 month period. However, if patients that absconded more than once were to be considered separately (\(n=10\)), then 50% (\(n=5\)) absconded twice and 50% (\(n=5\)) absconded three times.

4.7.2 Comparison

Figure 13 is shown below and compares absconding events by patients that abscond more than once to patients that abscond only once. Figure 14 compares patients that abscond once to patients that abscond more than once. When these figures are shown together, meaningful comparisons can be made.
Absconding events by patients that abscond more than once accounted for nearly half (39.06%) of all absconding events. However, this group represented only 20.41% of patients that abscond overall. This demonstrates the need for patient or event based calculations to be clearly stated within the findings.
4.8 Absconding times

For ease of reference, one histogram (Figure 26) is presented showing the times between 12:00 to 23:59. During the hours between 00:00 to 11:59 there were 10 absconding events; 1 event at 00:00 to 00:59, 1 event at 01:00 to 01:59, 2 events at 09:00 to 09:59, 3 events at 10:00 to10:59 and 3 events at 11:00 to 11:59.

**Figure 15. The times when absconding occurred - 12:00 to 23:59: event based**

As is shown in Figure 15, there were 54 events during the hours of 12:00 to 23:59. The most frequent times of absconding over the 24 hour period were between the hours of 19:00 to 20:59. The next highest time of absconding was between 15:00 to 15:59.
4.9 Conclusion

The findings of this research have been presented in this chapter. A total of 64 absconding events by 49 patients were analysed and comparisons made. The absconding rate, broad demographics of patients that abscond and patients that abscond more than once were identified within the data; and the legal status of patients that abscond and mode of absconding times were determined. A discussion of these findings will be presented in the following chapter.
Chapter 5: Discussion

5.0 Introduction

This chapter discusses the significance of the findings of the study, identifies implications for future practice and research, and, makes suggestions for future nursing practice to reduce the incidences of absconding.

5.1 Rate and profile of absconding

The findings in Chapter 4 presented an absconding rate in the detained inpatient population only. However, it should be noted that in the hospital, most of the acute care inpatient population (77.42%) were detained. The calculated rate of absconding therefore by detained patients was 13.33%, but there is no data available about voluntary patients leaving this hospital without formal approval at this stage. For this reason, these findings need to be interpreted with caution and cannot be generalised to a total ward population (of voluntary and detained patients). The rate within this study of 13.33% is higher than two studies have reported (Meehan, Morrison & McDougall 1999; Bowers, Simpson & Alexander 2003), but lower than a number of others (Pages et al. 1998; Dickens & Campbell 2001; Bowers, Simpson & Alexander 2003; Carr et al. 2008; Khisty et al. 2008).

As identified in Chapter 2 (Section 2.8.3), calculations of the rate of absconding varies, and how the rates were calculated are not always stated in research papers, hence useful comparison of rates remains problematic (Bowers 2000). However, the findings in this
The profile of patients that abscond were identified in this study as being predominately male diagnosed with some form of Schizophrenia (57.14% of all patients that abscond). Whilst the average age of patients that abscond was 33.33 years, 46.94% of patients that abscond were aged between 20 and 29 years. This finding was then compared to that of male patients that abscond diagnosed with schizophrenic disorders, whereby, the average age was 32.17 years, however 53.57% of these patients were aged between 20-29 years. This is in keeping with the profile of patients that abscond developed in previous studies (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; JBI 2007a). However, these findings should be considered within the context that a high proportion of the overall acute hospital inpatients are males diagnosed with schizophrenic disorders (40.48%). So while it can be suggested that this group is at higher risk of absconding, caution in labelling this group is necessary.

Consistent with previous findings, the highest principal diagnoses of patients that abscond for both males (75.68%) and females (50%), was some form of Schizophrenia;
although 8.16% of patients that abscond had no recorded diagnosis. Consistent with as well with previous findings, 66.67% of female patients that abscond diagnosed with schizophrenic disorders were aged between 20 to 29 years. Of particular note however, was that while the majority (33.64%) of the female inpatient hospital population diagnosed with schizophrenic disorders were aged between 40 to 49 years, there were no female patients diagnosed with schizophrenic disorders that abscond aged in this range. In addition, of interest in this study was that 25% of absconding patients were female. In this study, the absconding rate of detained females was 9.79% which is only 5.05% less than that of males. The literature published to date indicates females that abscond do so in smaller numbers than the findings of this current study (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; JBI 2007a); and only three studies have reported comparable absconding rates in both male and females (Walsh et al. 1998; Dickens & Campbell 2001; Khisty et al. 2008). In this current study, from the detained inpatient hospital population, 29.79% were female and 8.39% of detained females abscond; while 70.21% of detained patients were male and 10.78% abscond. While males abscond in higher proportions to females, the findings indicate that there is a higher ratio of females that abscond to the detained hospital inpatient population of females (≈1:4) when compared to males (≈1:7). Therefore these findings suggest that more attention to females as patients that abscond may be warranted and indicates the age of female patients may be a contributing factor towards absconding risk.
5.2 Ethnicity and patients who leave hospital without permission

The lack of research in this area has created difficulty for any meaningful understanding of ethnicity and its relationship towards absconding either globally or nationally. CALD populations have been historically under investigated within the context of mental health, and in particular, absconding. Only two articles in 12 years have sought to identify ethnicity as a contributing factor towards absconding, with mixed results (Pages et al.1998; Dickens & Campbell 2001).

In this study, 20.41% of patients that abscond were identified as being from a CALD population group as opposed to 67.35% of patients that abscond being identified as Caucasian. These findings indicate CALD patients that abscond are overrepresented when compared to the broader hospital population demographics (11.45% of patients from a CALD background, as opposed to 65.32% of Caucasian patients). Overall, 8.15% of the total Caucasian inpatient population abscond, while 14.08% of the CALD inpatient populations abscond. Within this population group 13.04% of the ATSIs inpatient population abscond, yet the overall ATSIs inpatient population was only 7.42%. In addition, within the CALD inpatient population, Other patients from a CALD background represented 4.03% of the overall hospital population, yet 16% of patients from this population group absconded. Thus the relationship between the inpatient hospital population to patients that abscond becomes inverted when comparing the population group of Caucasians to patients from a CALD background. The data therefore indicates that patients from a CALD background abscond at higher rates than
the Caucasian population group, and consideration of these population groups to be included within an absconding risk profile may be useful.

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 as the ethnicity of 23.23% of the hospital population was not known. Nevertheless, the findings in this research suggest CALD population groups are at higher risk of absconding. Even so, these findings should be interpreted with caution as a large number of CALD absconding events originated from one ward (with 100% of ATSI patients that abscond absconding from this ward); which is designated for rural and remote patients, and, as indicated previously, the ethnicity of a large number of patients within the hospital inpatient population is unknown.

5.3 Ethnicity, mental health determinants and the hospital population

There is a paucity of mental health knowledge relating to those patients of a CALD background (Patterson 2000; Summerfield 2008). Research indicates that not only does poor mental health consist of social and economic disadvantage, but also arises when there is lack of investment into effective health interventions and insensitivity towards cultural differences (Larson et al. 2007). There are persistent relationships between health indicators and socioeconomic variables and consistent associations between poor mental health outcomes and racial discrimination (Larson et al. 2007). Thus, culture is identified as a contributing key factor towards the determinant of health, with presentation, classification and attribution of mental disorders varying between cultures.
(WHO 2004; WHO 2007; Summerfield 2008). Statistical data for the mental health of CALD populations is scarce, yet significant health inequalities appear (WHO 2004; Resnik & Roman 2007; WHO 2007). Generating new knowledge that is specifically focused on CALD population groups can therefore facilitate a greater understanding of mental health on both a multicultural and global level.

On a national level, Vicary and Westerman (2004) indicate that the ATSIs population are particularly disadvantaged and cite behaviours within the context of mental health that may be reactions to dispossession, racism and oppression. Within their personal history, there exists cultural genocide, economical disadvantages, trauma, grief and poor health outcomes. This serves to exacerbate and contribute towards negative outcomes overall and is demonstrated in the findings, whereby 64.79% of the CALD inpatient population were ATSIs.

That said, a number of other population groups exist within Australia, in particular refugees, whose personal history encompasses displacement, genocide, dispossession, war and trauma (and includes the impact of mandatory detention) and represent over 12% of total permanent additions to Australia (ABS 2007). This personal history however may in turn lead to a wide range of psychological reactions (Murray, Davidson & Schweitzer 2008). Within the context of this current research, it is unknown whether these population groups were represented within the hospital inpatient population (4.03% Other and 23.23% Not Known). Nevertheless, CALD population groups have been identified as bearing a disproportionate burden from unmet mental health needs; and it is likely that a small sector of the hospital population contained patients who have
experienced displacement, genocide, war and trauma (Silove 2002; Shelton 2004; ABS 2008a).

Concern has been expressed within the literature that there may be exaggerated assessments of risk for patients of ethnic origins (Prins 1993 cited in Bowers et al. 2008, p. 199) and are more likely to be perceived as more violent than their Caucasian counterparts (Singh 1998). These exaggerated assessments of risks may also be reflected in the criteria for detention orders; whereby clinicians determine the level of risk of harm to self and others being the basis for a detention order to be issued Mental Health Act 1993 (SA), s.2 (12). The detention rates of the hospital population were considered within this context. 11.65% of the overall inpatient population were patients from a CALD background and was comparable to the overall detained inpatient population whereby 12.50% were patients from a CALD background. However, population groups were also examined and CALD patients were detained at a higher rate (84.51%) than Caucasian patients (78.52%); and within the CALD inpatient population, the ATSIs inpatient population was detained at a rate of 84.78%. The voluntary and detained inpatient population comprised of 65.32% of Caucasians and 8.15% of this population group abscond. Conversely, this was reversed when comparing this to patients from a CALD background, whereby 11.45% of the voluntary and detained inpatient populations were patients from a CALD background, and 14.08% of this population group absconds.

The finding of these higher rates for patients of a CALD background suggests that these patients are more likely to be detained and later abscond. However, the reasons as to why the detention and absconision rates of CALD population groups are higher than
other population groups, together with the overrepresentation within the hospital are
unknown; indicating that further research is necessary. Nevertheless, the comparison
between patients that abscond from a Caucasian background versus a CALD
background has enabled a greater understanding of CALD patients that abscond
previously examined in Section 5.3 and adds to the aforementioned profile of patients
that abscond. These findings may also aid in the compilation of risk assessment upon
admission should health professionals consider these findings within the above context.
However, generalisation from these results cannot be made as data from only three
acute care wards in one large Australian psychiatric hospital has been used in this
research.

5.4 Involuntary patients who leave hospital
In this study, the highest percentage of absconding events occurred whilst the patient
was on their first 21 day detention order (62.50%). This is an important finding, as to
date, a number of studies that have investigated absconding have included both
voluntary and involuntary psychiatric patients; however they have not identified the
patients legal status upon absconsion (Farragher, Gannon & Ahmad 1996; Walsh et al.
1998; Andoh 1999; Bowers et al. 1999c; Brook, Dolan & Coorey 1999; Meehan
Morrison & McDougall 1999; Bowers et al. 2000; Moore 2000; Shah & Ganesvaran
2000; Bowers, Alexander & Gaskell 2003; Bowers, Simpson & Alexander 2003; JBI
2007a; Carr et al. 2008; Khisty et al. 2008). Only one study identified the legal status of
patients upon absconsion, however, failed to interpret the results (Dickens & Campbell
2001). Overall, the general consensus is however, that patients who abscond are more
likely to be involuntarily detained.
The findings in this current research suggest that there is a high risk of absconding when the patient is on their first 21 day detention and adds to the aforementioned profile of patients that abscond. These findings should be interpreted with caution as only involuntary patient data were analysed and therefore these findings cannot be generalised to a total ward population of voluntary and detained patients.

5.5 Patients that abscond repeatedly

The findings in this research have demonstrated that nearly 40% of absconding events were by patients that had previously absconded. However, only 20.41% of patients that abscond were responsible for these events. The findings also demonstrated that there was an equal likelihood of a patient absconding twice or three times. The finding that nearly 40% of absconding events were by patients who had previously absconded is higher than reported in Meehan Morrison and McDougall (1999), which found over one third of all absconding incidences were by the same individuals. A small sub group of patients that abscond accounted for nearly half of all absconding incidences in this current research study, and absconded two or three times. Factors are unknown as to why the characteristics of this group compel them to leave repeatedly, nor why such a small minority. However these findings suggest that a history of absconding increases the risk of this behaviour in the future and therefore serves as a possible future predictor of absconding.

5.6 The times that patients abscond

Absconding occurred with higher frequency between the hours 1900 to 2059, and the second peak of absconding occurred between the hours 1500 to 1559. At this hospital,
nursing handover is between the hours of 1900 to 1959 and afternoon tea for the nursing staff is between the hours of 1500 to 1559. This finding is similar to that of other studies (Walsh et al. 1998; Bowers et al. 1999b; Dickens & Campbell 2001; Carr et al. 2008). This seems to indicate that there is a relationship between nursing observation and absconding times and suggests that the reduction of nursing staff during these times may provide opportunities for a patient intent on absconding that is not available at other times.

5.7 Reasons for absconding: a CALD perspective

A number of reasons for why patients abscond have been explored within Chapter 2, however literature published to date has not explored this from a CALD perspective; and there is limited literature available investigating why CALD populations are overrepresented in psychiatric facilities (Murray, Davidson & Schweitzer 2008, pp. 6-8). Roxbee and Wallace (2003) suggest that there is a relationship between mental health, social disadvantage, cultural components and historical origins. In addition, health care within Australia is based predominately upon the biomedical model. However, holistic health is becoming more popular within the main stream population, and is vitally important to CALD populations (Vicary & Westerman 2004). The constructs that are important include the mind, body, spirituality and environmental (Summerfield 2008). The above relationships and constructs outlined above coexist within the Australian mental health system. Therefore, issues that arise within this context include difficulties understanding treatments prescribed and the explanations provided which affect freedom (Department of Health 2005). There are differing perspectives of mental health, unsafe cultural practices within treatment units (including no staff present of the same origin as the patient or same sex staff), racist providers,
linguistic barriers, poor literacy, deficient cultural explanations for causation prior to diagnosis and treatment, absence of cross cultural support and communication difficulties whereby familiarity does not necessarily mean understanding (Brown 2001; Bhugra & Flick 2005; Department of Health 2005; Thomas & Anderson 2006).

Cultural safety is therefore an important issue for a patient from a CALD background. Perceptions of racism results in a reluctance to access mental health services (Kowanko et al. 2004; Larson et al. 2007) and may lead to feelings of being unsafe and therefore can lead to absconding. The forced dislocation of CALD populations (Department of Health 2005) can create difficulties for the recovering patient and may be inconsistent with the principles of least restrictive care (WHO 1996). Fear may be also a contributing factor, as many remote ATSIs have been institutionalised; returning a different person and being unable to fulfil their family and community roles (Vicary & Westerman 2004). Loss of family and separation from own kin, together with separating an Indigenous person from their land (Brown 2001; Zeldenryk & Yalmambirra 2006) may also serve to provide an impetus towards absconding.

Cultural traditions and mores may also contribute towards absconding events. For example, Janca and Bullen (2003) established that ATSIs populations do not view time as a linear concept. Time is perceived as static, with important events being viewed as closer in time than other irrelevant events; of which hospitalisation is one (Janca & Bullen 2003). Vouching is also an important tool used by the ATSI communities and means the conveyance of positive and negative information regarding health professionals. Many ATSIs will not see a non Indigenous health professional if they
have not been vouched for in a positive way and is problematic in the case of forced admission (Vicary & Westerman 2004).

All of these issues may serve to make a patient from a CALD background uncomfortable in their surroundings thus contributing towards absconding. By conducting an assessment of the specific factors that are important to the patient and their implications, it has the ability to ensure culturally safe care and the potential to reduce adverse events.

5.8 Limitations

There are a number of limitations within this current study. There is incomplete data, as the hospital recorded the absconsions of only detained patients. Therefore this research is not generalisable to the entire hospital population. In addition, most of the published literature to date refers to absconsions by both voluntary and involuntary patients. Thus comparisons are difficult to make within a wider setting.

While many reasons have been suggested regarding why patients from a CALD background abscond, the data is incomplete as there are a large number of patients whose CALD background is unknown. However because data were provided in this way, there is no way to rectify this. Furthermore, the reasons of why patients left without permission were not explored; yet it is clear that reasons are an important component of the phenomenon in question.

This research was unable to determine the harm rate of patients during their period of absence or links to aggression and violence. Furthermore, because of the confines of
this thesis, there were time constraints that were necessary to complete this honours program. Therefore the data collected and analysed was restricted to patients admitted to the acute care sector of this hospital (three acute care wards; one of which was closed/locked). However it would have been useful to have included the rehabilitation sector as well. By doing so a richer understanding of the phenomenon would have occurred.

5.9 Suggestions for practice and conclusion

Research findings have contributed to a growing body of knowledge in relation to the phenomenon of absconding. Unfortunately, direct comparisons with other studies were not possible due to the study samples and methods used; however, this current study adds to the limited available research about absconding in Australia. In this study, approximately one in eight patients abscond and this indicates that absconding is a problem of sufficient enormity to warrant greater attention.

Whilst the profile of patients that abscond concurs with available literature to date, patients were slightly older than previously reported and almost 25% were women (Walsh et al. 1998; Dickens & Campbell 2001). Patients from a CALD background were at higher risk of absconding and were overrepresented within the inpatient population. The findings suggest that once a patient absconds, the risk is then increased. Men are more likely to abscond than women, however closer attention to female patients that abscond is warranted. By placing the patient on their first 21 day detention order, there is a risk of absconding, and decreased nursing staff present on the ward may also contribute towards absconding risks.
However, other factors need to be considered, and have been identified by Muir-Cochrane and Mosel (2008a) and explored partially in Chapter 2 and Section 5.8. These include; the psychological profile and characteristics of the individual patient, the meaning of the admission, alienation, social structure of the unit, situational and environmental factors and precipitating events. There is little known about ethnicity and multicultural factors and links to absconding, nor have correlations and implications of containment and absconding been established.

Within this context, nurses should be mindful to treat each patient as an individual and aim to predict and prevent absconding, being aware of the negative outcomes that may eventuate. To do this, nurses should strive to promote optimal care that recaptures the sense of what an admission means to the patient; the result being therapeutically meaningful care (Bowers 2003). Nurses may utilise the profile of patients that abscond and the identified contributors towards absconding that are outlined within these chapters. However nurses should be aware to treat these as warning signals and potential predictors, rather than absolutes; and should take care not to label patients (Lake 2006).

In summary, this thesis sought to present a snapshot of absconding from one Australian psychiatric hospital campus. The findings of this research have provided data within an Australian setting that future studies may be compared against, and it is anticipated that this will also provide a platform for future research to be undertaken. It is this researcher’s hope that the reasons of absconding are established within an Australian setting, and effective nursing interventions be developed within Australia to reduce the
incidences of harm to self and others that appear with prevalence in the literature to date.
References


Appendix 1

Systematic Literature Review

Appendix 2

Description of articles included in systematic literature review

<table>
<thead>
<tr>
<th>No.</th>
<th>Authors</th>
<th>Country</th>
<th>Title</th>
<th>Journal</th>
<th>Evidence Rank</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andoh</td>
<td>UK</td>
<td>Selected characteristics of absconders and non-absconders from mental hospitals: a comparison.</td>
<td><em>International Journal of Social Psychiatry</em></td>
<td>L 3.3 credible</td>
<td>This paper compares selected characteristics of absconders with those of non-absconders matched for age group, sex, type of ward and length of stay.</td>
</tr>
<tr>
<td>3</td>
<td>Bowers 2000</td>
<td>UK</td>
<td>The expression and comparison of ward incident rates.</td>
<td><em>Issues in Mental Health Nursing</em></td>
<td>L 4 credible</td>
<td>The expression of ward incident rates in past research has been unclear and disorganized, resulting in incomparability of information between studies and a lack of precision.</td>
</tr>
<tr>
<td>4</td>
<td>Bowers 2003</td>
<td>UK</td>
<td>Runaway patients.</td>
<td><em>Mental Health Practice</em></td>
<td>L 4 Case study interview</td>
<td>Professor Bowers reports on research which offers useful insights into why patients abscond and discusses how absconding rates might be cut.</td>
</tr>
<tr>
<td>5</td>
<td>Bowers, Alexander &amp; Gaskell 2003</td>
<td>UK</td>
<td>A trial of an anti-absconding intervention in acute psychiatric wards.</td>
<td><em>Journal of Psychiatric &amp; Mental Health Nursing</em></td>
<td>L 4 credible</td>
<td>The aim of this trial was to evaluate the impact of an intervention to reduce absconding by patients from partially locked acute psychiatric wards. Five acute psychiatric wards in one hospital were entered into a stepped, before-and-after controlled trial.</td>
</tr>
<tr>
<td>6</td>
<td>Bowers, Jarrett, Clark, Kiyimba &amp; McFarlane 1999a</td>
<td>UK</td>
<td>Absconding: how and when patients leave the ward... part 2</td>
<td><em>Journal of Psychiatric &amp; Mental Health Nursing</em></td>
<td>L 4 credible</td>
<td>This paper reports relevant findings from a large scale study of absconding conducted in the East End of London. harder to develop supportive alliances with patients.</td>
</tr>
<tr>
<td>7</td>
<td>Bowers, Jarrett, Clark, Kiyimba &amp; McFarlane 1999b</td>
<td>UK</td>
<td>Absconding: nurses views and reactions...part 4</td>
<td><em>Journal of Psychiatric &amp; Mental Health Nursing</em></td>
<td>L 4 Case study interviews</td>
<td>This paper reports the views of 25 staff nurses working on acute mental health wards in East London about absconding. Interviews explored how staff feel when a patient absconds, the complexities of risk assessment and observation policies, who is blamed when patients abscond and what might reduce absconding.</td>
</tr>
<tr>
<td>8</td>
<td>Bowers, Jarrett, Clark, Kiyimba &amp; McFarlane 1999c</td>
<td>UK</td>
<td>Absconding: outcome and risk... part 3.</td>
<td><em>Journal of Psychiatric &amp; Mental Health Nursing</em></td>
<td>L 4 Quant</td>
<td>This paper reports the findings of a large prospective study of absconding in the East End of London.</td>
</tr>
<tr>
<td>9</td>
<td>Bowers, Jarrett</td>
<td>UK</td>
<td>Absconding: why patients leave... part 1.</td>
<td><em>Journal of Psychiatric &amp; Mental Health</em></td>
<td>L 3.2 Quant case</td>
<td>This paper describes the methodology of a major prospective study of absconding.</td>
</tr>
<tr>
<td>Reference</td>
<td>Country</td>
<td>Study Type</td>
<td>Setting</td>
<td>Journal</td>
<td>Study Design</td>
<td>Summary</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>------------</td>
<td>---------</td>
<td>---------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>Clark, Kiyimba &amp; McFarlane 1999d</td>
<td>UK</td>
<td>Determinants of absconding by patients on acute psychiatric wards.</td>
<td>Nursing control interview credible</td>
<td>Journal of Advanced Nursing</td>
<td>L.3.1 control groups randomized comparison credible</td>
<td>This paper reports on a prospective study of absconders from 12 acute admission wards in three English National Health Service Trusts over 5 months, compared to a control group matched for ward. Extensive data on absconder and control characteristics were collected from case records and from nursing staff.</td>
</tr>
<tr>
<td>Bowers, Jarrett, Clark, Kiyimba &amp; McFarlane 2000</td>
<td>UK</td>
<td>Patient-staff conflict: Results of a survey on acute psychiatric wards.</td>
<td>Social Psychiatry and Psychiatric Epidemiology</td>
<td>L.3.3 credible</td>
<td>The aim of this study was to assess the frequency and relationship between the differing conflict behaviours of patients, and explore the relationship between professional containment measures and those conflict behaviours.</td>
<td></td>
</tr>
<tr>
<td>Bowers, Simpson &amp; Alexander 2003</td>
<td>UK</td>
<td>Real world application of an intervention to reduce absconding.</td>
<td>Journal of Psychiatric &amp; Mental Health Nursing</td>
<td>L.4 credible</td>
<td>A self-training package, and offered freely to wards across the UK who agreed to implement it and audit the results. Fifteen wards completed this distributed audit, and achieved overall a 25.5% decrease in their absconding rates, as measured by official reports.</td>
<td></td>
</tr>
<tr>
<td>Bowers, Simpson &amp; Alexander 2005</td>
<td>UK</td>
<td>Absconding of patients detained in an English Special Hospital.</td>
<td>Journal of Forensic Psychiatry</td>
<td>L.3.3 credible</td>
<td>This study set out to examine the significance of previously identified clinical factors and specific absconder profiles in risk assessment, by comparing the frequency of key variables in a group of Special Hospital absconders and non-absconders.</td>
<td></td>
</tr>
<tr>
<td>Brook, Dolan &amp; Coorey 1999</td>
<td>UK</td>
<td>Discharge against medical advice from inpatient psychiatric treatment: a literature review.</td>
<td>Psychiatric Services</td>
<td>L.4 Literature review credible</td>
<td>The authors searched the PubMed and PsycINFO databases and selected articles for review if studies had been conducted in an inpatient setting or included discharge against medical advice as one of the aims or results.</td>
<td></td>
</tr>
<tr>
<td>Carr 2006</td>
<td>Global</td>
<td>Evidence summary: absconded patient: clinician information</td>
<td>JBI</td>
<td>L.3.2 Evidence summary review of literature</td>
<td>Reports findings from a multicentre service evaluation project conducted in acute psychiatric inpatient units in NSW, Australia. Overall rates of aggression, absconding and early readmission are reported, as well as length-of-stay profiles and associations between these outcomes and selected sociodemographic and clinical characteristics.</td>
<td></td>
</tr>
<tr>
<td>Carr, Lewin, Sly, Conrad, Tirupati, Cohen, Ward, &amp; Coombs 2008</td>
<td>Australia</td>
<td>Adverse incidents in acute psychiatric inpatient units: rates, correlates and pressures</td>
<td>Australian and New Zealand Journal of Psychiatry</td>
<td>L.4 Data analysis</td>
<td>Reports findings from a multicentre service evaluation project conducted in acute psychiatric inpatient units in NSW, Australia. Overall rates of aggression, absconding and early readmission are reported, as well as length-of-stay profiles and associations between these outcomes and selected sociodemographic and clinical characteristics.</td>
<td></td>
</tr>
<tr>
<td>Enser &amp; MacInnes 1999</td>
<td>UK</td>
<td>The relationship between building design and escapes</td>
<td>Journal of the Royal Society for the Promotion of</td>
<td>L.4 Retrospective study and</td>
<td>The research presented is a survey of all of the identified forensic psychiatry Medium Secure Units (MSUs) within Great Britain. The</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Author(s) &amp; Year</td>
<td>Location</td>
<td>Research Design</td>
<td>Journal/Source</td>
<td>Methods</td>
<td>Findings</td>
</tr>
<tr>
<td>----</td>
<td>----------------</td>
<td>----------</td>
<td>----------------</td>
<td>---------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>19</td>
<td>Farragher, Gannon, &amp; Ahmad 1996</td>
<td>Ireland</td>
<td>Historical study</td>
<td>Irish Journal of Psychological Medicine</td>
<td>Retrospective analysis of data from secure units.</td>
<td>Studied the number and nature of all escapes from these units over a 42-month period.</td>
</tr>
<tr>
<td>20</td>
<td>Higueras, Carretero-Dios, Muñoz, Idini, Rincón, Prieto-Merino, &amp; del Aguilä 2006</td>
<td>Spain</td>
<td>Case study</td>
<td>International Journal of Clinical and Health Psychology</td>
<td>Effects of a humor-centered activity on disruptive behavior in patients in a general hospital psychiatric ward.</td>
<td>The aim of this quasi-experimental study was to investigate the effects of a humor-based activity on disruptive behaviors in patients hospitalized in a psychiatric ward.</td>
</tr>
<tr>
<td>21</td>
<td>JBI 2007a</td>
<td>Australia</td>
<td>Evidence summary review of literature</td>
<td>JBI</td>
<td>Absconded patient: recommended practice.</td>
<td>Studied patients consecutively admitted to an open psychiatric ward over a 2-month period. We compared those who absconded with those who did not.</td>
</tr>
<tr>
<td>24</td>
<td>LePage 1999</td>
<td>USA</td>
<td>Data analysis</td>
<td>Psychiatric Services</td>
<td>The impact of a token economy on injuries and negative events on an acute psychiatric unit.</td>
<td>A token economy was introduced on an acute care unit in a rural hospital, and rates of negative events were compared before and after implementation significant.</td>
</tr>
<tr>
<td>25</td>
<td>Manchester, Hodgkinson, Pfaff &amp; Nguyen 1997</td>
<td>Australia</td>
<td>1 case study</td>
<td>Brain Injury</td>
<td>A non-aversive approach to reducing hospital absconding in a head-injured adolescent boy.</td>
<td>This paper presents a nonaversive (token economy) approach to hospital absconding in a head-injured 17-yr old male.</td>
</tr>
<tr>
<td>26</td>
<td>Meehan, Morrison &amp; McDougall 1999</td>
<td>Australia</td>
<td>Case study – no controls interviews</td>
<td>Australian &amp; New Zealand Journal of Psychiatry</td>
<td>Absconding behaviour: an exploratory investigation in an acute inpatient unit.</td>
<td>The aim of this study was to identify patient and environmental characteristics associated with absconding behaviour, and to gain an understanding of the behaviour from the patients perspective.</td>
</tr>
<tr>
<td>Page</td>
<td>Author(s)</td>
<td>Country</td>
<td>Study Title</td>
<td>Journal</td>
<td>Case Design</td>
<td>Credibility</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>28</td>
<td>Moore &amp; Hammond 2000</td>
<td>Global</td>
<td>When statistical models fail: problems in the prediction of escape and absconding behaviour from high-security hospitals.</td>
<td><em>Journal of Forensic Psychiatry &amp; Psychology</em></td>
<td>L.3.3 Cases retrospective comparison credible</td>
<td>This study explores the prediction of absconding behaviour from maximum-security hospitals.</td>
</tr>
<tr>
<td>29</td>
<td>Muralidharan &amp; Fenton 2006</td>
<td>Global</td>
<td>Containment strategies for people with serious mental illness.</td>
<td><em>Cochrane database of systematic reviews</em></td>
<td>L.1 Review of literature unequivocal</td>
<td>Literature review</td>
</tr>
<tr>
<td>30</td>
<td>Neilson, Peet, Ledsham, &amp; Poole 1996</td>
<td>UK</td>
<td>Does the nursing care plan help in the management of psychiatric risk?</td>
<td><em>Journal of Advanced Nursing</em></td>
<td>L.3.2 Case control random sample credible</td>
<td>The study explores the use of nursing care plans and the impact on patient care and clinical outcomes. Findings include detained patients were most likely to abscond.</td>
</tr>
<tr>
<td>31</td>
<td>Pages, Russo, Wingerson, Ries, Byrne, &amp; Cowley 1998</td>
<td>USA</td>
<td>Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital.</td>
<td><em>Psychiatric Services</em></td>
<td>L.3.3 Case control credible</td>
<td>The study examined predictors of discharge against medical advice (AMA) and outcomes of psychiatric patients with AMA discharges.</td>
</tr>
<tr>
<td>32</td>
<td>Quinsey &amp; Coleman 1997</td>
<td>Canada</td>
<td>Proximal antecedents of eloping and reoffending among supervised mentally disordered offenders.</td>
<td><em>Journal of Interpersonal Violence</em></td>
<td>L.3.2 Case control credible</td>
<td>Discusses the factors that triggers mentally disordered offenders to elope and reoffend from mental institutions. Potential predictors of eloping and</td>
</tr>
<tr>
<td>33</td>
<td>Shah &amp; Ganesvaran 2000</td>
<td>Australia</td>
<td>Completed suicide among psychiatric in-patients with depression in an Australian mental hospital.</td>
<td><em>International Journal of Methods in Psychiatric Research</em></td>
<td>L.3.2 Case control credible</td>
<td>Twenty-two completed psychiatric in-patient suicides with depression, over a 21-year period, in a large psychiatric hospital in Melbourne, Australia, were examined.</td>
</tr>
<tr>
<td>34</td>
<td>Tammelleo 1999</td>
<td>USA</td>
<td>Mental patient escapes through hole in fence. (suit alleges hospital negligence).</td>
<td><em>The Regan report on hospital law</em></td>
<td>L.4 credible</td>
<td>Legal cases</td>
</tr>
<tr>
<td>35</td>
<td>Tammelleo 2001</td>
<td>USA</td>
<td>Psych. hosp. fails to follow policy: pt. elopes -- suicide results.</td>
<td><em>Hospital laws regan report</em></td>
<td>L.4 credible</td>
<td>Legal cases</td>
</tr>
<tr>
<td>36</td>
<td>Tammelleo 2006</td>
<td>USA</td>
<td>Fall from third floor in escape from mental hospital.</td>
<td><em>Nursing law s regan report</em></td>
<td>L.4 credible</td>
<td>Legal cases</td>
</tr>
<tr>
<td>37</td>
<td>Walsh, Rooney, Sloan, McCauley, Mulvaney, O’Callaghan &amp; Larkin 1998</td>
<td>Ireland</td>
<td>Irish psychiatric absconders: characteristics and outcome.</td>
<td><em>Psychiatric Bulletin</em></td>
<td>L.3.3 credible</td>
<td>95 psychiatric inpatients who absconded from an Irish hospital over a 12-month period were reviewed</td>
</tr>
<tr>
<td>38</td>
<td>Williams, Badger, Nursten, &amp; Woodward, 1999</td>
<td>UK &amp; Scotland</td>
<td>A review of recent academic literature on the characteristics of patients in British special hospitals.</td>
<td>Criminal Behaviour and Mental Health</td>
<td>L.4 Review of literature credible</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This literature is analysed to provide summaries of findings on prevalence, demographic characteristics, legal categories, psychiatric diagnoses, offences, histories, behaviour within the special hospitals, security needs, and discharge records.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Systematic literature review: country of where the included studies originated from.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of studies</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>5</td>
<td>13.16%</td>
</tr>
<tr>
<td>Canada</td>
<td>4</td>
<td>10.53%</td>
</tr>
<tr>
<td>Global</td>
<td>4</td>
<td>10.53%</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Ireland</td>
<td>2</td>
<td>5.26%</td>
</tr>
<tr>
<td>Spain</td>
<td>6</td>
<td>15.79%</td>
</tr>
<tr>
<td>UK</td>
<td>18</td>
<td>47.37%</td>
</tr>
<tr>
<td>USA</td>
<td>6</td>
<td>15.79%</td>
</tr>
</tbody>
</table>

Origin of literature chart
Appendix 4

Systematic literature review: the evidence rankings of the included studies.

Evidence rankings of studies

<table>
<thead>
<tr>
<th>Levels</th>
<th>No. of included studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative</td>
<td>1</td>
</tr>
<tr>
<td>Level 1</td>
<td>1</td>
</tr>
<tr>
<td>Level 2</td>
<td>1</td>
</tr>
<tr>
<td>Level 3.1</td>
<td>10</td>
</tr>
<tr>
<td>Level 3.2</td>
<td>7</td>
</tr>
<tr>
<td>Level 3.3</td>
<td>19</td>
</tr>
<tr>
<td>Level 4</td>
<td>31</td>
</tr>
<tr>
<td>Qualitative</td>
<td>2</td>
</tr>
<tr>
<td>Unequivocal</td>
<td>0</td>
</tr>
<tr>
<td>Credible</td>
<td>0</td>
</tr>
<tr>
<td>Unsupported</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix 5

Ethics approval: University of South Australia

Section 1 and 2 provided
The Ethics protocol (or application for ethics approval) is in three sections:

- **Section 1** is a coversheet which records your contact details and the title of your project.
- **Section 2** is a checklist of yes/no responses which identify key issues.
- **Section 3** is the proforma which provides the ethics committee with more detail about your project and particularly your interaction with research participants.

**Guidelines** to help you prepare your ethics protocol are accessible from the Research and Innovation Services, website [www.unisa.edu.au/res/ethics/human.asp#forms](http://www.unisa.edu.au/res/ethics/human.asp#forms)

Please complete and submit all three sections.
Please submit 17 copies and the original to the Ethics Officer

---

**Section 1: Coversheet**

<table>
<thead>
<tr>
<th>Researcher's name</th>
<th><em>Associate Professor Eimear Muir-Cochrane</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrian Esterman, Tahere Zaiai, Krista Mosel</td>
<td></td>
</tr>
<tr>
<td>If there is more than one researcher, please indicate who should receive correspondence</td>
<td></td>
</tr>
<tr>
<td>Researcher's School and Division</td>
<td>School of Nursing and Midwifery</td>
</tr>
<tr>
<td></td>
<td>Health Sciences</td>
</tr>
<tr>
<td>Postal address for correspondence</td>
<td>City East Campus</td>
</tr>
<tr>
<td></td>
<td>Centenary Building C610</td>
</tr>
<tr>
<td>Telephone number/s</td>
<td>0883022751</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:eimear.muir-cochrane@unisa.edu.au">eimear.muir-cochrane@unisa.edu.au</a></td>
</tr>
</tbody>
</table>

Please circle the type of research being undertaken

- Staff
- PhD Professional
- Doctorate
- Masters Research
- Masters Coursework
- Grad Dip/
- Grad Cert
- Honours Undergraduate
- Other

**Title of research project**  Absconding from psychiatric hospitals

**Plain English title**  Patients running away from psychiatric hospital

**Proposed commencement date**  September 8th 2007

**Researcher’s signature**

_I certify that the protocol is complete and the research will be conducted in accordance with the protocol and in an ethical manner._

**Supervisor’s signature (if researcher is a student)**

_I certify that this protocol has been completed in accordance with the requirements of the UniSA’s protocol guidelines. I have_
considered the ethical implications of the proposed research and believe that the research will be conducted in accordance with the relevant local, state, national and Uni SA policies, guidelines, regulations and legislation.

Supervisor's name (if researcher is a student)  
Associate Professor Eimear Muir-Cochrane

Supervisor's contact details (mail and email addresses, telephone number/s)  
As above

Please note that protocols which do not provide sufficient information for HREC or DEC to make an adequate assessment may be returned for revision.

Section 2: Checklist

Please circle your response to each of the following questions:

Does the research involve participation of Aboriginal or Torres Strait Islander people who have been selected YES / NO as research participants because they are indigenous Australians?

Does the research involve any artifacts that are of cultural, spiritual or religious significance to YES / NO Aboriginal or Torres Strait Islander people?

Does the research involve an unusually dependent relationship between the researcher and any of the YES / NO research participants?

Could the research place research participants in an unusually vulnerable situation? YES / NO

Is there any potential risk (physical, emotional, social or legal) to individual participants’ well being, YES / NO beyond that normally encountered in everyday life, as a result of their involvement in the research?

Does the research involve the administration or application of drugs and/or Clinical Trial Notification Scheme (CTN) documentation? (see www.unisa.edu.au/res/ethics/human.asp#forms) YES / NO

Is there any reasonable likelihood that the research will result in the reporting of suspected child abuse? YES / NO

Is there any potential risk to the researcher’s safety, beyond that normally encountered in everyday life, as a result of their involvement in the research? YES / NO

Do you plan to vary the usual written consent processes? YES / NO

Is the study known to involve research into illegal activities? YES / NO

Does the study have potential legal implications for the researcher or the University? YES / NO
Have you applied for funding for this research (other than Divisional funds)? YES / NO

If YES, please give the name of granting body applied to and the type of grant sought.

UniSa NHMRC Development Grant 2007

- Staff, PhD, Professional Doctorate and Masters by Research proposals must be considered by the Human Research Ethics Committee.

- All other student research should be considered by the appropriate Divisional Ethics Committee unless the researcher answered YES to any of the questions above.

- If you are uncertain about how to answer any of the questions or whether HREC or a Divisional Ethics Committee should consider your proposal please seek advice from the chair of the Divisional Ethics Committee.

The checklist continues on the next page. Please answer the remaining questions

What research methodologies will you use (tick those applicable)

<table>
<thead>
<tr>
<th>Methodologies</th>
<th>Questionnaires requesting intimate personal, identifying, or sensitive information</th>
<th>Questionnaires requesting intimate personal, identifying, or sensitive information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anonymous questionnaires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet questionnaires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other questionnaires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face to face interviews which do not request personal or sensitive information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation of participant’s usual activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation of an activity set up for the purposes of the study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to medical records (or records which contain intimate personal information, and are individually identifiable and are not publicly available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(please specify)

Access to non-identifiable data provided from central patient database at Glenside hospital in a cleaned form

Use of carcinogenic and/or toxic chemicals, including heavy metals. (Refer additional approval requirement: www.unisa.edu.au/res/ethics/biohaz.asp#biological)

Use of Radiation (Ionising and/or Non-ionising) (Refer additional approval requirement: www.unisa.edu.au/res/ethics/biohaz.asp#biological)
Please tick the group/s from which your sample of participants will be drawn for this study

General public

Friends or family

Work colleagues

People with whom you have an ongoing professional relationship (eg students or clients)

Other (please specify)

In which country is data collection to take place?

_____________________________________________________________________________

List the organizations where the research will be undertaken. (Please note that written approval from all organizations must be obtained before the research can commence).

Glenside Hospital Campus, Adelaide

_____________________________________________________________________________

Will the research involve access to individuals, clients or records required from any organization? YES / NO

(Refer additional approval requirement www.unisa.edu.au/res/ethics/human.asp#access)

If YES, has approval been received from these organizations? YES / NO

Will the research involve access to Uni SA staff, students or data? YES / NO

(Refer additional approval requirement www.unisa.edu.au/res/ethics/human.asp#access)

If YES, has approval been received? YES / NO

Will you access individually identifiable information about participants from any government department? YES / NO

or from another organization (for example a state based register, education department, hospital, health department, correctional services)? YES / NO

If YES, list the government department(s) and/or organisation(s)

_____________________________________________________________________________

Have you received approval to access this information from the government department(s)/organization(s) listed above? YES / NO

Will the research take place in South Australia in schools, preschools, child care centres or other educational facilities? YES / NO

(If YES, refer Police Clearance requirement www.unisa.edu.au/policies/codes/miscell/policeclear.asp)
Are the following appendices attached?

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reference list</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Research tools</td>
<td>YES / NO/ Not required for this study</td>
</tr>
<tr>
<td>3</td>
<td>Recruitment material</td>
<td>YES / NO/ Not required for this study</td>
</tr>
<tr>
<td>4</td>
<td>Information sheet</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5</td>
<td>Consent form</td>
<td>YES / NO / Not required for this study</td>
</tr>
<tr>
<td>6</td>
<td>Correspondence</td>
<td>YES / NO / Not required for this study</td>
</tr>
</tbody>
</table>

Language of the Consent Form, Participant Information Sheet and any other material provided to research participants if other than English.

How do you intend to report your research?

<table>
<thead>
<tr>
<th>Type</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thesis/dissertation</td>
<td></td>
</tr>
<tr>
<td>Conference presentation</td>
<td>X</td>
</tr>
<tr>
<td>Journal article/s</td>
<td>X</td>
</tr>
<tr>
<td>Commissioned report</td>
<td></td>
</tr>
<tr>
<td>Research paper</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

Will research participants have the opportunity to receive a copy of your final report or summary of the findings if they wish?  YES / NO

If YES, how will you provide a copy of the final report or summary of the findings and/or, if NO, detail reasons why a copy will not be provided.

_______________N/A___________________________________________________________

_______________

_______________

_______________

Will research participants receive any payment in relation to their participation?  YES / NO

Ethics approval will not be finalised until copies of all necessary materials have been received by the executive officer of the ethics committee considering your protocol.
Appendix 6

Conditions for ethics approval: University of South Australia

UNIVERSITY OF SOUTH AUSTRALIA

CONDITIONS FOR ETHICS APPROVALS

Human Research Ethics Approval is always made on the basis of a number of important conditions:

- Your research MUST NOT commence until the University’s Human Research Ethics Committee has granted full approval.

- Any serious or unexpected adverse effects on research participants must be reported immediately to the Ethics Officer.

- Any unforeseen events that might affect the continued ethical acceptability of the research project must be reported immediately to the Ethics Officer.

- The Ethics Committee must be notified of, and approve, any changes to the original protocol.

- The Ethics Committee must be notified of any changes in membership of the research team.

- In Australia there is a legal obligation for raw data arising from human research to be held securely. The University requires that research data be retained for a period of seven years. If your school does not store your data, the school must be aware of its location.

- Information for participants should include the name of the Executive Officer of the UniSA Human Research Ethics Committee as a person who is able to discuss any ethical concerns about the research project. These details should read:
  
  The University of South Australia’s Human Research Ethics Committee has reviewed this study. Should you wish to discuss the project with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study, or your rights as a participant, please contact the UniSA Ethics Officer, Ms Vicki Allen on 8302 3118; fax 8302 3921; email: Vicki.allen@unisa.edu.au

- Approval is for a period of twelve months only. Researchers, including Masters by Research and PhD students, must make annual requests for extension using the Application for Extension form available at http://www.unisa.edu.au/res/ethics/human.asp#forms

- A project completion report must be made to the Human Research Ethics Committee or Divisional Ethics Committee (whichever granted the original approval) within three months of the project’s completion. The Project Completion form is available at http://www.unisa.edu.au/res/ethics/human.asp#forms

March 2004
Appendix 7

Research in brief publication

Appendix 8

Research in brief acceptance email


04-Aug-2008

Dear Ms. Mosel:

It is a pleasure to accept your manuscript entitled "A retrospective analysis of absconding behaviours by psychiatric inpatients in one psychiatric hospital campus in Australia" in its current form for publication in the Journal of Psychiatric and Mental Health Nursing. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Please find attached an Exclusive Licence Form which you should print out, complete in full and return to me by post at the address noted on the form. Once we have received this, your paper will be submitted to our production office. Unfortunately, at this stage it is not possible to tell you which issue your paper will be appearing in, but we will contact you in due course.

As part of the Journal’s continued commitment to its authors, the Editorial Office and Publisher wish to keep you informed about what will happen next and, as the attached paper/footer contains important information regarding journal publication and services for authors, you may wish to save it for future reference.

On behalf of the Editors of the Journal of Psychiatric and Mental Health Nursing, we thank you for your contribution and look forward to your continued support.

Sincerely,

Prof. Dawn Freshwater
Editor in Chief, Journal of Psychiatric and Mental Health Nursing jpmhn@leeds.ac.uk