Psychiatric Patients who Abscond from Acute Care

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AWOL research

- Literature reviews in 1998 and again in 2010
- Exploratory research 1998
- Prevention research 2001
- Further analytic research 2005
- Locked doors research 2007
- Literature review on inpatient suicide 2008
- Multiple scientific publications
Why is absconding important?

- Risk of harm to self
  - Suicide
  - Self-harm
  - Self-neglect
- Risk of harm to others
- Staff anxiety
- Disrupted treatment and recovery
- Cost: NHS and Police
- Decreased confidence of relatives/carers
Inpatient suicide

• Numbers declining in England (74 in 2010), but crisis services increased (150 in 2010)
• Approx. 1/3 following abscond (lower in England, 15% 2010)
  – Agreed leave 1/3
  – Absence of support and supervision
  – Family conflict
• On the ward
  – Ligature point removal
  – Use of intermittent observation
  – Areas and times
  – Caringly Vigilant and Inquisitive
• Admission is an effective suicide prevention intervention
Missing persons

- Absconds part of a very big picture: care homes, general hospitals, children, the elderly, physically ill people
- Missing persons are the biggest drain on police time
- 1/3 Police helicopter time is spent on missing persons
- Responses become routinised and thoughtless. Repeats are common.
- There are 1,000 missing person fatalities every year
- There are still 1,000 unidentified missing persons from past 40 years
- One in ten of all missing person reports are from hospitals
- Basic misper activities cost the Police services £1,325
- An abscond costs the NHS approx. £200
- This doesn’t count the impact on the patient and those around them
Definitions and reporting of absconding

• Context: acute psychiatric care
• Research definition: missing without permission for >1 hour
• Detained vs. informal patients (risk)
• Duration absent
• Missing vs. Officially reported
• Police notified for only 47% of absconds
• Mostly within the first hour, however sometimes they were not contacted until up to 48 hours later
How and when patients leave

- From the ward directly
- Via the front door
- Locked doors, “door stops” and special observation circumvented (also: out of windows, fire doors, over fences, etc. HiB theory)
- Shift handover = peak time to leave (NB and attempt suicide)
- During first few weeks of admission
- Destination: home
Why patients leave

- Bored
- Frightened of other patients
- Feel trapped and confined
- Household responsibilities
- Miss relatives and friends
- Worried about security of home and property
- Psychiatric symptoms
- “Angrily leaving” vs. “Going to”
- “Refusers” v. “Disputers”
Absconders: risk indicators

- Suicide the main risk:
  - 21% of absconding patients had a recorded history of at least one suicide attempt
  - 5% had a history of self mutilation of one form or another
  - 32% were considered by staff to be at risk of self harm
- 27% were considered to be at risk from the use illicit drugs
- 16% at risk of self neglect
- 20% were considered to pose a risk to others
- 23% had a history of contacts with forensic psychiatry, courts, or prison
- 5% had been involved in officially reported ward incidents

(NB %’s overlap)
## Actual outcomes

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm to self</td>
<td>12</td>
<td>2.4</td>
</tr>
<tr>
<td>Harm to others</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>Property damage</td>
<td>4</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Drug/alcohol use</td>
<td>30</td>
<td>6.0</td>
</tr>
<tr>
<td>No harm</td>
<td>441</td>
<td>88.6</td>
</tr>
<tr>
<td>Total</td>
<td>498</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Returns to hospital

- 63% return of own accord
- 2% returned by ward staff
- 8% by relatives/friends
- 13% by the police
  - 23% of those officially reported
  - Sig. more likely to be returned by police if a known risk of harm to self or others
  - Level of response variable
- 2% other
- 11% not at all (discharged in absence, placed on leave, still absent at end of research, or lost to follow up)
Prevention: anti-absconding nursing intervention

• Reduces absconds by 25%
  – Four ward trial
  – 15 ward/hospital implementation
• Rule clarity: signing in and out book
• Identification of those at high risk of absconding with targeted nursing time for those at high risk
  – Promoting contact with family and friends
  – Promotion of controlled access to home
  – Careful breaking of bad news
  – Post incident debriefing
  – MDT review following two absconds
• Impact on suicide?
  – Support provision
  – Timing of suicide
Prevention: hospital environments

• A high quality physical environment, including secure access to fresh air, reduces the risk of absconding by 12%

• Impact on suicide?
  – Valuing patients
  – Self esteem and the impact of admission
  – Keeping present in supportive and supervised environment

• Ligature point removal
  – Doors, windows, sheets, towels, clothing
Prevention: Locking ward doors

• Upside: suppresses absconding by 25%
• Downside: low self-esteem, loss of hope, feeling stigmatisation and rejection, anger, prison identity, resistance, institutionalism and dependency
• Downside: increases aggression, assaults, self-harm and medication refusal
• Evidence suggests no beneficial impact on inpatient suicide rates
Recommendations

• Implementation of the anti-absconding intervention
  – Integration into quality improvement methodologies as a bundle
  – Embedding into clinical audit process and continuous reporting
  – Entering into clinical policies and ward staff job descriptions
  – Identification of a ward absconding reduction lead to champion the intervention
  – Absconding reduction a static agenda item at ward team meetings and at supervision of ward managers and at acute care for a
  – Monitoring of training/workbook completion
  – Including into ward induction for new staff
  – Making it stick, wards are high erosion environments!
• Work towards clear risk communication with graded Police response
• Intensify support and supervision
• Intermittent observations, CVI, area/time supervision, night shifts
• Therapeutic constant observation packages
• Establish agreed leave support mechanisms
• The family may be the treatment unit
Looking to the future

- Absconding trial published 2003, widespread implementation: 2013
- Prevention of inpatient suicide work published 2010/11: widespread implementation: *not yet, but e-learning available*
- Safewards: results 5th September 2013, three tier international implementation planned
- Riddor incidents with HSE: 2014/15
- Patient-patient violence: 2014/15
- SPICES: 2015/16
- Further work upcoming: patient requests, intermittent observation, medication refusal, specific staff effects, restraint near misses