

Runaway Patients

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Patients abscond for many reasons, many of which would surprise healthcare professionals. Len Bowers reports on some innovative research which offers useful insights into why patients abscond and discusses how absconding rates might be cut

When a patient absconds, it's a worrying thing for the nurses on any acute psychiatric ward. Questions buzz through their heads, such as: 'will he be all right?' 'Will she go home and threaten the neighbors?' or 'What will his parents say when they find out?' Nurses are right to be worried about absconding. Patients who abscond can come to all sorts of harm. There is a link to suicide (about a quarter of inpatient suicides are by patients who have absconded prior to harming themselves), and absconded patients have been known to inflict serious harm on others (Bowers *et al* 1998).

During an abscond, patients are likely to go without the medication they need to treat their condition, or they may consume alcohol or drugs that exacerbate their problems. A small minority are never found and may be lost to psychiatric follow up.

Fortunately, these negative outcomes are rare. The vast majority (96 per cent) of absconds from acute psychiatric wards pass off without any harm to anyone (Bowers *et al* 1999). Most patients who abscond simply go home, and choose to come back of their own accord the same day. However there are absconded patients who do come to some harm, or perpetrate some harm. It's not common, but it does happen with about four in every 100 absconds. This might not sound a great many, but an average 20-bed acute psychiatric ward, working at full capacity has about 120 absconds every year. That means it's likely that five times a year there will be absconds from an acute ward resulting in harm to the patient or others. Most of this harm will be relatively minor, but in rare cases **it** will be serious. Nurses are therefore right to be worried. But it's flat only the burden of anxiety that has to be considered here. There are the many hours of paperwork involved in dealing with and reporting these absconds. There is also police time to be accounted for~ as about half of all absconds are reported to the police, who then have to invest time and personnel in trying to return patients to hospital.

Why do patients abscond?

Since 1997, here at City University, in partnership with East London and the City Mental Health Trust, we have been conducting a programme of research into the problem of absconding from acute psychiatric wards. In the first of those studies, we interviewed 62 absconders on their return to hospital, asking them how and why they left, what they did while they were away, and how it was they came back to hospital. When we looked at all of those interviews, we discovered there was seldom any single reason why patients ran away. Different patients had different reasons, and most had more than one reason for going. Sometimes there was an event that triggered their abscond, and sometimes not. But a patient's decision to abscond was made against the background of a range of discontents with psychiatry and life on the ward.

Some of the things we expected to find as reasons for absconding, or linked to it, proved not to be correct. For example, we found few absconding patients who

complained about the food, or the ward's general decor, cleanliness and so forth, or noise, or an inability to sleep. Nor did we find that absconding was any more frequent on warm, sunny days, as opposed to cold wet ones.

However, many of the reasons why absconders are dissatisfied will be familiar to acute ward psychiatric nurses. They were bored on the ward, and complained there was nothing to do except for watching television and sleeping. They felt confined because they were unable to go out, and this feeling of restriction was abhorrent to adults who were used to going where they pleased. The sense of constraint grated, making them uncomfortable and irritable. Many patients missed their friends and relatives, whether they received visits or not. Perhaps this was about wanting to meet their friends and family as equals, rather than take up the role of the visited sick person where there is a sense of obligation in the contact. Indeed, some absconders went to see friends and family when they left the ward. Some patients left the ward because they were frightened of other patients. The media stories of 'dangerous maniacs

Impact not just on the public's fears, but also on patients' views of each other. They can be extremely wary of each other, and any small incident can heighten those fears. One patient told us about an incident at night; when she was waken with a fright by shouting on the ward. Nothing happened, but she was so scared that the next day she packed her bags and absconded. Other patients leave because they are concerned about their homes or property. They fear that they may be burgled, or are concerned they are going to miss important post or bills, or simply want the reassurance and relaxation of being at home. Some have household responsibilities they feel they have to fulfill, either to keep things clean, or responsibilities to friends, neighbours or family.

Psychiatric symptoms also contributed to absconding decisions, but among the people we interviewed, these were coupled with other, rational reasons for leaving the ward. Some patients left in a huff, following a decision that went against them (for example, a refused leave request). Others were in long-term dispute with psychiatry, and either considered that they were well and did not need to be in hospital, or considered themselves to be ill, but not in the way the professionals thought.

The experience of admission

It would seem that we, the professionals, all too easily lose sight of what an admission actually means to the patient. From the nursing point of view, admissions are short, and we know that most of our patients are discharged within a few weeks. The constraints on patients seem, from our point of view, to be few, temporary, and trivial. The ward, we believe, is a warm, generally friendly place where there is solidarity and common cause between patients.

This is not necessarily the way it seems to patients. To our patients, admission can be a serious derailment of their lives. They may have had to leave their home in a hurry, without making sure everything was prepared or safe. They might find themselves on a ward with a bunch of strangers, some of whom behave in way that are frightening, and that can feel very lonely. They may feel separated from their normal contact with friends and family, forced to take treatment unwillingly, and required to stay in a limited, monitored environment, unable to go out whenever they want. A delay in their weekend leave is to us nothing more than a small hiccup in their path towards discharge, but to

the patient it might seem more like an extension of a prison sentence.

Locking the ward door

Many acute psychiatric wards have now become permanently locked in order to prevent absconding. The nurses we interviewed in our research were very reluctant to contemplate doing this, but nearly all wards now seem to lock their doors when they have high concerns about patients absconding. Unfortunately, we don't know if this is an effective strategy, or what other impacts it may have on patients or staff. Our research has shown that patients do tend to abscond at times of reduced staff surveillance, typically during shift handovers. On the other hand, we have also found no link between the ease of observing a ward, or the number of exits, and rates of absconding, indicating that physical security is not the whole story.

Locking the ward doors may also impact on the use of psychiatric intensive care (PICU) beds. In units operating an open door policy, high-risk potential absconders may be transferred to the PICU, which is locked. However, if acute wards are locked, this implies less demand for PICU beds, and higher occupancy on acute wards. The locking of acute psychiatric wards is a new phenomenon in the UK. It is not supported by the current Mental Health Act Code of Conduct, and its implications have yet to be worked out.

What should be done?

We need to recapture the sense of what an admission means to the individual patients on our ward, discover what their worries and concerns are, and do the best we can to address these. A change of perception is required on our part, coupled with a new willingness to listen to what our patients have to tell us. What is routine to us, is not necessarily so to our patients. What has become normal behaviour on acute wards for us, may be quite frightening to other patients, even when those other patients are themselves behaving quite abnormally. Instead of watching our patients and dealing with crises when they arise, we need instead to talk, and listen to what they have to tell us about what their admission means to them, and what impact it is having on their lives and the things they value. In managing the whole ward as a social environment, we need to pay more attention to the way patients respond to disappointments in their own progress towards discharge. We also need to attend to the way the patients on the ward respond to threatening or frightening events, even ones that to our eyes are minor, and manage that in a much better way.

Using these lessons we learned from our previous research, we have recently conducted a trial of a nursing intervention to reduce absconding. The trial took a year to complete, and involved training staff in live acute wards in the east end of London. The results from that trial showed that it is possible to reduce absconding rates by about one quarter. This means that the average acute psychiatric ward could achieve 30 fewer absconds each year, with a consequent reduction in risk to patients, anxiety for the staff, and workload for nurses and the police. However, not only did the staff manage, through the use of the intervention, to reduce absconding. They also made a significant reduction in the number of hours the ward doors were locked.

Participation

We would now like to invite nurses working on acute wards to join us in a distributed audit of this method of reducing absconding. If you would like to try out the intervention we have devised, and will provide us with information on your absconding rates before and after, we will provide your ward teams with a package enabling you to train yourselves in the intervention, and implement it on your ward.

The package contains a handbook for the ward manager on the implementation process, workbooks and laminated reminder cards for all the ward nursing staff, and signs for the ward office. There is no charge for this package. If you are an acute ward manager and would like to participate, then write to me with your name, ward, hospital and address, at: St Bartholomew School of Nursing and Midwifery, City University, Philpot Street, London E1 2EA., or email me at:

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Further reading

Bowers L (1998) Absconding: A literature review. *Journal of Psychiatric and Mental Health Nursing*. 5, 343-353.

Bowers L *et al* (1999a) 1. Absconding: why patients leave. *Journal of Psychiatric and Mental Health Nursing*. 6, 3, 199-206.

Bowers L *et al* (1999b) 2. Absconding: how and when patients leave the ward. *Journal of Psychiatric and Mental Health Nursing*. 6, 3, 207-212.

Bowers L *et al* (1999c) 3. Absconding: outcome and risk. *Journal of Psychiatric and Mental Health Nursing*. 6, 3, 213-218.

Bowers L *et al* (2000) Determinants of absconding by patients on acute psychiatric wards. *Journal of Advanced Nursing*. 32, 3, 644-649.

Bowers L *et al* (2003) A controlled trial of an intervention to reduce absconding from acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*. 10, 410-416

Bowers L *et al* (in press) Absconding by psychiatric patients in East London: relationship to ethnicity and culture. *Health, Risk and Society*

Clark N *et al* (1999) 4 Absconding: nurses' views and reactions. *Journal of Psychiatric and Mental Health Nursing*. 6, 3, 219-224.

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