Definition of absent without approval/ absconding

Queensland Health (2017a, 2017b) defines absconding or absent without approval (AWA) as a person who:

- Absconds (flees) while being lawfully detained under the *Mental Health Act 2016* (e.g., in an inpatient facility, emergency department or community facility, while being transported under the Act, or while being escorted on limited community treatment or a temporary absence).
- Is being treated in the community under a treatment authority, forensic order or treatment support order and does not attend an AMHS (Authorised Mental Health Service) as required.
- Is made subject to a treatment authority, forensic order, treatment support order, or judicial order which requires the person to be detained in an AMHS and the person is not in an AMHS at the time the order is made.
- Is subject to a treatment authority, forensic order or treatment support order and is required to return to the AMHS due to the revocation or suspension of limited community treatment, revocation of a temporary absence, or change of category of the order or authority to inpatient.
- Is subject to a forensic order and is required to return to an AMHS by the Chief Psychiatrist due to the suspension of limited community treatment or the change of category from community to inpatient.
- Fails to return from unescorted limited community treatment or approved temporary absence at the required time.
- Does not attend a health service facility as required (e.g. to attend a scheduled appointment or review, to comply with conditions of an order or authority).
- Does not attend as required by the Act for:
  - a review of a treatment authority by an authorised psychiatrist
  - for an examination for a psychiatrist report
  - for an examination under an examination order made by a magistrate, or
  - for an examination directed for by the Mental Health Review Tribunal (Queensland Health, 2017).

In the literature, absconding is broadly defined as detained consumers being absent without permission (e.g. Muir-Cochrane & Mosel, 2008). While some researchers have defined absconding as once the patient leaves the hospital grounds, others have defined it as a patient leaving the ward without permission (Mosel, Gerace, & Muir-Cochrane, 2010) or a failure to return from an authorised leave (Bowers, Jarrett, Clark, Kiyimba, & McFarlane, 1999; Dickens & Campbell, 2001).

Absconding may be understood differently across health services. The length of time to qualify as absconding has ranged from more than one hour to when noticed missing (Meehan, Morrison, & McDougall, 1999).

Incidence of absconding

The frequency of reported absconding rates differs across studies, in part due to variations in the definition and measurement of absconding (Wilkie, Penney, Fernane, & Simpson, 2014). A systematic review by Bowers, Jarrett, and Clark (1998) reported a mean absconding rate of 12.6%, with a range of 2% to 44% for general psychiatric wards (excluding forensic psychiatric services). A more recent review reports similar absconding rates of between 2.5% and 34% for psychiatric facilities (Muir-Cochrane & Mosel, 2008). Rates of absconding specifically from psychiatric facilities in Australia range from 12%-21% (Gerace et al., 2015; Meehan et al., 1999; Mosel et al., 2010; Muir-Cochrane, Mosel, Gerace, Esterman, & Bowers, 2011). Absconding rates from secure forensic services have generally been reported as slightly lower – ranging between 1% and 20% (Brook, Dolan, & Coorey, 1999; Cullen et al., 2015; Moore, 2000; Wilkie et al., 2014).

Impact of absconding on consumers, staff and communities

Absconding has been recognised as a significant problem within mental health and forensic settings (Mosel et al., 2010). Patients who abscond may represent a risk to their own life, health or safety, or the safety and wellbeing of others (Queensland Health, 2017b). Previous research, including two

large systematic reviews (Bowers et al., 1998; Muir-Cochrane & Mosel, 2008), have examined the risks associated with absconding behaviour for consumers, staff and communities/others. These risks include those to:

- Consumers
  - self-neglect and harm (Bowers et al., 1998)
  - suicide (Muir-Cochrane & Mosel, 2008); a UK study over a 10-year period, found that one-quarter of inpatient suicides involved a patient who had absconded (Hunt et al., 2010)
  - alcohol consumption (Muir-Cochrane & Mosel, 2008)
  - not taking medication (Muir-Cochrane & Mosel, 2008)
  - interruptions to treatment (Gerace et al., 2015; James & Maude, 2015; Wilkie et al., 2014).
- Mental health staff
  - staff are involved in time-consuming procedures and paperwork that detract from care of other patients (Muir-Cochrane & Mosel, 2008)
  - staff express a sense of failure when consumers abscond and report feeling that the event should have been prevented (Muir-Cochrane & Mosel, 2008)
- Communities
  - aggression (Bowers et al., 1998; Muir-Cochrane & Mosel, 2008)
  - violence (Bowers et al., 1998; Muir-Cochrane & Mosel, 2008)
  - homicide (Bowers et al., 1998)
  - loss of confidence with psychiatric services (Bowers et al., 1998)
  - potential legal liability towards the hospital (Bowers et al., 1998)
  - high profile cases increase the stigma toward individuals with mental illness by amplifying the link between mental illness and risk of harm (Cullen et al., 2015).

Predictors of absconding behaviour

Research on factors linked to absconding has been conducted in acute mental health units and in forensic units. Factors are similar across the two services and have been combined for simplicity. The factors listed below have been found to be predictive of absconding behaviour. Bolded factors have more robust evidence supporting their inclusion as predictors of absconding behaviour.

Static factors

- **History of absconding** (Beer, Muthukumaraswamy, Khan, & Musabbir, 2009; Brook et al., 1999; Cullen et al., 2015; Dolan & Snowden, 1994; Gerace et al., 2015; Meehan et al., 1999; Mezey, Durkin, Dodge, & White, 2015; Mosel et al., 2010; Muir-Cochrane & Mosel, 2008; Muir-Cochrane et al., 2011; Wilkie et al., 2014).
- **History of substance misuse or co-morbid substance use disorder** (Beer et al., 2009; Carr et al., 2008; Cullen et al., 2015; Gerace et al., 2015; Martin, McGeown, Whitehouse, & Stanyon, 2018; Muir-Cochrane & Mosel, 2008; Wilkie et al., 2014).
- **Younger than 30 years of age** (Brook et al., 1999; Moore & Hammond, 2000; Mosel et al., 2010; Muir-Cochrane & Mosel, 2008) (Dickens & Campbell, 2001).
- **Legally detained** (Dickens & Campbell, 2001; Meehan et al., 1999; Muir-Cochrane & Mosel, 2008; Short, 1995).
- **Being diagnosed with schizophrenia** (Gerace et al., 2015; Meehan et al., 1999; Mosel et al., 2010; Muir-Cochrane & Mosel, 2008; Muir-Cochrane et al., 2011), (but see Beer et al., 2009 for an alternate view; Brook et al., 1999; Moore & Hammond, 2000).
- **Male gender** (Dolan & Snowden, 1994; Gerace et al., 2015; Meehan et al., 1999; Mosel et al., 2010; Muir-Cochrane et al., 2011), (but see Dickens & Campbell, 2001; Mosel et al., 2010 who report no gender differences in absconding).
- **Offending prior to admission** (Dolan & Snowden, 1994).
- **Treatment non-compliance** (Brook et al., 1999).

Dynamic factors

- **Within one to three weeks of admission** (Meehan et al., 1999; Mosel et al., 2010; Muir-Cochrane & Mosel, 2008; Muir-Cochrane et al., 2011).
- **During nursing handover** (Bowers et al., 1999; Carr et al., 2008; Dickens &

Campbell, 2001; Mosel et al., 2010; Muir-Cochrane & Mosel, 2008).
- **Impulsive/aggressive behaviour** (Brook et al., 1999; Cullen et al., 2015).
- **Frustration/boredom** (Martin et al., 2018; Wilkie et al., 2014).
- **Having experienced a stressful, significant event in the two weeks prior** to the absconding event (e.g. upcoming review tribunal hearings, cancelled visits with family) (Martin et al., 2018).

Queensland Health guidelines regarding absconding

Queensland Health (2017b) provides absconding guidelines. Individual strategies must be based on assessment of the individual's risk of absconding.

The risk assessment must be conducted on the person's initial contact with the service and be reviewed at regular intervals. Particular attention must be given to those who may be at risk of absconding, for example:
- recently admitted persons
- persons voicing thoughts about wanting to leave
- persons with a history of violence
- persons with a history of trauma
- young persons
- persons who because of their ethnic, social or cultural background are at increased risk of becoming absent without approval.

An 'Absent Without Approval Prevention and Response Plan' is mandatory for involuntary patients. This plan sets out the clinical strategies to minimise the risk of an absence and the actions to be taken by the service if the individual becomes AWA. The individual and their support person(s) must, to the greatest extent practicable, be involved in the development of the plan and assisted to understand the actions that will be taken if they become AWA. The plan must be accessible in CIMHA and any other relevant clinical record.

Absconding checklist

Research indicates that static factors (e.g., male, younger age, diagnosis of schizophrenia) are of limited value in predicting who will abscond (Khisty, Raval, Dhadphale, Kale, & Javadekar, 2008; Meehan, Mansfield, & Stedman, 2019). A recent study by Meehan et al. (2019) surveyed 178 mental health staff with more than 12 months experience in an acute inpatient service to ascertain the most important factors in predicting absconding. The staff in this study had a clear preference for dynamic factors when predicting risk of absconding (Meehan et al., 2019). The brief checklist presented on the next page was developed to aid in identifying potential absconding behaviour.

Failure to return from leave checklist (Meehan et al., 2019)

Instructions: In collaboration with the consumer, please complete the checklist using the following rating scale:

- mark '0' if factor absent
- mark '1' if factor present
- mark 'NK' if status not known.

Domains	Date/Time
1. History of absconding from leave Patient has history of absconding on this and or previous admissions.	
2. Current substance misuse Patient is asking to leave to smoke or use other drugs – is unlikely to return to unit due to current substance misuse.	
3. Behavioural cues Patient is pre-occupied with leaving unit–checking doors/waiting at exit points. Other behaviours to note include being impulsive, restless, or angry.	
4. Verbal cues Patient is openly talking about leaving the unit to complete chores in community or at home. Patient may express fear of other patients or feels trapped/confined in the unit.	
5. Lack of engagement Patient does not see need for treatment/hospitalisation – is refusing medication.	
6. Change in mental state Observe for marked improvement (may indicate decision to harm oneself) or deterioration in mental state–observe for changes in delusional/suicidal thoughts and or insight.	
Total score	

For patients granted leave, ask about intended destination, transport, available money, expected time of return and provide them with contact number for ward should they be delayed.

The authors recommend that the above checklist be completed as part of a larger discussion with the consumer about their episode of leave, if they have been granted approval for leave (Meehan et al., 2019).

Absconding interventions

A review of absconding interventions is beyond the scope of this review; however, a number of interventions have been shown to be successful. Bowers, Simpson, and Alexander (2005) implemented an intervention with six elements, which resulted in a 25.5% reduction in absconding rates. The six elements included:

- rule clarity through the use of a signing in and out book
- identification of those at high risk of absconding
- targeted nursing time for those at high risk
- careful breaking of bad news to consumers
- post-incident debriefing
- multidisciplinary-team review after two absconding incidents.

Non-compliance with adhering to prescribed medication and out-patient appointments

Queensland Health (2017b) has expanded the definition of AWA to include not adhering to treatment regimens, such as not taking prescribed medication for serious mental illnesses or not attending scheduled appointments. As such, a brief review is provided on these topics.

Adherence to prescribed medication can be defined in terms of full, partial or non-adherence in taking prescribed medication. Adherence rates vary widely, depending on the definition of adherence (full versus partial), the population under investigation and the time frame for adherence. A systematic review of 13 studies examining adherence to antipsychotics in individuals with schizophrenia reports adherence rates of 47-95% (Sendt, Tracy, & Bhattacharyya, 2015).

Predictors of non-adherence with antipsychotic medication in treatment of schizophrenia include:

- negative attitudes to medication (Sendt et al., 2015)
- poor illness insight (Ascher-Svanum, Zhu, Faries, Lacro, & Dolder, 2006; Lambert et al., 2010; Sendt et al., 2015)
- previous history of non-adherence (Ascher-Svanum et al., 2006)
- recent illicit drug/alcohol use (Ascher-Svanum et al., 2006; Lambert et al., 2010; Lang et al., 2010)
- prior or current treatment with antidepressants (Ascher-Svanum et al., 2006; Lang et al., 2010)
- newly starting treatment (Lang et al., 2010)
- younger age (Lang et al., 2010)
- poor premorbid functioning (Lambert et al., 2010).

This set of risk factors can be used to identify patients who are predisposed to poor adherence, who would benefit from additional support to promote treatment compliance.

Non-compliance with attending the first outpatient appointment following discharge from psychiatric hospitalization is associated with poorer outcomes for the individual (e.g. more likely to be hospitalised in the same year) (Cheng, Huang, Tsang, & Lin, 2014; Nelson, Maruish, & Axler, 2000). Predictors of non-compliance with attending outpatient appointments after psychiatric hospitalization include:

- involuntary legal status at discharge or leaving against medical advice (Cheng et al., 2014; Compton, Rudisch, Craw, Thompson, & Owens, 2006)
- history of substance abuse (Cheng et al., 2014; Marino et al., 2016; Nose, Barbui, & Tansella, 2003)
- longer number of days from hospital discharge to the follow-up appointment (Compton et al., 2006; Nelson et al., 2000)
- younger age (Kruse, Rohland, & Wu, 2002; Nose et al., 2003)
- male gender (Cheng et al., 2014; Nose et al., 2003)
- lack of insight (Nose et al., 2003)
- having a poorer family support system (Kruse et al., 2002)
- unemployment (Nose et al., 2003)
- low social functioning (Nose et al., 2003).

Resources for clinicians

Consult the relevant documentation regarding procedures and notification for Involuntary Patient Absences for your health service.

Further information on responding to and managing involuntary patient absences can be found in the Chief Psychiatrist Practice Guidelines – Involuntary Patient Absences https://www.health.qld.gov.au/__data/assets/pdf_file/0024/574017/pg_patient_absence.pdf

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