TECHNICAL COMMENTARY

Absconding

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Introduction

Absconding refers to the departure of patients from hospital wards without permission. The definition of absconding can vary depending on the length of time required for an absence to be considered absconding (e.g. one hour or when they are first noticed missing), and on the method of departure (e.g. leaving a locked ward, leaving the hospital grounds, or failing to return from day leave). Absconding status is influenced by the patient's admission, whether it be voluntary, involuntary, or legally detained. There are significant implications of absconding for patients, carers, and other family members.

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2000 that report results separately for people with a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder or first episode schizophrenia. Reviews were identified by searching the databases MEDLINE, EMBASE, CINAHL, Current Contents, PsycINFO and the Cochrane library. Hand searching reference lists of identified reviews was also conducted. When multiple copies of reviews were found, only the most recent version was included. Reviews with pooled data are given priority for inclusion.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis[1]. Reviews rated as having less than 50% of items checked have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCT) may be downgraded to moderate or low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large or if there is a dose dependent response. We have also taken into account sample size and whether results are consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)[2]. The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

Results

We found one systematic review that met our inclusion criteria[3].

- Moderate to low quality evidence suggests inpatients who abscond are often young men in the first three weeks following admission. Absconding may occur in up to 34% of admissions, and up to 80% of absconders return within 24 hours. A large proportion of absconders indicate intent to leave, and most commonly abscond directly

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from the ward. There is insufficient evidence regarding interventions for preventing absconding.

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Muir-Cochrane, E, Mosel KA

Absconding: A review of the literature 1996–2008

International Journal of Mental Health Nursing 2008; 17: 370-378

View review abstract online

Comparison	**Profiles, rates, outcomes, and interventions for absconding in a mixed sample of psychiatric inpatients, of which the majority had a diagnosis of schizophrenia.**
Summary of evidence	**Moderate to low quality evidence (small samples, unable to assess consistency or precision, direct,) suggests inpatients who abscond are often young men in the first three weeks following admission. Absconding may occur in up to 34% of admissions, and up to 80% of absconders return within 24 hours. A large proportion of absconders indicate intent to leave, and most commonly abscond directly from the ward. There is insufficient evidence regarding interventions for preventing absconding.**

Absconding profiles

9 reports suggest the profile of an absconder is often a young male, less than 26 years, and legally detained, however one additional study suggests no effect of gender.

Limited evidence suggests absconders have a history of substance use and the potential for self-harm. One study suggests absconding is likely to occur within 7 to 21 days of admission.

One study (N = 52) interviewed patients regarding reasons for absconding, and found that 42% of patients felt fear, 26% felt isolated, 42% were homesick, and 42% were bored. Three studies suggest that rational reasons (e.g., household or family responsibilities) often exceed psychiatric symptomatology as reasons for absconding.

Rate of absconding

Six studies report absconding rates between 2.5% and 34% of all admissions, however comparative data are difficult as studies calculate rates differently.

Two studies report nursing handover to be peak time for absconding.

Outcomes of absconding

Two studies (N > 66) found that patients returned 91 to 100% of the time, with 69 to 80% returning within 24 hours, and around 11% did not return for more than a month.

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Three studies (N = 374) found that 22 to 71% returned on their own or by a relative or friend; 35% were returned while on hospital grounds; 2 to 14% were returned by ward staff; and 13 to 33% by the police. Eight studies support a link between absconding and serious harm to self or others. One study reports a 20% rate of suicide for absconders (N not reported), with over 65% of these using a violent method of suicide. Two other studies reported that around 1.6 to 4% of absconders harmed themselves or others. Four studies indicated that other risk behaviour resulting from absconding included medication non-adherence, alcohol abuse, and aggression or violence.
Methods of absconding
One study reported that over half of the patients who absconded had previously indicated their intention to leave, and that 82% absconded directly from the ward; 14% left when temporarily off the ward; 3% failed to return from day leave. Another study suggested that 61% of absconds occurred on community outings and 39% occurred directly from the ward. A third study indicated that 80% of patients in an unlocked ward simply walked out, while 29% in locked wards absconded while on agreed leave. Others methods of absconding included stealing keys, taking advantage of inadvertently unlocked doors or windows, or taking advantage of staff being distracted. Two studies indicate that on return, no changes were made to patient management. However, a third study suggests that around one-fifth of patients were transferred to a high dependency unit.
Absconding interventions
Three studies indicate that absconding produced feelings of guilt and anger in nurses. The process for reporting an abscond was reportedly time-consuming and detracted from care of the rest of the ward. Two studies also report that public perception often rested blame for the abscond on the hospital system. Up to half of abscond events were reported by nurses to the police (1 study), particularly when patients were considered high risk or had been legally detained. Short absconds from low risk patients were often overlooked. Two further studies suggest that patients perceived as manipulative were more likely to have prior threats of suicide or abscond ignored. Limited evidence is available for interventions to reduce the occurrence of absconding. Proposed strategies include locking ward doors; close observation of patients; seclusion; or chemical restraint (4 studies), but there is limited evidence supporting the use physical containment for absconding. Other recommendations from one study included the staff engaging with patients soon after admission to develop a therapeutic relationship; involving relatives to encourage continuity of care; and establishing close contact with the police and community mental health professionals.

Consistency in results	Authors report considerable variability in results.

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Absconding

Precision in results	Unable to assess; no measure of precision is reported.
Directness of results	Direct

Explanation of acronyms

N = number of participants

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Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small[4].

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomised trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardised mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) that allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. Less than 0.4 represents a small effect, around 0.5 a medium effect, and over 0.8 represents a large effect[4].

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. A medium effect is considered if RR > 2 or < 0.5 and a large effect if RR > 5 or < 0.2[5]. lnOR stands for logarithmic OR where a lnOR of 0 shows no difference between groups. Hazard ratios measure the effect of an explanatory variable on the hazard or risk of an event.

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Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often unforseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised (*b*) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. I^2 is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity. I^2 can be calculated from Q (chi-square) for the test of heterogeneity with the following formula[4];

$$I^2 = \left(\frac{Q - df}{Q}\right) \times 100\%$$

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed[6].

‖ Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

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