Absconding and inpatient suicide

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AWOL/suicide 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
- NPSA suicide attempt data 2010
- Multiple scientific publications
Best practice statements

• Please think about these while listening to me
• Write them down
• After this presentation you are going to share them in groups, refine and discuss them, and then identify your top five
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**
Zoning

Fig. 1. Example of 25-bedded acute ward zoning board

<table>
<thead>
<tr>
<th>Zone and criteria</th>
<th>Team member</th>
<th>Team member</th>
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<th>Team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED: those at high risk/ in crisis and whose care requires constant review</td>
<td>Sophie</td>
<td>Steven</td>
<td>Anthony</td>
<td>Ella</td>
</tr>
<tr>
<td>AMBER: those who remain unwell but do not present major risk factors</td>
<td>Jim</td>
<td>John</td>
<td>Kristin</td>
<td>David</td>
</tr>
<tr>
<td>GREEN: those who are stable and in the process of being discharged or transferred to a less intensive service</td>
<td>Sarah</td>
<td>Catherine</td>
<td>Edward</td>
<td>Lynda</td>
</tr>
<tr>
<td>Enhanced Family Support</td>
<td>Sarah</td>
<td>James's parents</td>
<td>Steven's</td>
<td>Beth</td>
</tr>
</tbody>
</table>

Issues:
Criteria for zones
Extra meetings
Precise link to CO
No outcome research

The introduction of care zoning has enthused the nursing teams and the mental health service to adopt care zoning as a supervisory framework that increases their capacity to communicate clinical needs, share information, and gain invaluable support from one another in addressing clinical needs. This includes increased opportunities for staff to feel supported in asking for assistance in understanding and addressing complex clinical presentations.
Zoning

- **Assets:**
  - Provides a systematic framework for risk management
  - Staff who use it tend to like it
- **Question marks:**
  - Criteria absent (but usually relative perceived risk)
  - Introduces paperwork/systems/bureaucracy, i.e. takes time and effort
  - Uncertain link to observation use
  - Zero outcome evidence
- **More research needed:**
  1. Before/after intervention study, using officially collected data
  2. Cross site implementation survey, identify different ways of doing it, reported difficulties, anticipated outcomes, perceived outcomes.
  3. Red zone – what actions are taken for what risks
  4. What zones, what patients, what times, what risks – descriptive analysis on one site.
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, training
• 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, 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
- New CQC strategy being formulated – monitoring and comparison of seclusion and restraint
- NICE guidelines on violence currently being revised
Best practice statements

- Share
- Refine wording
- Identify top five
- Put them on a flip chart and pin them up

YOU HAVE 15 MINUTES