The Consequences of Absconding from Mental Hospitals

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This article focuses on the consequences of absconding from mental hospitals, a topic hitherto only dealt with by previous studies in piecemeal fashion. All absconsions over a 12-month period from three conventional mental hospitals in England were studied, the absconders' case notes and various hospital documents were perused and various hospital staff, police officers and a sample of absconders and non-absconders were interviewed. It was found, *inter alia*, that absconding affected the absconder himself, his hospital, the public (including his family) and the police (who played the major role in retaking absconders and returning them to hospital). Measures are recommended to help reduce the incidence of absconding from mental hospitals.

Introduction

Absconding from mental hospitals is an important issue both from the criminological and clinical points of view. The term 'patient', or 'person of unsound mind' was substituted by the Mental Treatment Act 1930, s 20(5), for the word 'lunatic' (except in the phrase 'criminal lunatic' or in relation to persons detained as lunatics outside England). Today, under the Mental Health Act 1983 such people are still referred to as 'patients' or persons suffering from mental disorder.[1] The criminological literature suggests some link between mental disorder and crime, especially, certain types of offence; for example, epileptics are from time to time prone to violent outbursts, homicide is often the result of mental disorder, and mentally impaired persons (that is, persons of low intelligence) frequently commit certain sexual offences (Home Office and DHSS (1975); Walker (1968); Rollin (1969); Hall Williams (1982); Prins (1986); Peay (1997)).[2]

The topic is also important clinically and so various studies on it have been conducted in the United Kingdom, North America and also India (Dewar

1 Section 1 of the Act defines 'mental disorder' as including 'mental impairment', 'severe mental impairment', 'psychopathic disorder' and 'mental illness'.

2 Moreover, mentally disordered persons, according to Gunn *et al* (1991), are progressively concentrated in the criminal justice system.

(1961); Muller (1962); Coleman (1966); Milner (1966); Kernodle (1966); Antebi (1967); Cancro (1968); Kanjilal (1969); Morrow (1969); Rollin (1969); Raynes and Patch (1971); Rollin and Day (1971); Lal *et al* (1977); John *et al* (1980); Gangadhar *et al* (1981); Tomison (1989); Falkowski *et al* (1990); Farid (1991); Huws and Shubsachs (1993); Short (1995), etc). However, the consequences of such absconding has been a largely ignored area. The few studies which have considered it (eg, Rollin and Day (1971)) have done so only in piecemeal fashion. Yet, such absconding often affects the absconder himself, the hospital he absconds from, the public (including his family) and the police. In some cases it affects only the patient concerned or one of the other three parties, but in other cases any two, any three or all four of them are affected. This article, based on an empirical investigation, looks at the consequences of absconding on each of the four parties and makes recommendations to help reduce the incidence of absconding from mental hospitals.

Method

Over a period of 12 months (from 11 June 1989 to 10 June 1990) all absconsions from three English conventional mental hospitals (Hospital A in London, Hospital B in Hertfordshire and Hospital C in Essex) were studied. The case notes of the absconders and various ward and daily reports of the hospitals were all perused. In addition, the staff of the absconders' wards and a sample of 80 absconders and 80 non-absconders (matched for age group, sex, type of ward and length of stay) were interviewed. A random sample of 50 uniformed constables of the three Police Forces in the areas of the hospitals (namely, the Metropolitan Police, the Hertfordshire Constabulary and the Essex Police) were also interviewed.

For the purposes of this study 'absconder' was defined as:

(a) any compulsory or informal patient of a mental hospital who the hospital without medical advice or without informing staff, failed to return by midnight and was, therefore, h absent in the hospital records, or

(b) any compulsory patient who failed to return from le

appropriate time.

The legal position was that, whereas a compulsory patient could be retaken and returned to hospital against his wish (eg, under ss 18(1) and 138(1), Mental Health Act 1983) if he absconded, there was no such power over an informal patient, who could only be persuaded to return. That is still the position today.

The Hospitals

Hospital A was a large Victorian mental hospital situated in London. The average hospital population during the period of the study was 653 patients (322 males and 331 females).[3]

Hospital B was a much smaller hospital situated in Hertfordshire. The average hospital population during the study period was 338 patients (140 males and 198 females).

Hospital C was situated in Essex. During the study period, the hospital accommodated an average of 469 patients (195 males and 274 females).

Findings and discussion

There were in all 311 absconders (242 from Hospital A, 45 from Hospital B and 24 from Hospital C). They were responsible for 812 absconsions (675 from Hospital A, 109 from Hospital B and 28 from Hospital C).

The abscondings had mostly adverse consequences for the absconders themselves, their hospitals, the public (including their families) and the police. (See Tables 1-5 below.)

I. Consequences for the Absconder

The consequences of absconding for the absconder are of two types: negative and positive.

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[3] Three years after the study had been completed, however, that hospital was closed down (in 1993).

Negative consequences

Although the instances stated hereunder are referred to as possibilities, nearly all of them were real cases found by the researcher. (See Table 1 below.) Since absconding necessarily implies absence from hospital for some time (hours, days, weeks, etc), it also implies, in the case of patients on regular medication or who receive some other form of treatment, an interruption of that treatment, the severity of the interruption depending on factors such as duration of the absence.

Absconding may affect the absconder adversely in terms of his physical and/or mental condition. The effect on his mental state depends on the type of mental disorder from which he is suffering. For example, a paranoid-schizophrenic absconder may return (or be returned) to hospital with more paranoid delusions than he had before the absconsion; a depressed absconder may become more depressed and even attempt, or actually commit suicide or, if he is also an alcoholic, may further impede his treatment programme by getting drunk while at large. Aggravation of symptoms may occur where the absconder is suffering from a physical illness as well. For example, a diabetic or epileptic absconder who misses his regular medication by virtue of his absconsion may go into a coma or have a fit, respectively, during the period of his absence from hospital. The asthmatic patient-absconder who misses his regular medication may return (or be returned) to hospital in a worse physical condition.

The absconder may also be the victim of a road, rail or other accident, or the perpetrator or victim of a crime. In the case of a sexually promiscuous patient or a user of hard drugs (who shares needles with other drug-users/addicts), there may be a risk of contracting the HIV virus (that is, the virus that causes acquired immune deficiency syndrome, a condition which destroys the body's resistance to infection, with fatal consequences) or some other infection.

Furthermore, there are some patients who, after absconding, find it quite difficult to manage to live outside the hospital; some of them live rough, get famished and have to steal to survive, get cold, especially in the Winter, or walk the streets night and day and return (or are returned) to hospital looking lean, hungry and unkempt.

All these negative effects were actual findings of the study, as can be seen in Table 1.

Table 1
Consequences of absconding for the absconder
Number of Absconsions

Hospital	A	B	C	Total
Very harmful effect (fatal effect or one that led or nearly led to the destruction of the patient's health or lifestyle), eg:				
Suicide or attempted suicide.....	2* (0.3%)			2 (0.2%)
Patient missed essential regular medication for epilepsy, diabetes, etc	1 (0.1%)	1 (0.9%)	1 (3.6%)	3 (0.4%)
Patient the victim of an accident....	1** (0.1%)	1*** (0.9%)	1 (3.6%)	3 (0.4%)
Patient was seriously assaulted and mugged.....	1 (0.1%)			1 (0.1%)
Moderately harmful effect (where the patient was in a worse mental or physical condition not amounting to very harmful effect, eg was more hallucinated, slept rough, sustained injuries through drunkenness, etc)...	26 (3.9%)	5 (4.6%)	6 (21.4%)	37 (4.6%)
Hospital	**A**	**B**	**C**	**Total**
No harmful effect other than missed regular medication.....	644**** (95.4%)	102 (93.6%)	20 (71.4%)	766 (94.3%)
Total	675	109	28	812

* One suicide and one attempted suicide.

** The patient was hit by a car ('hit and run'); he was drunk then. He died a few weeks later in another hospital from his injuries.

*** The absconder died instantly.

**** 5 were by the same patient: he went to look for work.

Positive consequence

On the other hand, an absconsion may have a positive effect on the absconder in terms of being of some therapeutic value. For example, if a patient suffering from agoraphobia (fear of open spaces) absconds, the absconsion will clearly be a sign of improvement in his mental condition. A patient may also abscond in order to go and look for work or accommodation or to go and sort out some financial problem, eg welfare benefits. This is also shown by Table 1.

Clearly, as can be seen in Table 1, in the vast majority of cases in all the three hospitals there was no harmful effect of the absconsion on the patient concerned other than his missing regular medication or treatment. In 26 out of 675 cases in Hospital A, 5 out of 109 cases in Hospital B and 6 out of 28 cases in Hospital C the absconsion was moderately harmful to the absconder. But, the fact that loss of life ever resulted at all suggests that absconding can have very serious consequences for the absconder. In addition, since an absconsion results in the interruption of treatment, it may be said generally that each absconsion was prejudicial to the absconder.

II. Consequences for the Absconder's Hospital

The consequences of absconding for the hospital from where a patient absconds are mainly negative. They are: (a) financial consequences, (b) the possibility of adverse publicity/ reports in the media, c) anxiety by staff members and other patients about what the patient may do or get into while absent without leave, and (d) the bad influence of the absconding behaviour on other patients, especially in the absconder's ward. It must, however, be

emphasised that every absconsion does not necessarily have adverse consequences for the absconder's hospital; and, where any such consequences do occur, they may not occur simultaneously. One positive consequence is the relief felt by hospital staff when a particularly dangerous or troublesome patient absconds.

Rollin (1969) and *Rollin and Day* (1971) drew attention to the financial consequences of absconding for the absconder's hospital. There are two aspects of this issue: firstly, the expense of transporting absconders back to hospital and, secondly, the cost in time and manpower. *Rollin and Day* (1971) found that it cost Horton Hospital, Epsom, approximately £350 in 1968 to retrieve their absconders from various places around the country. (That figure, by today's prices, would be about £1,400.)

In the present study it was found that:

(i) In London, the staff of Hospital A had to return 13 patients from various police stations and other places, namely:

   (a) Southend Police Station, Kettering, Bedford and Nottingham (one patient),
   (b) Cambridge and Peckham, south east London (one patient),
   (c) Stevenage Police Station (Hertfordshire) and King's Cross Police Station, London (one patient),
   (d) Salisbury (Wiltshire), Stevenage, Scotland, St Pancras (London), Tottenham (north London), Finchley (north London), Clerkenwell (north London), Guy's Hospital (south-east London), Camden (north-west London) and Stoke Newington (north London).

A mini-cab was hired by the hospital on all those occasions, costing a total of approximately £2,216.

(ii) In Hospital B, in Hertfordshire, only one patient was returned by the hospital staff (from a district about 7-9 miles away from the hospital). The expense involved was, therefore, nominal (approximately £12).

(iii) However, in Hospital C, on six occasions absconders were transported back to the hospital by the hospital's own vehicles from various locations, namely: Southend (Essex), Hockley (Essex), Bishopsgate (London), Wickford (Essex), King's Cross (London) and Holloway (London).

Therefore, it was not possible to calculate the cost (of transportation) incurred by that hospital. But, had the hospital hired mini-cabs on all those six occasions, the total cost would have been about £197. Table 2 illustrates the return to hospital of absconders by hospital staff in all the three hospitals during the study period.

Table 2
Return of absconders by hospital staff

Hospital	**A**	**B**	**C**	**Total**
Number of times absconders were returned by hospital staff:				
From a place within the hospital's catchment area	5 (0.7%)	0	3 (10.7%)	8 (1%)
From outside the hospital's catchment area	13 (1.9%)	1 (0.9%)	3 (10.7%)	17 (2.1%)
Total returns by hospital staff	18 (2.7%)	1 (0.9%)	6 (21.4%)	25 (3.1%)
Cases where the patient was later put on leave, was discharged or died in absentia	47 (7%)	13 (11.9%)	5 (17.9%)	65 (8%)
Remaining cases	610 (90.4%)	95 (87.2%)	17 (60.7%)	722 (88.9%)
Total absconsions	675 (100%)	109 (100%)	28 (100%)	812 (100%)

Overall on only 3.1% of occasions (that is, 25 out of 812 absconsions) were the absconders returned by hospital staff. However, the percentage of returns by hospital staff was higher outside London than in London although numerically there were twice as many returns by hospital staff in London (18) than outside London (7). Whenever an absconder has to be escorted back to hospital, therefore, a financial demand is imposed on that hospital.

A further demand is imposed on the hospital's manpower. It was found in the study that normally two nurses had to accompany the hospital driver (if any) or mini-cab driver to return an absconder. The time involved varied but basically depended on from where the absconder was returned; it varied from an hour to about four hours, valuable time indeed, especially in a period of shortage of staff in hospitals. In such situations, therefore, the hospitals concerned had to engage extra staff (temporarily), ask some of their members of staff to work overtime or just cover the ward/s affected as best as they could during that period.

Another negative consequence of absconding for the absconder's hospital is adverse publicity by the media, particularly where the patient is known to be dangerous or to have criminal propensities or actually commits an abhorrent crime while he is at large. This is because such media reports (especially the highly critical ones) may lower the estimation of the hospital concerned in the eyes of right-thinking public members. But, newspapers and radio and television broadcasters have to inform the public of matters of interest to them and, as long as they do so stating the true facts, they cannot generally be sued for defamation.[4] There was, however, no media publication of a dangerous patient's absconsion from any of the three hospitals during the period of the study.

The third adverse consequence of absconding for the absconder's hospital is that members of staff and other patients in the absconder's ward may worry about what he may do or what may happen to him during his absence, eg whether a very depressed and actively suicidal absconder may commit suicide, whether a paranoid-schizophrenic absconder may seriously harm a member of the public who is the object of his paranoid delusion(s), etc.

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4 See, for example, *Loughams v Oldham Press Ltd* [1963] CLY 2007, and *Prager v Times Newspaper Ltd* [1988] 1 WLR 77.

In addition, there is the possibility of the absconding behaviour being emulated by other patients in the absconder's ward. Another possibility is that of patients with a more dominant personality (often psychopaths) encouraging weaker characters to abscond with them and actually financing the venture.

However, there is a positive consequence of absconding for the hospital in question: the absconsion of a particularly dangerous or troublesome patient brings some relief to the hospital staff, especially those in his ward. But, this reprieve may be only temporary unless the patient is a non-restricted patient who stays absent without leave for six months or a period further than the period he is liable to be detained, whichever is the longer, and becomes no more liable to be retaken.[5] This is because restricted patients can be retaken and returned at any time. Ward reports and interviews with ward staff and patients in all three hospitals indicated these effects of absconding.

III. Consequences for the public

In some cases the absconsion of a patient may cause fear in the residents of the area surrounding the hospital (and of other nearby areas), and/or in the patient's relatives and friends of what the patient may do while absent, especially if he is known to be violent, and his absconsion becomes known to the public. In other cases his relatives and friends may just worry about his welfare and/or have to return him to hospital if they find him or he goes to them.

Another consequence of absconding for the public is that some absconders actually commit criminal offences of all sorts while at large. For example, as reported in *The Guardian*, 17 December 1993, a convicted armed robber attacked three girls after absconding from Broadmoor Hospital. Also, in 1997 another patient, Michael Calladine, absconded from a mental hospital, Highbury Hospital, in Nottingham and, while at large, bought a knife with which he stabbed a baby girl in a random attack in front of her mother in a shopping precinct (*The Times*, 4 June, 1997). The present study found that the following types of offence were committed by absconders during their period of unauthorized absence: criminal damage, shoplifting, breach of the peace

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5 S 18(4), Mental Health Act 1983, as amended by the Mental Health (Patients in the Community) Act 1995, s 2(1).

and assault. (One absconder from Hospital C actually tried to strangle his father at home but did not succeed because of the timely intervention of the police: see Table 3.)

Moreover, absconders who are HIV positive (that is, have the HIV virus) and are prone to sexual promiscuity or injecting themselves with (illicit) drugs and share needles for that purpose, pose a danger to society because they may infect other people in the community with the virus. Such cases may not be many (in the present study only one absconder in London was HIV), but the risk is real.

Table 3 illustrates the actual effect of absconding on the public as found by the present research.

It can be seen from that table that only a few offences were committed by the absconders while they were at large (8 actual offences, 7 of which were by absconders from Hospital A). In the majority of cases (96.4% in London, 82.6% in Hertfordshire and 60.7% in Essex), there were no known complaints or effects on the public although there might have been others which were not reported (or recorded) or which the researcher did not hear about. Nevertheless, the fact that some offences (though less serious) were committed by some absconders while at large, that some absconsions (8 in London, 17 in Hertfordshire and 8 in Essex) got the absconders' relative(s) or friend(s) worried (as recorded in the absconders' case notes), that one absconder in London was HIV positive, that another absconder caused nuisance in a public place and that 5 absconders (4 in London and 1 outside London) behaved aggressively towards their relatives should be a cause for concern.

Table 3
The actual effect of absconding on the public
Number of Absconsions

Hospital	A	B	C	Total
The absconder committed (or was arrested for): causing criminal damage	3 (0.4%)	0	0	3 (0.4%)
theft (or shoplifting)	2 (0.3%)	0	0	2 (0.2%)
breach of the peace	2 (0.3%)	0 (3.6%)	1	3 (0.4%)
other offence(s) (reported by the absconder)*	3 (0.4%)	2 (1.8%)	1 (3.6%)	6 (0.7%)
Worry by relative(s) or friend(s), etc, about what the absconder might do or suffer while at large	8 (1.2%)	17 (15.6%)	8 (28.6%)	33 (4.1%)
Hospital	**A**	**B**	**C**	**Total**
High risk of the patient infecting other people with the HIV virus, etc	1 (0.1%)	0	0	1 (0.1%)
Other effect: (a) causing nuisance in a public place	1 (0.1%)	0	0	1 (0.1%)
(b) aggressive behaviour towards relative(s)	4 (0.6%)	0	1 (3.6%)	5 (0.6%)
No effect	651 (96.4%)	90 (82.6%)	17 (60.7%)	758 (93.3%)
Total number of absconsions	675	109	28	812

* *The offences were criminal damage (3 times), shoplifting (twice) and assault.*

IV. Consequences for the Police

It is almost impossible to think of circumstances where absconding from mental hospitals could have positive consequences for the police. They are mostly of a negative kind. Absconding imposes a demand on police time and resources in terms of manpower, equipment and, therefore, money. This is because the police are often informed by mental hospitals when patients abscond and are requested to retake and return those patients. This is what normally occurs in the case of compulsory patients because there is power under,for example, s 18 of the Mental Health Act 1983 (as amended by the Mental Health (Patients in the Community) Act 1995) to retake them.[6] Although the power to retake compulsory patients who abscond may be exercised by both hospital staff and the police, the hospitals often request the police to do the retaking; where the absconder is a compulsory patient, they conduct a full inquiry and exercise their power to retake him.

The police play a very important role whenever a compulsory patient (or an informal patient who is considered a 'grave concern') absconds from hospital. As can be seen in Table 4, it was found by the present research that on a considerable number of occasions absconders were returned to hospital by the police in London and outside London.

Unfortunately, the financial demand on them made by absconders is very indirect indeed because they deal with absconders from mental hospitals as part of their everyday work. Therefore, it was not possible to assess that demand although the researcher discussed it in an interview with three senior police officers (one Chief Inspector in London, one Inspector in Hertfordshire and one Inspector in Essex), all of whom were in charge of 'missing persons' matters in their respective stations; their stations were the appropriate stations which received missing patient reports from the three hospitals in the study. The reasons why the financial burden imposed on the police by absconders

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6 Where, however, an absconder (who is not being chased/pursued by the police) is at premises, access to which is denied to the police, the police can, under section 135(2), Mental Health Act 1983, obtain a warrant from a justice in whose area the patient/absconder is, and then enter to retake that absconder. This is the power they should have used in *D'Souza v DPP* [1992] 1 WLR 1073; [1992] 4 All ER 545 (instead of s 17(1)(d), Police and Criminal Evidence Act 1984). According to the House of Lords in that case, the police were wrong in using s 17(1)(d) of the 1984 Act to retake the absconder in question (the appellant's mother) because s 17(1)(d) authorised entry and search of premises for the purpose of recapturing a person unlawfully at large **only if that person was being pursued, ie chased, by the police**.

from mental hospitals could not be assessed included the following:

(i) what the police did in respect of mental absconders was part of what they did in respect of missing persons generally;

(ii) the police officers (in the three areas) were on duty anyway, regardless of the particular assignment with which they were dealing;

(iii) where an absconder was first taken to a police station, the custody officer in the station was in charge of all persons in custody there, irrespective of whether they were absconders from a mental hospital or persons arrested for actually committing an offence;

(iv) the police officers were almost always dealing with more than one thing at a time or were often available for other matters, even when already dealing with something;

(v) owing to limited time and resources, the researcher could not assess the man-hours or money spent by the police on circulating messages, recording details and having enquiries made in other police areas, and also the time spent by staff in central services, eg putting details of missing patients on the Police National Computer; such a task could only have been undertaken in a 12-month period (not by one researcher but by a team of researchers based in all the three police areas concerned).

It was, therefore, thought that the consequences of absconding from mental hospitals on the police could be better illustrated by the use of case histories. For that purpose, a random selection was made of 50 out of the 90 cases of individual absconders where the police did more than just circulate the absconder's description and other details.[7] In each case one of the police

[7] The random selection was done by taking every second case in a chronological list and starting the same process again with the unselected cases after the end of the list had been reached (until the 50 cases were selected).

officers who returned the absconder to hospital (if he was returned there by the police) or any other officer from his/her station who knew of the case was asked the following questions:

(i) when and how the police first encountered the absconder;

(ii) what the absconder's mental and physical condition looked like then;

(iii) where the absconder was found;

(iv) what the absconder was doing at the time;

(v) whether the absconder was first taken to the police station and, if so, whether he was seen by the police surgeon;

(vi) (a) whether the absconder was willing to return, or be returned, to hospital, and
(b) how many officers returned him and the time they did so.

The answers to these questions and other relevant information about the absconder (bearing in mind undertakings regarding confidentiality which the researcher had to give to the three hospitals and three police forces) and about the circumstances surrounding the absconsion were compiled into case histories.

Four observations were made from them:

(i) at least two police officers accompanied each absconder who was returned to hospital by the police;

(ii) at least one police vehicle was used for each absconder;

(iii) a police surgeon was called out to see an absconder at a police station very rarely (the minimum call-out fee for a police surgeon was £25 on any occasion during the study period);

(iv) the time it took the police to return an absconder to hospital (after he had been retaken) varied according to the distance between the hospital and the place where he was found.

Moreover, where an absconder was returned to hospital by the police, they provided in several cases a swift, free taxi-service because, as one constable told the researcher, that was in general the better option in that it ensured the hospital got back its patient quickly and also avoided any further cost to the police (eg a police surgeon's fee). Tables 4 and 5 show the number of occasions the police returned an absconder to hospital during the study period.

Table 4
Return of Absconders to Hospital by the Police

Hospital	A	B	C	Total
Total number of times absconders were returned by the police	86* (12.7%)	11 (10.1%)	6 (21.4%)	103 (12.7%)
Total number of absconsions	675	109	28	812
Number of absconders in respect of which the police did more than circulate absconder's description	61 (25.2%)	19** (42.2%)	10 (41.7%)	90 (28.9%)
Total number of absconders	242	45	24	311

* *The police returned one absconder 7 times, another absconder 5 times, one other absconder 4 times, 5 absconders 3 times, 8 absconders twice and 39 absconders once.*

** *One absconder was killed by a train.*

Table 5
Number of Police Officers who returned an absconder to Hospital

	Number of Times			
Hospital	**A**	**B**	**C**	**Total**
2 officers	63	11	6	80
3 officers	22	0	0	22
More than 3 officers	1	0	0	1

Although in only nearly 13% of cases (103 out of 812 absconsions (86 cases in London and 17 cases outside London)) the absconders were returned to hospital by the police, two things stand out clearly so far as the consequences of absconding for the police are concerned:

(i) overall, the police returned absconders to their hospitals far more times than the hospitals' employees did; this indicates more involvement by the police than by hospital staff in the return of absconders;

(ii) the demand made by absconding from mental hospitals on police time and resources seems considerable, especially in London because there were more police returns in London than outside London and far more officers were involved in returning absconders to hospital in London than outside London; in London two officers returned an absconder to hospital 63 times whereas outside London two officers so returned an absconder only 17 times; moreover, although at least three officers returned an absconder to hospital 23 times in London, there was no occasion outside London where three or more officers returned an absconder to hospital (see Table 5).

Absconding from mental hospitals, therefore, as shown above, has

consequences for the absconder himself, his hospital and the public (including his family) as well as the police. Those consequences are mostly of a negative type and so constitute a cause for concern.

Some recommendations will now be made to help reduce the incidence of absconding from mental hospitals.

Recommendations

During the empirical investigation, the sample of absconders who were interviewed stated their reasons for absconding. A considerable number of those reasons were either exclusively hospital-related or partially hospital-related (for example, dislike of hospitalisation, dislike of compulsory detention, dislike of hospital rules, dislike of the attitudes of the staff, feeling fed up with the hospital, dislike of the amount of medication, threatening or unsafe atmosphere in the ward/hospital, etc).

The sample of non-absconders was also asked what would make them abscond. The things they mentioned which were solely or partially hospital-related included the following:

- not getting the right treatment,
- pressure by the staff to take medication,
- feeling unsafe in the ward,
- too much noise in the ward,
- not being allowed to go out,
- being upset by the staff,
- being threatened by another patient and the staff doing nothing to help,
- row or disagreement with the staff,
- staff not listening to patients,
- staff brutality or maltreatment of patients,
- staff picking on patients, and
- staff not making patients feel wanted in the hospital.

Accordingly, it was felt that, if something could be done about the absconders' hospital-related reasons for absconding and the hospital-related factors which the non-absconders said would make them abscond, the incidence of absconding could be reduced considerably. The following

measures are, therefore, recommended:

(a) the atmosphere in each ward needs to be such that the patients feel reasonably happy, safe, wanted and not bored; the patients need to be reasonably independent, to enjoy freedom from monotony through being able to take part in various activities, etc;

(b) relatives and friends must be encouraged to visit the patients and to be discreetly advised not to incite, or exert any pressure on, them to abscond because that will interrupt their treatment;

c) the attitudes of some members of staff need to be modified; the ward staff should not deliberately upset a patient, have a row with a patient, pick on him or maltreat him; instead they should do their best to adopt a warm and flexible attitude towards their patients, share activities with them where that is appropriate, make them feel wanted, listen sympathetically to them, reassure any patient who is threatened by another patient and to be seen, if possible, by the threatened patient to have intervened on his behalf and to counsel the patient issuing the threat;

(d) patients should be regularly counselled so that they may feel they are getting the right sort of help;

(e) poor channels of communication between staff and also between staff and patients need to be corrected so that the patients, especially the very sensitive ones, may not feel their care is being negatively affected thereby;

(f) patients should be encouraged as much as possible to be more concerned about each others' welfare and to tell the staff about any unusual event(s) in the ward, eg a patient's plan to abscond;

(g) there should be more vigilance by staff in the admission wards (and specific rehabilitation wards), from which patients usually abscond; there should also be more observation of patients more likely to abscond

(that is, patients referred by the police, compulsory patients, patients who receive less than weekly, or no, visits, patients who have no job to go to, patients with a history of alcohol abuse and patients with a history of abuse of other drugs) and also of known frequent and persistent absconders; this will help reduce absconsions without having any prejudicial effect on the open-door policy generally operated by conventional mental hospitals;

(h) there should be careful supervision and counselling of patients known to be most likely to influence other patients to abscond;

(i) behaviour modification techniques to make frequent and persistent absconders stay in hospital are worth trying; for example, those patients could be rewarded periodically (if not daily) with soft drinks or some other appropriate 'token' if they stay in the ward and do not abscond;

(j) in order that patients may not feel bored and choose to abscond as a result, existing recreational, occupational and other activities in hospital must be made, as far as financial limits permit, more exciting and appealing to the patients; encouragement could also be given to such events as snooker or other games competitions between wards and/or between patients and staff, etc;

(k) as soon as practicable after an absconsion the ward staff need to meet and review the situation and discuss, especially in the case of frequent and persistent absconders, what can be done (legally, of course) to prevent or reduce future incidents of absconding by them.

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