Descriptive Title: Risk assessment and absconding: Perceptions, understandings and responses of mental health nurses

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No conflicts of interest are reported.

Risk assessment, management and absconding: Perceptions, understandings and responses of mental health nurses

ABSTRACT

Aims: This paper reports mental health nurses' perspectives of absconding. The aims of the study were to explore nurses' perceptions of risk assessment and management practices regarding absconding from acute inpatient psychiatric settings, and their affective responses when patients absconded.

Background: Nurses are directly involved in managing the risk of patients leaving hospital while acutely unwell, as well as dealing with the implications of an absconding event. However, despite their key role, few studies have explored nurses' perceptions of absconding.

Design: An interpretive inquiry was undertaken using a systematic thematic approach.

Methods: Mental health nurses (n =11) from three acute inpatient mental health units in Australia took part in semi-structured interviews, with a focus on the nurses' experiences of working with patients who had absconded. Data were analysed using systematic thematic coding procedures.

Results: Nurses' assessment of a patient's risk of absconding involved the use of clinical judgement, focusing on markers of absconding including the patient's history and clinical presentation. The acuity of the perceived risk determined the type of risk management strategy implemented, which could include support, observation and/or the use of containment procedures. Nurses responded with a myriad of affective reactions when patients absconded dependent on their assessment of the patient's risk.

Conclusions: Support and debriefing is required for mental health nurses following an absconding event. Additional research is vital to identify alternative absconding

assessment and management strategies to ensure the best possible outcome for patients and nurses.

Relevance to clinical practice: Mental health nurses play a central role in risk assessment and management for absconding, with fear of repercussions a significant consequence for them. This research highlights the importance of both clinical judgment and standardised instruments in assessing absconding risk. Further research is needed to identify alternative evidence-based absconding management strategies to support nursing practice.

KEY WORDS

Mental Health, Nurse, Perceptions, Absconding, Risk

WHAT DOES THIS PAPER CONTRIBUTE TO THE WIDER GLOBAL CLINICAL COMMUNITY?

- Assessing and managing a patient's risk of absconding occupies a prominent position within mental health nursing worldwide.
- This paper provides valuable insight into how mental health nurses assess and manage absconding risk, and their affective responses to absconding events.
- Results highlight the need for individualised care plans, improved management strategies and support for nurses following an absconding event.

INTRODUCTION

The concept of risk in mental health can refer to a number of areas, including risk of harm to self and others, risk of substance use and risk of absconding (Nolan *et al.* 1999, Raven & Rix 1999, Crowe & Carlyle 2003, Ashmore 2008). Such risks are generally taken-for-granted as necessary aspects of mental health nursing (Crowe & Carlyle 2003). It is perhaps because of this that the recognition and utilisation of risk assessments by mental health nurses in informing clinical practice is under-researched (Muir-Cochrane & Mosel 2008). In particular, the role of the nurse in the assessment and management of patients' risk of absconding (leaving a hospital ward or grounds without permission) has been given relatively little attention. This is despite the fact absconding involves potentially harmful outcomes including medication non-compliance, self-neglect, disruptions to treatment, lengthened recovery times, harm to self and others and extended stays in hospital (Bowers *et al.* 1999, Bowers, Brennan *et al.* 2006, Muir-Cochrane & Mosel 2008).

The frequency of absconding reported in the literature varies significantly due to differences in how the behaviour is measured and defined (Wilkie *et al.* 2014). Bowers *et al.* (1998) reported a mean rate of 12.6% of all patients in general psychiatry, with a range of 2-44%. Recent Australian studies reported rates of 15.7% (Carr *et al.* 2008) and 10.21% (Mosel *et al.* 2010). Absconding remains a concern in mental health care worldwide, as evidenced by recent international investigations into this behaviour (Nurjannah *et al.* 2009, Lang *et al.* 2010, Sheikhmoonesi *et al.* 2012, Beghi *at al.* 2013, Hearn 2013, Hunt *et al.* 2013, Andreasson *et al.* 2014, Bowers 2014, Martin & Thomas 2014, Wilkie *et al.* 2014).

Nursing staff have an important role in assessing and managing whether a patient is likely to abscond while an inpatient. They are well placed to observe

potential indicators for absconding due to their 24-hour presence on the ward and core role of ensuring the safety of patients, staff and visitors (Bowers, Simpson *et al* 2005, Bishop & Ford-Bruins 2003). In addition, nurses are directly involved in dealing with the implications of an absconding event; yet the impact of absconding on nurses has been under-researched despite the recognised potential impact on staff of serious incidents (Bowers, Simpson *et al* 2006).

BACKGROUND

The last decade has seen an increasing focus on risk assessment, risk containment and minimisation in the delivery of contemporary mental health services internationally (Raven & Rix 1999, Crowe & Carlyle 2003, Kettles *et al.* 2004, Ashmore 2008). Consequently, nurses are required to engage in assessment of risk and enact risk management techniques on a daily basis (Barker & Buchanan-Barker 2005a, Ward 2011). Risk assessment processes involve the consideration of actual and perceived risk to patients and others, which include consideration of such factors as current or past behaviour and mental state (Kettles *et al.* 2004). This assessment data results in the identification of high-risk patients, which is used in formulating a care plan targeting interventions to those in need.

Risk assessment can be conducted using clinical judgement, actuarial risk assessment approaches using instruments designed specifically for assessing risk, or a combination of the two, termed structured clinical judgement (Woods 2012). There has been extensive debate and discussion about the accuracy of risk assessment in predicting the risks a patient actually poses. Actuarial approaches are reported to be better than clinical judgement alone, while structured clinical judgement may be the

best approach because it allows for the flexibility to consider case specific factors (Doyle & Dolan 2002).

Risk management involves actions to address and minimise the assessed risk. It may include the use of intensive support, time out, sedating medication, as well as containment methods such as seclusion, restraint, increased observation levels and the locking of ward doors or parts of units (Neilsen *et al.* 1996, Bowers, Brennan *et al.* 2006, Whitehead & Mason 2006, Ashmore 2008, Briner & Manser 2013). There is much debate as to the effectiveness of containment methods to manage risk – Bowers, Brennan *et al.* describe these methods as "contentious and emotive" with "little evidence or agreement about their efficacy" (2006, p. 166) – as well as ethical issues associated with their use (Cotter 2005, Muir-Cochrane & Mosel 2008, Moylan 2009, Cox *et al.* 2010, Nijman *et al.* 2011). The ongoing relevance of these issues can be seen in the recent move by the state government in Queensland, Australia, to lock the doors of all Queensland Health adult mental health hospital inpatient facilities and expand the use of ankle bracelets (non-removable bracelets placed on the ankle to enable GPS tracking of a patient's movements), a step that has angered and frustrated mental health professionals (RANZCP 2013).

Assessing and managing a patient's risk of absconding occupies a prominent position within mental health nursing worldwide, and the need to anticipate and prevent absconding can create anxiety in staff (Muir-Cochrane *et al* 2012). This is because attempts to abscond could potentially be made by any patient within a mental health unit (Moore 2000) and may on occasion lead to serious consequences (Bowers *et al* 1999). Absconding rates vary widely in the international literature, with rates of between 2.5% and 34% of all psychiatric admissions reported (Meehan, Morrison & McDougall 1999, Muir-Cochrane & Mosel 2008). An Australian study of three acute

care psychiatric wards found that over 10% of compulsorily hospitalised patients absconded at least once during their admission (Mosel *et al.* 2010).

A number of strategies have been proposed to reduce and manage patients' risk of absconding, including locking ward doors, increased availability of short term escorted leave for patients and decreased ward numbers (Clark *et al.* 1999, Ashmore 2008). Muir-Cochrane and Mosel (2008) reviewed 39 articles on absconding from 1996 to 2008 and concluded that many of the containment and management techniques currently practiced, such as locking ward doors, derive from their perceived efficacy to increase ward safety, but are not evidence based. Locking doors appears to have only modest effects on preventing patients from leaving units without permission (Nijman *et al* 2011); probably increases aggression on wards (Bowers *et al* 2009) and has been described by nursing staff as a method that erodes patients' freedom, independence and autonomy (Ashmore 2008). Patients perceive that there is a higher degree of anger and aggression expressed on locked wards, and that locking doors produces a non-caring environment (Ashmore 2008), with feelings of depression, stigma and low self-esteem also reported (Muir-Cochrane *et al* 2012). In spite of these findings, the proposed new security measures on inpatient units in Queensland, Australia were reportedly driven by a desire to prevent patients absconding. Other methods identified to reduce absconding from psychiatric settings include increasing observation levels and staff numbers, which is attributed to the belief that absconding occurs at higher frequencies during nursing handover periods (Mosel *et al.* 2010), although this relationship has not always been found (Bowers *et al.* 2000; Bowers, Alexander *et al.* 2003; Walsh *et al.* 1998).

Furthermore, Ashmore (2008) suggests that in some instances containment strategies may even increase the incidence of patients absconding or inadvertently

encourage patients to use higher risk strategies to abscond from inpatient units - the very thing they are meant to reduce. As a result when nurses are faced with minimising the risk of a patient absconding, they are often unaware of what are effective and evidence-based prevention methods (Clark *et al.* 1999). This highlights a significant gap in the knowledge base of professionals from both a risk assessment and quality care perspective.

In addition to dangers to the individual and, in some cases, to the public (Hunt *et al.* 2010), absconding creates added pressure on staff caring for an acutely unwell patient and can have negative consequences for nurses' emotional wellbeing. Meehan *et al.* (1999) found that common affective reactions for nurses to patients absconding include fear, anger, concern and anxiety combined with a sense of failure to prevent this event. A study by Clark *et al.* (1999) identified that 42% of nurses interviewed "felt vulnerable to being blamed for absconds" (p. 224), which resulted in nurses at times feeling at risk of being suspended, or even possibly losing their jobs. It has also been suggested that even if an absconding event does not result in harm to the patient there is still considerable anxiety caused to staff (Bowers, Simpson & Alexander 2005). These negative reactions are understandable for, as Crowe and Carlyle (2003, p. 21) outline, "if a clinician fails to make an accurate risk assessment she or he is regarded as negligent".

Overall the literature reveals that absconding has the potential to create numerous negative outcomes for patients and staff, but that there is only a small amount of literature examining the role of, and impact on, the nurse. This is concerning because risk assessment and management are an ongoing process fraught with difficulties and challenges for clinicians working in acute mental health units (Moore 2000). While there is a lot of information regarding how clinical risk is

calculated, little attention is devoted to how these inform the therapeutic process (Arya & Nicholls 2005). Similarly, while there is a lot of research on the characteristics of absconding events, there is a shortage of material that examines the actual practice of nurses and health professionals in translating this knowledge into care of the patient (Ashmore 2008, Muir-Cochrane & Mosel 2008). The aim of this study was therefore to examine what information and knowledge is used in determining risk of absconding, and how risk assessment and management is used in nurses' daily practice. The study also examined understandings of absconding minimisation strategies currently used and their perceived effectiveness, as well as nurses' reactions to using these. Finally, the impact absconding has on nurses, both professionally and personally, was examined.

METHODS

Design

The primary focus of the study was on the complexity of nurses' experience, which depends on their perceptions, inclinations and sensitivities (Sandelowski 2000). A qualitative, interpretive methodology was therefore chosen. Interpretive inquiry takes a naturalistic approach that seeks to understand phenomena in context-specific settings (Bailey 1997).

Participants

A purposeful sample of 11 acute inpatient registered mental health nurses were recruited from three acute unlocked metropolitan psychiatric inpatient units in one state in Australia. Participant inclusion criteria were being a nurse with mental health nursing postgraduate qualifications and having had experience with involuntarily hospitalised patients who had absconded. Nurses working in the units

were invited to participate in an interview via an email sent to their work email address. The nurses were asked to contact the researcher if they were interested in participating in the study or required further information.

Ethical approval was obtained from the university and hospital ethics committees. Of the 11 participants interviewed, six were female. Participants ranged in age from 35 to 60 years. They were experienced in their profession, with an average of 30 years working in the nursing profession; including most (n = 7) participants having between 10-30 years of experience working specifically in the mental health setting.

Data collection

The interview guide included 20 semi-structured interview questions, allowing the participants to expand on areas they perceived as important without influence from the researcher. The questions focused predominantly on two main areas, namely the nurses' role in the assessment and management of absconding risk, and the nurses' perceptions about absconding. The interviews were audio-taped and transcribed verbatim.

Analysis

A thematic analysis approach was used following the process outlined by Braun and Clarke (2006). After familiarisation with the data, initial codes were generated with a focus on coding interesting features of the data in a systematic way. This resulted in the identification of 23 codes. For example, one code involved how nurses assess absconding; another focused on problems identified with reducing absconding. Codes were then sorted into categories (e.g. Management Strategies; Impact on the Patient; Impact on the Nurse) which were then grouped into themes, where a 'theme' "captures something important about the data in relation to the

research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke 2006, p. 82). Initial coding and the development of early themes were undertaken by one author, with the other authors involved in further development of themes. Data were managed using the software program NVivo 8 (QSR International Pty Ltd, Melbourne, Victoria, Australia).

RESULTS

Three themes were identified: Risk Assessment; Risk Management; and Responses to Absconding. Although each of these is discussed separately it is important to recognise that the themes overlap and interconnect to form the entirety of nurses' perceptions and experiences of risk assessment, risk management and absconding. No identifying information is included alongside quotes to maintain participant confidentiality and anonymity, with just the interview number provided.

Risk assessment

Nurses believed that every patient arriving at the ward should be assessed for potential risk of absconding because *'how would you know their risk if you haven't actually assessed it?' (11).* However, while all nurses agreed that assessment of a patient's risk should be made as soon as possible after the patient has arrived on the unit, they indicated that this assessment is not a clear cut process as *'every case is different' (3).* Interestingly, despite nurses acknowledging the dynamic and complex nature of risk assessment, they stated that assessing risk of absconding involved significant clinical judgment, particularly since there were no risk assessment tools being used to predict absconding.

When reflecting on their practice nurses were able to identify several markers for assessing the risk of absconding. These revolved around the consideration of a

patient's past history and current clinical presentation. Clinical judgement was used to weigh up all potential risks in order to ascertain a change in factors such as the patient's mental state, suicidality, or psychotic features that nurses believed would assist in determining the patients' likelihood of absconding:

> It's like an amalgamation of a lot of features, if you get the risk score that's raising (sic) or there's a change in behaviour or you just get a sense in your gut that something's wrong that informs you as to whether or not there's ... something going on. (2)

Nurses perceived the most prevalent marker was drawing on a patient's past history. Mainly, this involved whether they had absconded before or had previously expressed frustration regarding their hospitalisation. There was reflection amongst the nurses that clues and patterns of a patient's desire to leave are established from past admissions. Understanding past admissions allowed staff to get to know the patients and their habits, which enabled them to make judgments as to whether the patient is likely to abscond:

> If someone is susceptible to abscond on numerous admissions I think you have to take it into account. (5)

However, it was also noted that history is used carefully as *'every case is obviously got to be at the exact moment that it's happening' (2).* It was also recognised that presentations change between admissions and can even fluctuate throughout the day. As a result, nurses reported that they do not rely solely on the patient's history; instead they also acknowledge the vital importance of current clinical presentation in making an assessment.

The main areas identified when looking at a patient's current presentation included the content of their conversation and their behaviour. A specific focus was on whether the patient was pacing, appeared to be hyper-vigilant, severely distressed, agitated, tormented, expressing suicidal ideation, or simply asking if they can go to the shops. Other predictive factors included the patient's level of functioning, and their level of ability to comprehend, understand and comply with the admission process:

> We like to meet with them as soon as practicable to assess their mental state, ... fairly quickly you often pick up whether they're a high risk person for absconding or for self-harm through their level of unwellness (sic), a risk to themselves through misadventure. (10)

Despite the identification of the use of these two areas in determining risk, and in most cases an apparent individual preference of the nurses as to their importance, no clear consensus was made as to what information was of the most benefit in making the assessment. As a result the nurses questioned the accuracy of their assessments: *'In assessing the risk yes, I don't think we do it do very well' (3)*.

Risk management

The nurses' perceptions of the acuity of the patient's risk determined the type of management practice implemented. In the case of absconding, the greater the perception of risk, the more restrictive the management strategies were. When discussing management strategies nurses often spoke of containment. Seclusion, transfer to a closed ward, increased observations, locked doors, and the use of chemical restraint in the form of extra medication, were all cited as methods of

containment currently used.

Nurses also identified providing emotional support as a way to calm patients as well as family involvement prior to the implementation of containment strategies. Nurses revealed, however, that the support strategies identified were often only used until a more 'appropriate' strategy could be implemented. This generally involved the use of more restrictive methods. Increased observation was the most common approach discussed. This was perceived to be a helpful measure for nurses as it allowed them to know where a patient perceived to be at high risk was at all times. It also provided a positive reflection on the nurse because they were seen to be supportive of patients, *'quite a few clients see it as a positive thing that people are checking on them … when the nurse comes in to check if they're still there, they could stop the nurse and talk to them'* (*11).*

The desire to lock the ward was discussed at length. This was due to the perception that it was the best method available to contain those patients who were at particularly high risk of absconding. Its use was also believed to take the pressure off nursing staff because the main method of absconding, namely patients walking freely out the open doors, would no longer be available: *'It's less easy to abscond' (2).* This was despite the identification that when the ward doors were locked, nurses had experience of patients using higher risk methods (going over a fence or unit wall, breaking through the door) to abscond. Despite the awareness that locking ward doors *'raises risk all the time' (2)* and recognition by four nurses that it breached ward policy, two nurses believed that wards doors should be locked permanently or at least a specific locked area of the ward should be available.

> This is my own thought and doesn't meet with policy; I like it when the door's locked because then I think "well that's that out of the way". (2)

Regardless of the lack of agreement as to the efficacy of locking ward doors, the foremost concern appeared to be the appropriateness of involuntarily hospitalised patients being in open wards in the first place. A common belief among participants was that the very nature of detaining someone against their will to a mental health facility is meant to safeguard the person, and as such everything should be done in terms of their safety. This includes being sent to a closed ward or at least the limitation of the number of patients being admitted who were at risk of absconding so that adequate nursing time can be spent with them:

> My personal view is that if you're detained [involuntarily hospitalised] you should go to a closed ward, you shouldn't be in an open ward. (3)

Closely related to the belief that locking ward doors decreases the incidence of absconding was the notion of getting the balance right between patient safety and their right to autonomy. This was discussed within the context of risk management, in which the acuity of other patients and the skill level of staff were also considered. This is of particular importance considering some nurses believed the containment and isolation of clients through the use of locking ward doors makes patients *'feel trapped and less in control of their environment'* (2), which was perceived to create possible risks to patients' own safety and the safety of others in the ward.

The main problem identified by the nurses regarding the management of absconding was the lack of available and appropriate alternatives that not only look after the patient and their wellbeing, but also consider nurses' safety. As explained by one nurse, the focus on safety is complicated by the pressure of caring for patients using the least restrictive practice:

> It's difficult, it is really difficult. I think the mental health system has a big task in terms of what this society expects the system to do and sometimes it's impossible. (2)

Participants referred to general engagement and rapport as affecting the incidence of absconding on the ward, *'I think here we're relatively blessed because the staff do attempt to engage in a therapeutic alliance' (7)*. Good relationships between staff and patients and time spent together helped patients to feel that they could talk to their nurses and express concerns, *'so try to glean from them what it might be that can help settle them and if it's at all possible or practicable to introduce that' (10)*. This communication included discussion of ward rules and the patient's rights. While participants often discussed specific issues they believed affected absconding, such as patients inappropriately (in their view) admitted to open wards, they were unable to offer suggestions on how to improve this situation:

> I felt more frustrated about it than actually thought of any solutions. My answer is probably I don't know what could be done, that's a truthful answer. (2)

Nurses' responses to absconding

In addition to the role of risk assessment and containment strategies to prevent absconding, nurses also discussed their feelings when a patient absconds. For patients that were perceived to be at high risk due to their illness, nurses' affective responses included anxiety, guilt, distress, concern, sickness and dread. Feelings of self-blame and concerns about blame from others after a patient absconded were most common for high-risk patients:

> We sort of always felt that we were the ones to blame because "they're your client, why weren't you keeping a close eye on them?" (1)

Eight participants reported concern that they would receive some form of repercussion as a result of a patient absconding, whether from the patient's family or friends, or from the organisation. Two nurses specifically mentioned the possibility of having to attend Coroner's Court as a major concern, resulting in them at times doubting the competence of their clinical practice. This then leads to further feelings of worry, anxiety, concern, and dwindling optimism and diminishing confidence:

> I think, as every psych nurse would've had, I've had lots of experience with absconders and the whole protocol related to it and the worry that eats away at you and you think "... have I done everything?" (2).

Another major concern was the potential for negative attitudes of the police. Examples of their interactions with police include: *'oh we've done this all before, why are we doing it again' (1)* and *'here's one of yours and look after them better next time' (1).*

A majority of nurses interviewed also expressed dissatisfaction in decision-

making processes by managers. This included the availability of adequately skilled nurses to manage at-risk patients, formal debriefing, and lack of involvement by the organisation in terms of support available when a patient absconds. Seven nurses in the study reported there was no adequate support available to them following an abscond event. Instead they believed that the organisation would be more concerned with blaming than support:

> I suppose organisational wise they would try to point the finger at the nurse … they will try to say this nurse failed in her care delivery or her assessment or in her judgment, so it's quite punitive. A lot of absconding reflects badly on the nurse. (11)

However, some participants felt that staff counselling may not be a big issue, because the management of risk and its associated adverse outcomes were considered part of the nurses' role:

> I don't think there is any counselling services or anything like that; I don't know that that's necessary because I think the skill level of the staff in the unit is pretty high in terms of them being able to cope with that. (3)

Interestingly, however, for patients who were known to habitually abscond or were considered to be a low risk by the nurse**,** the concern and worry appears reduced and other emotions such as frustration, anger, and annoyance are experienced. This divergence in emotions was attributed to the belief that the patient would not come to harm while absent from the ward:

> If the patient absconds and I don't think they're at risk then I find it more of an inconvenience and an annoyance actually. (2)

These feelings were augmented if it was discovered that the patient absconded to obtain illicit substances or rebel against their treatment plan. For example, one nurse suggested nursing time and resources have been '*wasted on this person who actually was just trying to get some booze [alcohol]' (11).*

DISCUSSION

In this paper we have explored nurses' risk assessment, risk management and affective responses relating to absconding from inpatient psychiatric care. The paper offers new information by describing *how* mental health nurses assessed and managed risk in relation to absconding, an area that has not previously been explored in the literature. Nurses reported that they relied on clinical judgement, focusing on patient history and clinical presentation, to assess a patient's risk of absconding. There was no evidence that staff drew on relevant research evidence around reasons patients abscond and how this may be attenuated (Bowers, Simpson, Alexander *et al* 2005). Literature on risk assessment has reported that a reliance on clinical judgement alone is ineffective (Woods 2012). The nurses themselves recognised that current methods of risk assessment were inadequate, highlighting the need for structured tools to be used in combination with clinical judgement (Woods 2012). Further, nurses seemed unaware of the need for ongoing structured risk assessment of absconding, with one nurse saying 'every case is different', when it is known that absconding reducing interventions have proven to be effective (Bowers, Alexander & Gaskell 2003).

The nurses also reported a reliance on containment strategies for managing

absconding risk, despite confusion as to the appropriateness and effectiveness of these strategies. This was complicated by an awareness of ongoing debate in research and policy literature regarding their use, particularly the view that some forms of containment are perceived by both patients and staff as controlling, punitive and at times excessive (Meehan *et al.* 2004, Bowers 2006). However, some findings suggest that the practice of containment is "one of the few options open to staff to manage violent or aggressive patients" (Happell & Harrow 2010, p.166), which is reflective of participants' views of containment as their only option for managing absconding risk, even though few patients that abscond are violent (Bowers, Simpson & Alexander 2003).

The most effective containment practice identified by the nurses was locking ward doors. For this reason, some nurses believed that ward doors should be permanently locked. While nurses acknowledged that patients could feel 'trapped', they believed that this outweighed the risk of patients absconding given the lack of alternatives. Recent research by Muir-Cochrane *et al* (2011) found that of the three acute and seven rehabilitation wards studied, the greatest number of absconding events occurred from a locked acute ward. Bowers *et al* (2009) also report a strong association between locked doors and increased violence and aggression on wards and suggest that introducing effective structure and order on the ward, alongside other quality improvements, may be more effective interventions (Bowers 2009).

The locking of wards also directly contrasts with the recovery model and could be argued illegal detention of the voluntary patients on the ward (Bowers et al. 2002). Additionally, it was perceived that locking ward doors results in a higher degree of aggression on the ward and incites patients to use more dangerous methods of absconding, which supports findings from previous studies (Ashmore 2008; Muir-

Cochrane & Mosel 2008). While participants were aware of these issues, and that this practice was against their workplace policy, they stated it was difficult to negotiate the balance between moral and safety issues when locking ward doors if a patient is perceived to be at risk of absconding.

Findings in this study showed that there is a profound impact on mental health nurses when patients abscond from inpatient settings, which is not limited to their professional lives but also impacts on them personally. The negative impact was attributed to nurses' awareness of the potential negative outcomes of absconding echoed in the literature (Bowers *et al.* 1998, Bowers, Brennan *et al.* 2006, Muir-Cochrane & Mosel 2008). Previous work on nurses' feelings and emotions when patients abscond is limited, with the most common affective reactions identified being feelings of fear, anger, guilt, and concern (Clark *et al.* 1999, Raven & Rix 1999, Muir-Cochrane & Mosel 2008). This study offers new insight into nurses' affective responses to absconding with the finding of a link between the nurses' responses to absconding and their judgment of the patient's risk. While 'low risk' patients elicited anger and frustration when they absconded, the fear of ramifications from management such as blame and the possibility of having to attend Coroners' Court were common responses to absconding by 'high risk' patients.

Other studies also demonstrate nurses' feelings of blame and fear of being suspended or losing their jobs when patients abscond (Clark *et al.* 1999) but there does not appear to be any evidence to support this. Furthermore, nurses are reported to draw on risk management strategies such as locking doors as a method of protecting themselves from criticism and blame, reflecting a risk avoidance approach where nurses practice "*defensively* rather than *defensibly*" (Buchanan-Barker & Barker 2005, p. 544, italics in original). This may explain the nurses' preferences for

door locking despite recognising the negative consequences and lack of policy support for this practice.

Despite the acknowledged importance in mental health of nurse and patient interactions characterised by empathy, understanding, trust and rapport (Cleary 2003, Peplau 1991, Reynolds 2000), participants focused discussion on assessing indicators for absconding rather than the methods they used to ascertain this information (e.g. engaging with a patient). However, when asked specifically what they believed would reduce absconding on the ward, therapeutic relationships were discussed. The aims of the study to examine risk assessment and management might have led to such a focus by participants. Responses may also be indicative of a wider preoccupation with risk in mental health care, with an emphasis on risk aversion and risk avoidance (Cutcliffe, 2013). This has implications for a recovery focus in acute care, where nurses may find it difficult to implement principles of recovery, such as patient ownership and the potential for change and growth, when the patient is involuntarily hospitalised as a result of risk they are seen to pose to themselves or others (Barker & Buchanan-Barker 2005b, Davidson et al., 2006). More specific to absconding, a focus on a good partnership with patients remains important, as it is likely to lead to nurses detecting markers of absconding such as patient perceptions of safety, fear, distressing symptoms, boredom, and concerns relating to home responsibilities (Gilburt *et al.* 2008, Meehan *et al.* 1999, Muir-Cochrane *et al.* 2013). This then allows the nurse to implement strategies to ameliorate some of these risks through being available, ensuring patients feel listened to and that their concerns are addressed (Muir-Cochrane *et al.* 2013).

CONCLUSION

This is a qualitative, exploratory study involving a small number of participants and as such is limited in terms of generalisability. However, it does offer new insight into mental health nurses' experiences with absconding, and in particular their assessment of absconding risk using clinical judgement and controversial management strategies. Nurses often needed to balance the risks identified with patient rights in their management of the potential for absconding. When patients absconded the feelings and emotions of nurses varied depending on the perception of the acuity of this risk. Further research exploring the extent to which these findings are applicable in other settings is needed.

RELEVANCE TO CLINICAL PRACTICE

Findings from this study indicate the central role of mental health nurses in the assessment and management of absconding risk in acute mental health care. Employers and mental health nurses need to be aware of the fallibility of individual perceptions of risk and the need to use a combination of clinical judgement, research evidence and standardised instruments. Nursing care is also impeded by the apparent failure to use effective, evidence-based alternatives to containment practices currently used to address absconding risk (Bowers, Simpson *et al* 2005). These are serious issues given nurses' fears of repercussions resulting from absconding events. Consequently, a formal process of support and debriefing suitable to staff needs should be available to support nurses when absconding events occur.

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