Critical Incidents During Leave From an Australian Security Hospital – A 12 Year Audit

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All critical incidents between 2003 and 2015 relating to leave episodes from the High Security Inpatient Services, Brisbane, Australia were audited. The audit found that since March 2003, when the High Security Inpatient Service opened, there was a very small number of critical incidents related to over 46,000 leave episodes. Of the 17 patients who went absent without permission over the 12-year study period, only 2 patients re-offended and 1 patient deliberately self-harmed during a leave episode. One patient assaulted his escort nurse during a leave and four patients attempted unsuccessfully to flee their escort nurses during escorted off-ground leave. No patient committed a serious violent offence and no patient committed suicide during an absence from leave. Only 4 of the 17 patients who went absent during leave between 2003 and 2015 remain as inpatients in the High Security Inpatient Service.

Key words: Authorised leave; critical incidents; security hospital.

The term “critical incident” refers to any substantial event that disrupts the everyday living for an individual and which requires the expertise of others to intervene in its management.¹ Critical incidents during leave from a mental health unit can be narrowly defined to include serious breaches of the conditions of the leave (including attempting to flee escort nurses or assaulting an escort nurse), failure to return from leave by the designated time (absence without permission or “AWOP”), criminal offending, harming others or self-harming.

A large prospective multi-centre study of over 5000 admissions to acute psychiatric inpatient units in New South Wales, Australia, found an absconding rate of 15.7% over the 12-month study period.² In contrast

to general psychiatric inpatient units, forensic mental health services have developed more sophisticated levels of security and the trinitarian model of relational, procedural and physical security has evolved.³ All of the critical incidents defined in the present study constituted breaches of both procedural and relational security.

Critical incidents can have a variety of adverse effects. A three-year retrospective analysis of 184 AWOP incidents involving 88 patients from a United Kingdom psychiatric hospital found at least 16% of incidents had serious adverse outcomes.⁴

A critical incident may be associated with a patient using substances, becoming unwell, harming him or herself, harming others or

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offending in some way. As part of the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness in the United Kingdom, a national clinical survey found that 25% of all inpatient suicides occurred after the patient had absconded from the ward.⁵ Australian studies have found that over a 21-year follow-up, 36 patients who had committed suicide did so after absconding⁶ and in a 10-year follow-up of patients admitted for self-poisoning, 4 of the 24 who had absconded during an admission subsequently died within two years.⁷

Following a critical incident, the patient's mental state may deteriorate and engagement with his or her treating team may be prejudiced. The patient's recovery trajectory may be adversely affected and their inpatient treatment may be truncated.⁸ Critical incidents disrupt the therapeutic milieu of the inpatient unit,⁹ embarrass the mental health service, wastefully divert time and resources (including police resources¹⁰) and may traumatise¹¹ or generally demoralise mental health staff¹² and the patient's support persons. Patients with mental illness continue to be stigmatised¹³ and critical incidents can further demonise patients who have committed offences in the context of mental illness.¹⁴

Sensationalised reporting of critical incidents damages hospital-community relations and can impugn the reputation of the health service and the treating team. Critical incidents can also have more systemic ramifications when, particularly in response to lurid media coverage and ill-informed criticism,¹⁵ even more restrictive policies and procedures are imposed which add to bureaucratic administrative burdens and disadvantage all patients of the mental health service, including those who have availed productively of uneventful leave.¹⁶

Forensic Orders in Queensland, Australia

In the Australian state of Queensland, patients with mental illness who are found to have been of "unsound mind" when they

committed serious offences are made subject to Forensic Orders under the Mental Health Act 2000 (Qld)¹⁷ and may be ordered to continue to have inpatient treatment at a mental health facility.

The Mental Health Review Tribunal (MHRT), an independent statutory administrative tribunal, may authorise patients who are subject to Forensic Orders to have leave from a mental health facility. At MHRT hearings, the representative of the Attorney-General (who has a right of appearance at the MHRT hearings for patients who have been acquitted of the most serious violent offences) regularly opposes the approval of leave and the Attorney-General also regularly appeals decisions of the MHRT in which Forensic Order patients are granted leave.¹⁸

Pursuant to s203(4) of the Mental Health Act 2000 (Qld), in deciding whether to authorise a patient to have leave, the MHRT must have regard to the patient's mental state and psychiatric history, the offences leading to the patient becoming subject to a Forensic Order, the patient's social circumstances and the patient's response to treatment and willingness to continue treatment. By s204 of the Mental Health Act 2000 (Qld), the MHRT must not approve limited community treatment unless the MHRT is satisfied that the patient does not represent an "unacceptable risk" to the safety of the patient or others, having regard to the patient's mental illness.¹⁹ The legal term "unacceptable risk" has not been defined and, in the context of the forensic provisions of the Mental Health Act 2000 (Qld), the term has not been judicially considered.

Risk Assessment, Judgement and Management

"Risk" can be defined as the probability of an unwanted event that results in negative consequences (loss or injury).²⁰ In forensic clinical practice, "risk" is the product of two variables – outcome (including seriousness of adverse outcome) and likelihood. Whether an adverse outcome occurs will be influenced by many

factors, most particularly, how an estimated (or theoretical) risk is subsequently managed. It should be acknowledged that all good clinical practice entails taking some calculated risk and that “careful” or apparently “risk averse” management strategies which purport to reduce risk may, in fact, be counterproductive, counter-therapeutic or actually increase risk in another way.²¹ For instance, conservatively denying a patient the opportunity for some limited leave may be experienced as harmful, arbitrary or punitive by the patient and may be detrimental to the therapeutic alliance and the patient’s engagement with his treating team.

Making informed, defensible decisions about risk involves three steps – risk assessment, risk management and risk judgement. In the context of making decisions about the management of patients, risk assessment involves collecting information about the patient (including historical factors and dynamic or changeable factors) as well as information about the proposed plan of action and procedural and physical factors before making a prediction of the likelihood of a particular adverse outcome.²² After first considering possible adverse outcomes in the context of the proposed plan of action, risk management involves scenario (contingency) planning to devise a structure of controls and safeguards which address theoretical or possible risks and reduce the likelihood that a potential adverse outcome will occur.

Risk judgement involves making a decision that takes account of the risk assessment in the context of an informed risk management plan.²³ An example of a risk judgement may be the decision of a patient’s treating team that it is appropriate and prudent that a patient access a particular leave, subject to certain conditions having regard to the patient’s mental state, risk assessment and other factors.

Leave from High Security Hospitals

High security forensic inpatient services provide specialist care and treatment for patients

with mental illness who pose a significant risk to society or to themselves.²⁴ A study of high-security patients considered “ready” to be discharged generated seven themes that represented valued elements of their admission to the high security hospital: temporary suspension of responsibility, collaboration in care, learning from others, supportive alliances, specific interventions, a safe environment and opportunities for work.²⁵ A study to assess the needs of all of the patients in three high secure psychiatric hospitals in England systematically found that amongst patients who required long-term security, there was a group with “complex needs” in the areas of mental health, social functioning and offending.²⁶ However, there is no provision in any mental health legislation for preventive detention of persons who have offended in the context of mental illness. Rather, diversion into treatment, including detention in a security hospital, should offer an opportunity for specialised multi-disciplinary teams to address the complex and challenging needs of forensic patients.²⁷

The criteria for admission to a security hospital are the same criteria which predict increased theoretical risk of critical incidents and increased theoretical risk of future harm to the community. However, cautious, graduated leave from the hospital as a prelude to transition into the community is integral to the recovery, rehabilitation and discharge planning for all but the most problematic forensic patients. No forensic patient would be considered for transition into the community without having first negotiated stages of leave which are facilitated at the discretion of the patient’s treating team. As well as ameliorating boredom and frustration and mitigating therapeutic nihilism and institutionalisation, careful graduated leave enhances the therapeutic alliance and positively re-enforces a patient’s engagement with his or her treating team. Graduated leave offers an opportunity for better understanding, in a controlled way, of each patient’s individual risks.

Day leave with staff escorts provides an important opportunity to enhance the

relational security and engagement. A graduated leave programme which is linked to structured rehabilitation can also be used as a marker of the patient's recovery and progress.²⁸ Day leave into the community enhances the patient's social, planning and other life skills and enables a patient to avail of opportunities to spend time with their partners and family, participate in community rehabilitation activities, engage in drug and alcohol abstinence counselling, relapse prevention planning and other psychological interventions and also pursue adult education or pre-vocational training. Overnight leave, usually to supported accommodation or the home of a friend or relative, further facilitates a patient's transition into the community.

Repeat Absconding

A recent review of the international literature on absconding identified 75 empirical published studies, of which 31 were conducted in acute mental health units and 11 in forensic units.²⁹ The lack of standardised measures made it impossible to compare findings across studies, and contrasting individual studies was problematic because of the differences in the configuration of services and because characteristics of patients were not controlled for. A common finding was that a small sub-group of patients repeatedly absconded. The most recently published study from three acute adult inpatient units of an Australian metropolitan hospital found that 25% of absconding patients had done so multiple times.³⁰ An earlier study reported that the majority of absconding occurred after patients had actually been given permission to leave the ward unaccompanied.³¹

The majority of studies are descriptive and very few use multivariate techniques to analyse factors associated with absconding. Reliance upon officially recorded data means that whilst rates of absconding are generally susceptible to under-reporting, there is likely to be over-inclusion of involuntary patients

whose unauthorised absences would be more likely to generate concern.

Why Patients Abscond

There is limited research into risk factors for absconding^{32–34} and only a few studies have considered absconding behaviour from the patient's perspective. An early study of interviews with 76 consecutive absconders from an acute general mental health unit found that patients were concerned with the stigma of being in a psychiatric hospital and disliked both the staff and food provided.³⁵ However, almost one-quarter left hospital because of abnormal beliefs, including fears of being harmed while in hospital and in response to command hallucinations.

A survey of 98 patients over a nine-month period who absconded from a large psychiatric hospital in the West Midlands of the United Kingdom reported on patient-identified reasons for absconding and found variables of treatment failure such as poor doctor/patient alliance, issues with medication and active symptomatology were by far the commonest causes, as well as family problems or a lack of family involvement.³⁶ Other research into the experiences of patients in acute psychiatric units has found that fear and safety concerns (feeling threatened, harassed or having property stolen as well as patients perpetrating actual violence) were commonly reported.³⁷

A prospective analysis of 77 consecutive absconding incidents by 51 patients in an acute psychiatric unit in a large public general hospital in Australia included interviews designed to understand absconding behaviour.³⁸ Six issues emerged from the analysis: boredom, lack of interesting activities, disturbed ward environment, perceptions of the need for hospitalisation, concerns about issues at home, and the perceived rewards from absconding. Most of the patients found their stay in hospital tedious, particularly on the weekends when fewer structured activities were available. Most patients felt that the

available group activities were not helpful and in many cases contributed to their decision to leave hospital. The study also found that while situational and environmental factors were prominent in increasing the risk of absconding and that there were serious consequences for some of the relatively small number of patients who absconded, the vast majority of the absconding incidents were of little consequence.

A study conducted at the largest provider of forensic mental health inpatient services in Ontario, Canada, found 57 patients responsible for 102 AWOPs over two years.³⁹ Although patients who absconded were more likely to have a history of absconding attempts and a substance use disorder, as well as higher scores on a structured professional violence risk assessment measure, only one of the AWOPs included an incident of minor violence and very few included other illegal behaviour. The study found that the majority of AWOPs were characterised by feelings of boredom and frustration. The study found that the forensic system generates particularly strong motivations related to feelings of frustration and despair. The authors suggested that larger systemic and environmental issues could be examined to create a consistent, transparent and respectful milieu which could contribute to a sense of legitimacy that the patient might usefully attribute to their detention.

Prediction of Absconding

Most of the research into risk assessment for absconding appears in the mental health nursing literature. Although nurses regularly make informal assessments,⁴⁰ formal assessment of the risk of absconding is often not done in clinical practice.⁴¹ No research has generated a reliable “absconder profile” or risk assessment tool for absconding.⁴² Even the period that a patient has been an inpatient does not necessarily predict absconding risk. The longer a patient is known to mental health staff and has not absconded, the less likely staff may anticipate (and therefore manage the

risk) that the patient may abscond. In the dichotomy between “opportunity-takers” and “opportunity-makers”, the risk of absconding may actually increase with each leave episode as the patient is presented with an opportunity to abscond or, over a series of leaves, the patient gradually develops a plan to abscond and gathers observations and intelligence to enable their plan.⁴³

One survey of clinicians found that “stable dynamic factors” such as current symptoms of mental illness were most important in deciding whether to progress a patient’s leave.⁴⁴ An earlier study found similar factors to be important in understanding how clinicians perceive a forensic patient’s risk of violence.⁴⁵

A prospective review of 60 unauthorised absences which occurred during more than 70,000 leave episodes from a medium secure unit in the west of England found that unauthorised absences occur for many different reasons including poor clinical decision-making, a deterioration in the patient’s mental state or external factors.⁴⁶ The study concluded that risk management requires careful consideration of all dimensions of clinical skill, including diagnostic precision and mental state assessments, and consideration of dynamic factors on the ward and dynamic issues between staff and patients. However, even the most informed and careful risk assessment for absconding is probabilistic and an infrequent critical incident does not necessarily denote a failed or incompetent risk management plan. A very low or zero rate of critical incidents, particularly in the context of arbitrary restrictions on access to leave, is likely to denote inappropriate detention of patients whose further rehabilitation no longer requires the highest level of environmental and procedural security.⁴⁷

Risk of Harm to the Community from Absconders

The risk to the community from violence and offending by patients who have either

escaped or absconded from leave from forensic psychiatric hospitals is very low.⁴⁸ A useful comparison can be made by considering a prospective national cohort study of the rate of offending for 959 patients discharged from medium secure units in England and Wales which found a 15% re-conviction rate within two years⁴⁹ (compared to 61% for persons released from prison during a comparable period⁵⁰). In the national cohort study, only 6% of discharged patients committed violent offences.

Whilst a study of 195 Dutch forensic psychiatric patients reported that 6% of the patients who went on leave during the study period committed an offence while on leave, and at least 64% of these offenses resulted in extremely serious repercussions for the victims,²² a descriptive analysis of incidents of unauthorised absences from the three English high security hospitals emphasised both the very low rate of absconding from thousands of rehabilitation outings over a five-year period and the minimal risk to the public created by these incidents.⁵¹ These findings were similar to those described in previous studies.^{52–54}

Method

Setting

Prior to de-institutionalisation, Wolston Park Hospital in the outer suburb of Wacol in Brisbane was one of the largest mental health campuses in Australia. In 2001, Wolston Park Hospital was renamed The Park – Centre for Mental Health, Treatment and Research. The grounds of The Park are enclosed by the Brisbane River adjoined by two golf courses. The hospital grounds feature a kiosk with an outdoor dining area as well as a large activities pavilion, a patients' visiting area and a second-hand shop.

From 14 March 2003, all forensic patients at The Park – Centre for Mental Health, Treatment and Research were transferred to a new purpose-built security hospital called

High Security Inpatient Services (HSIS). HSIS currently consists of a 9-bed High Dependency Unit (opened in 2012), an acute 14-bed all-male unit, a 14-bed mixed (male and female) unit, a sub-acute 18-bed all-male unit and a mixed pre-discharge unit which, in June 2007, was enlarged from 10 beds to 15 beds. The 70-bed HSIS campus is enclosed by a high-security perimeter fence and motion detectors with a single air-locked entrance monitored by security staff and closed-circuit television cameras.

Materials, Definitions

Critical incidents during leave from HSIS were defined in the audit to include:

- serious breach of conditions of the leave (including attempting to flee staff escorts, assaulting a staff escort, using alcohol or substances);
- failure to return by the designated time from an unescorted day or overnight leave;
- offending; and
- self-harming or suicide.

Minor incidents, including attempting to bring in contraband (electronic devices, pornography, substances) and smoking in a “non-smoking” area, were not included as critical incidents.

Failure to return by the designated time or an AWOP was further defined as the breaching of the conditions of a regulated authorised leave by the patient's failure to return by the time designated and which generated a formal revocation of the leave and notification to the police and an authority to return.

A “technical AWOP” was defined as an incident in which the patient contacted the HSIS treating team to advise that he or she was delayed (vehicle breakdown, missed public transport connection) and in which the patient returned to the service after the designated time but of his or her own volition and without the involvement of police.

The study consisted of a retrospective descriptive audit of all critical incidents relating to patient leave episodes over 12 years which were cross-referenced with entries in the patients' medical records.

Before the study commenced, Ethics Committee approval was obtained and a Public Health Application was made to access patient records without the patients' consent. Patient details were de-identified during the study.

Results

Absences Without Permission from Day Leave

AWOPs were subdivided depending on the stage of leave from which the patient went absent. "Ground leave" was defined as leave authorised outside the secure perimeter fence of HSIS but within the non-secure grounds of the larger hospital campus. "Off-ground leave" was defined as leave authorised off the grounds of the hospital campus in the community.

There were a total of 27 AWOPs by 14 patients from day leave over the 12-year study period. From escorted or unescorted ground leave, there were 16 AWOPs by 11 patients. There were two AWOPs from escorted off-ground leave by one patient and nine AWOPs from unescorted off-ground leave by four patients. Six patients had more than one AWOP from day leave. All but one patient who went AWOP during day leave was returned to HSIS. The duration of the AWOPs ranged between one hour and seven days.

Absences from Ground Leave

From escorted ground leave, there was one AWOP by one patient. There were no AWOPs from escorted ground leave between February 2005 and 2015. From unescorted ground leave, there were 15 AWOPs by 10 patients. One patient had four AWOPs from unescorted ground leave. Two patients had two AWOPs from unescorted ground leave.

Of the 10 patients who had AWOPs from unescorted ground leave, 5 patients

subsequently had further uneventful leaves and were discharged from HSIS. Two patients died. Only three patients who had AWOPs from unescorted ground remained inpatients in HSIS at the end of the study period. Two of these three patients as of 2015 currently access unescorted ground and off-ground leave.

Absences from Off-ground Leave

From escorted off-ground leave, there were two AWOPs by one patient. From unescorted off-ground leave, there were 9 AWOPs by four patients. One patient had four AWOPs from unescorted off-ground leave, all of which were "technical AWOPs." Another patient had three AWOPs from unescorted off-ground leave. There were no AWOPs from unescorted off-ground leave between April 2007 and early 2015.

Three of the four patients who absconded from unescorted off-ground leave had been discharged from HSIS before the end of the study period. None of the three patients was re-admitted to HSIS by early 2015.

Temporary Absences – Off-ground Leave

From escorted temporary absences to attend court, medical appointments or investigations, there was no AWOP.

Absences Without Permission During Overnight Leave

From overnight leave in the community, there were a total of 10 AWOPs by four patients. Two patients had eight AWOPs between them, one patient had a total of five AWOPs and another patient had three AWOPs. Eight of the AWOPs were "technical AWOPs." All four patients who had AWOPs from overnight leave were subsequently discharged from HSIS. None were re-admitted to HSIS. There were no AWOPs from overnight leave after April 2007.

All patients who went AWOP during overnight leave were returned to HSIS. The

duration of the AWOPs ranged between one and four days. Most patients declined to provide a urine sample for analysis on their return from an AWOP. One person was found to be intoxicated with alcohol on his return from an AWOP.

Critical Incidents

There were seven non-AWOP critical incidents. All the patients who had critical incidents had a history of a psychotic illness and all were subject to Forensic Orders having been acquitted of serious violent offences including murder, attempted murder or assault occasioning bodily harm. All critical incidents occurred during off-ground or overnight leave. There were no non-AWOP critical incidents from ground leave.

One patient assaulted his escort during a leave and three patients attempted unsuccessfully to flee their escorts during a leave. One patient assaulted a fellow resident at a supported accommodation during an overnight leave. One patient returned from leave intoxicated and one patient attempted to bring a concealed knife into the HSIS on returning from overnight leave.

Police Involvement

Police were involved in the return of 14 patients following an AWOP. All of the

police-assisted returns were uneventful. All other returns from AWOPs were facilitated either by HSIS staff or through family or support persons.

Police were also involved in five of the seven non-AWOP critical incidents. In none of the critical incidents were police assaulted and no patient was charged with “obstructing police”, “failure to comply with lawful direction” or any similar offence.

Incidence of Absconding Relative to Total Leave Episodes

The retrospective audit found that each week in the HSIS there were at least:

- 10 escorted ground leave episodes
- 14 escorted off-ground leave episodes (including 3 escorted temporary leave of absences to attend court, medical appointments or investigations)
- 31 unescorted on-ground leave episodes
- 19 unescorted off-ground leave episodes

If it is assumed that these conservative average numbers of day leave episodes per week have been relatively constant over the 12-year study period, the total number of day leave episodes over the 624 weeks can be used to calculate an incidence of AWOPs relative to total day leave episodes (see [Table](#)).

Table

Type of Leave	Average number of Episodes of Day Leave per week (rounded)	Estimated Total Number of Episodes of Day Leave 3 March 2003 – 13 March 2015 (624 weeks)	Actual Number of AWOPs from Day Leave	Incidence of AWOPs as a proportion of Total Episodes of Day Leave
Escorted on-ground	10	6240	1	1 in 6240
Escorted off-ground	11	6864	2	1 in 3432
Temporary Absences off-ground	3	1872	none	zero incidence
<i>Total escorted off-ground</i>	14	8736	2	1 in 4368
Unescorted on-ground	31	19,344	15	1 in 1289
Unescorted off-ground	19	11,856	9	1 in 1317
<i>Total unescorted</i>	50	31,200	24	1 in 1300
TOTAL	74	46,185	27	1 in 1710

A history of absconding or attempting to abscond has been shown to be the strongest predictor of future absconding. In the present study, of the 17 patients who had AWOPs, 5 had repeated AWOPs from day leave and 2 had repeated AWOPs from overnight leave.

The most salient finding of the study was that during the 37 AWOPs from day and overnight leave, only two patients re-offended during the AWOP. One patient was charged with robbery offences relating to two incidents on the same day. The patient was not armed and was arrested later on the same day. Another patient was charged with a public nuisance offence and was immediately bailed into the community. None of the incidents of re-offending attracted any media attention. No patient was reported to have harmed anybody in the community during an AWOP.

One patient deliberately self-harmed during an AWOP. During an unescorted ground leave, the patient left the hospital grounds, consumed alcohol and self-harmed before self-presenting to another hospital for treatment.

Although police were involved in 14 returns to the HSIS, only 6 AWOPs attracted any media attention over the past 12 years. All of the police-assisted returns were uneventful. All patients co-operated with the police who facilitated their return to HSIS after the AWOP.

Limitations

The retrospective design was the major limitation of the present naturalistic study, which precluded gathering more detailed information which might be usefully obtained from debriefing patients involved in critical incidents, nursing staff, leave escorts or the treating psychiatrist who approved the leave. Examination of each critical incident in the present study relied upon the critical incident report, medical record documentation of the incident and any legal documentation.

In retrospective studies of higher prevalence events which may also have more

variable definitions (like inpatient violence⁵⁵), there is a greater likelihood that significant missed data, selection bias and other methodological problems will occur. However, because of the specificity of the critical incidents analysed in the present study and the imperative of contemporaneous documentation, it is unlikely that there were any significant missed data or selection bias.

It might be postulated that AWOPs in the earlier stages of graduated leave would pose the greater risk in principle to the community. However, the retrospective design of the present study precluded any statistical discrimination or any conclusions about each patient's motivation for the AWOP. Since AWOPs have been found to be largely context-dependent⁵⁶ and because of the very small numbers, no generalisation or sophisticated typology can be derived from this cohort.

Whilst it might be speculated that over the 12 years of the study, changes in policy and more restrictive procedures were confounding factors, the incidence of actual incidents was small and the numbers and turnover of inpatients and episodes of leaves from HSIS probably increased over the study period.

The audit demonstrated that over the past 12 years, record-keeping improved considerably with improved documentation of details of the risk assessment, crisis intervention plan and decision-making prior to leave episodes and root cause analyses following critical incidents.

Further procedural improvements might include introduction of a standard de-briefing protocol for patients who have been returned from a leave in which there has been a critical incident as well as for nursing staff or any others involved in the leave episode. Better prospective analysis of factors associated with a critical incident may further inform risk management of patients who are negotiating graduated leave, particularly those patients who have a past history of unauthorised absences or other critical incidents. Studies of interventions in high security forensic hospitals have a potentially high risk of bias

from validity threats.²⁴ Improved prospective analysis of critical incidents may also enable benchmarking of performance indicators to improve management decision-making and quality assurance in forensic mental health.⁵⁷

Discussion

The retrospective audit of authorised leave over the 12-year operation of the HSIS in Brisbane, Australia has demonstrated a very small incidence of critical incidents. It is not surprising that no serious self-harm occurred during AWOPs from HSIS. General adult mental health units are more likely to involuntarily detain patients at higher risk of deliberate self-harm than a security hospital for forensic order patients. However, given that all patients admitted to a security hospital have a history of serious violence, the finding of only two critical incidents of violence during a leave episode and no violent re-offending during an AWOP is significant. Most of the few AWOPs were relatively brief and none involved violence in which anyone in the community was harmed.

Patient selection and risk management has been shown to have been effective in minimising the risk to patients, escort staff and the community as a direct result of critical incidents during leave. The findings of the present study may help disabuse the public of false beliefs and allay concerns about critical incidents involving patients on leave from a security hospital. Given the findings of this 12-year study, the further overlay of “review committees” and “leave panels” (which are usually constituted by persons remote from clinical decision-making) and the imposition of even more restrictive policies or procedures in relation to leave seem unwarranted and are likely to be counter-therapeutic.

Absconding and Locked Mental Health Units

There is currently a debate in Australia and elsewhere over the relative costs and benefits

of locking mental health units.^{58,59} In December 2013, after the Queensland government announced that as a result of concerns about the number of patients absconding, all adult mental health hospital inpatient facilities in the state would be locked, the Royal Australian and New Zealand College of Psychiatrists referred to the fundamental tenet of “least restrictive practice” and condemned the decision as “a step back into history.”⁶⁰

Locked mental health wards contribute to the public perception that mentally ill patients are dangerous.⁶¹ A survey of patient, staff and visitor perceptions found that whilst there was general agreement that locking doors appeared to reduce absconding, staff expressed feelings of guilt, embarrassment and fear of being blamed when a patient absconded.⁶² Staff also reported that open wards created anxious vigilance to prevent absconding and increased the workload in allocating staff to watch the door, whereas staff on partially-locked doors also perceived an increased workload in letting people in and out of the ward. Patients had mixed feelings about the status of the door and expressed depression, a sense of stigma and low self-esteem when the door was locked.

Whilst the research which appears to show higher rates of absconding from open wards compared to locked wards suggests that increased environment and procedural security will reduce the risk of patients harming themselves and others,⁶³ other research has also found that depression⁶⁴ and increased self-harming⁶⁵ were associated with the locking of ward doors. A study of nurses’ accounts suggested that by intensifying certain negative ideation experienced by patients (including feeling confined, trapped and isolated from family and friends), locking ward doors may actually contribute to absconding attempts.⁶⁶

A 2006 Cochrane review has found no evidence from randomised controlled trials of any beneficial effects of non-pharmacological approaches (including locked wards) to contain disturbed or violent behaviour.⁶⁷

A study from an acute psychiatric ward in Berlin which was primarily closed for six months and primarily open for another six months found that absconding, aggressive incidents and coercive medications were observed significantly more often in the closed door period.⁶⁸ The study concluded that open doors reduce patients' discomfort, improve the ward atmosphere and do not appear to increase the risk of absconding. An earlier study consisting of semi-structured interviews of 20 patients voluntarily admitted to locked psychiatric wards found most advantages were categorised as "protects patients and staff against 'the outside'", "provides patients with a secure and efficient care" and "provides staff with a sense of control over the patients."⁶⁴ Most disadvantages were categorised as "makes patients feel confined", "makes patients feel dependent on the staff" and "makes patients feel worse emotionally." A literature review of 11 empirical papers found that whilst staff and patients reported both advantages (eg preventing ingress of illegal substances, preventing patients from absconding and harming themselves or others) and disadvantages (eg making patients feel depressed, confined and creating extra work for staff), locked wards were associated with increased patient aggression and poorer satisfaction with treatment.⁶⁹

A retrospective descriptive study aimed to identify the rate of absconding from a major Australian psychiatric institution over 12 months. The study found that although there tended to be an over-representation of absconding patients from locked wards, the difference was not significant, which suggested that locking the ward door will not necessarily serve as a deterrent for the patient who wishes to leave.⁷⁰

A large cross-sectional interview survey of 136 acute psychiatric wards in the United Kingdom considered a range of data on patients, staff and conflict and containment events, including door locking and absconding, over a six-month study period.⁷¹ The study found that, when measured on a shift-to-shift basis, 30% of the participating wards

operated with their doors permanently locked and that univariate analyses suggested little association between door locking practices and other exit security measures on the one hand, and absconding on the other.

A nursing intervention designed to reduce absconding has been shown to be effective without the use of door locking.⁷² The "anti-absconding package" contained several measures including identifying patients at high risk of absconding (using an algorithm based on previous research), facilitating social contact for those considered at high risk of absconding (via phone contact, encouraging visits or using all available resources to enable supervised leave), targeting nursing time daily for high absconding risk patients, sensitive and supportive breaking of bad news to patients and post-ward incident debriefing of patients.

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