



FACTORS ASSOCIATED WITH ABSCONDING BEHAVIOURS AMIDST INPATIENTS OF A REGIONAL PSYCHIATRIC HOSPITAL IN NIGERIA

***¹Raji S.O, ²Ikeji O.C, ²Omoaregba J.O**

¹Psychiatry Unit, Sarkin Maska Shehu Hospital (SMASH)) Funtua, Katsina State.

²Department of Clinical Services, Federal Neuro-Psychiatric Hospital (FNPH), Uselu, Benin-city, Edo State, Nigeria.

***Corresponding Author:** Dr. Raji S.O. Psychiatry Unit, Sarkin Maska Shehu Hospital (SMASH) Funtua, Katsina State. **Email:** rajisaheed2003@gmail.com

ABSTRACT

Background: Absconding from inpatient psychiatric setting is a potentially dangerous phenomenon for all the stakeholders in the mental health setting and the community at large. In order to put in place appropriate prevention strategies, there is a need to identify factors associated with absconding

Objectives: The study aimed to determine the rate of absconding behaviour in a regional psychiatric hospital in Nigeria, and identify its associated factors and predictors.

Study Design: This is a cross sectional study of admitted patients. A semi-structured socio-demographic questionnaire, Mini International Neuropsychiatric Interview

(MINI), and Global Assessment of Function (GAF) were administered to 406 admitted cases in the Federal Neuropsychiatric Hospital, Benin City. Data was analysed with SPSS 20, only thirteen cases of abscond were recorded during the study period.

Results: Abscond rate was found to be 3.2%. Male gender, diagnosis of psychoactive substance related disorders, and past history of escape in treatment setting were significantly related to absconding behaviours with the latter emerging as the best predictor.

Conclusion: Patients at high risk of abscond require special attention

Keywords: Abscond, Escape, Inpatients, Hospital, Nigeria

INTRODUCTION

Inpatient care modality can be employed in management of people with severe mental illnesses (SMIs). Appropriate discharge by the treating team is considered as the gold standard¹ after satisfactory symptom subsidence and due consideration for factors that could affect the course of the illness during subsequent outpatient post-discharge care. Other patients may be discharged by the treatment team prior to

satisfactory symptom subsidence for community rehabilitation, industrial action by health workers², during crisis discharge or due to financial inability of the caregiver to sustain continuous cost of inpatient care or other reasons. There are also instances of discharge or leave against medical advice (DAMA, LAMA) prior to satisfactory symptoms subsidence.

Absconding (absence without official leave,





AWOL, escape, unauthorized absence, elopement, runaway, missing patients) is a situation whereby a patient leaves premises of the hospital facility without appropriate notification or due permission of treating team or hospital authority during a period of inpatient care³⁻⁷. Several definitional issues have been discussed in literatures^{4,5}, with respect to duration of patient unavailability, legal status (voluntary or involuntary admission), knowledge of patients whereabouts, and whether the patient actually intended to leave the treatment setting.

The term 'abscond' is commonly used in literatures, though, 'escape' is preferred amidst health workers in the study centre because it is considered less pejorative as the former implied lexical meaning of taking something or somebody along during the leave, and is sometimes attributed to the prison service system⁸. However, both terms will be used interchangeably in this write-up. It is considered by some authorities as a form of discharge or leave against medical advice (DAMA, LAMA)³.

The phenomenon occurs in both psychiatric and non-psychiatric settings^{9,10}, and can pose a significant problem to hospital authority such as increased responsibility and workload of hospital staff, the executive manager, and the police department to return the patient to the hospital^{8,11,12}.

The society may also lose confidence in the service rendered by the institution, and the consequent negative media publication may harm the hospital reputation with potential legal liability^{9,10,13}. The attending staff (usually the Nurses) are anxious, embarrassed, angry,

with sense of guilt, failure and fear of job security¹⁰. Interview with Nurses in UK revealed that most were worried whenever a patient escaped from the ward and there were reports of other punitive measures from the hospital authority⁴.

Moreover, it can be significantly dangerous for patients to escape during period of inpatient care. Risk of treatment discontinuation, treatment non-adherence, self-neglect, self-harm, suicide, exposure to physical abuse, sexual abuse and death^{9,10} have been identified in the literature as possible consequences. Furthermore, other people involved in patients care and members of the public are exposed to risk of aggression and violence⁸.

Several reasons have been adduced to the concept of psychiatric escape and these include psychiatric symptoms (like delusion, hallucination), boredom, fear of co-patient, sense of undue confinement, sense of insecurity of relations and properties at home, need to fulfil official or domestic responsibilities, isolation from family and friends¹⁴.

Sociodemographic factors like the gender¹¹, employment status, age⁹ and clinical factors like clinical diagnosis¹⁵, psychoactive substance use, past history of abscond¹¹ have been related to absconding behaviour in literatures. Rates of abscond in psychiatric settings vary widely in literatures from different countries of the world. It ranges from as low as 0.4% in general hospital in Iran¹¹ to as high as 55% in Visakhapatnam¹⁶. This wide variation can be attributed to differences in the kind of methodology utilized for these studies, as well as



differences in the settings where the studies were conducted. In addition, Western, liberalized and more developed countries seem to have higher abscond rate than the developing and conservative ones. Abscond rate of 20.82% was reported in an Australian retrospective study¹⁷, compared to 3.3% reported in a similar retrospective study in India¹⁵. Higher abscond rate of 25% was reported in forensic psychiatric setting in South Africa¹⁸. However, most studies on psychiatric abscond were conducted outside the shores of Africa.

Absconding occurs in all psychiatric and non-psychiatric treatment settings worldwide, and can lead to grave consequences, but very little attention has been paid to this concept in Africa and Nigeria in particular.

This study aims to determine the proportion of escapees among inpatients in a Nigerian psychiatric hospital, explore demographic and clinical risk factors for escaping in these patients and discuss possible ways of mitigating its effects.

STUDY METHODOLOGY

This is a cross sectional study. It was conducted in the Federal Neuro-Psychiatric Hospital (FNPH) Uslu, Benin-city. The hospital is a 226 bed facility and provides inpatient/outpatient services to walk-in and referral cases across Edo and neighbouring states. Number of admissions on each day ranged from 0 - 6 cases and bed occupancy of up to 65% was recorded during the study period. Outpatient clinics run on all weekdays, excluding public holidays.

This is a subset of a more comprehensive prospective study of admission and

readmission patterns in patients that were admitted for treatment of severe mental illnesses (SMIs) between (February 1st till July 31st 2015) and followed up till discharged in the study center. All admitted patients within the age range of 18-64 years were approached to partake in the study. The study questionnaires were administered by RSO to those who gave written consent to partake in the study and they were assured that the information will be treated with confidentiality. Those who declined to participate were reassured that there would be no negative consequence. Other information that could not be provided by the patients was extracted from their case files. Patients with mental retardation, dementia or other cognitive impairment that may affect their understanding of the procedures were excluded from the study. Those who have been on admission for more than six months period or reside permanently in the hospital were also excluded from the study.

Study Instruments

1. A semi-structured socio-demographic/ clinical questionnaire designed by the researchers, detailing socio-demographic variables like age, gender, marital status, employment status, living arrangement, place of residence, educational status.

Clinical variables elicited include; nature of previous discharge (e.g. appropriate discharge with medical approval, repatriated, escaped, inability to sustain continuous cost of hospital care, discharged against medical advice, discharged during industrial action, or crisis discharge). Those who exhibited escape behaviour were classified based on whether they were



successfully apprehended in the neighbourhood by the hospital security staff (attempted escape), returned to inpatient care setting by caregivers or not returned to care settings. Nature or legal status of admission (voluntary or involuntary), indication for current admission (e.g. dangerousness to self /others, or to relieve care giver burden) were also captured in the questionnaire.

2. Mini International Neuropsychiatric Interview (MINI); The MINI was designed by Doctors Sheehan and Lecrubier in 1992¹⁹ as a brief structured interview for the major axis I psychiatric disorders of DSM-IV and ICD-10. Studies have shown that the MINI has similar reliability and validity properties with the CIDI (Composite International Diagnostic Interview) but can be administered in a much shorter period of time (mean 18.7 +_ 11.6minutes, median 15 minutes) than the above reference instrument¹⁹. When assessed with Cohen's kappa coefficient. Inter-rater reliability ranged between 0.81 for psychotic disorders to 1.00 for major depressive disorders, anorexia nervosa and bulimia nervosa. Test-retest reliability of up to 1.00 was obtained for most diagnostic classes. Sensitivity value of up to 0.94 was reported for most diagnostic classes when compared with CIDI. Specificity values were between 0.72 and 0.97 for all the diagnoses.

MINI has been used in several studies in Nigeria^{20,21}. In this study, the MINI was used to confirm the ICD-10 psychiatric diagnosis and the 18 diagnostic groups in MINI were regrouped into 6 classes (Schizophrenia and Related Disorders, Psychoactive Substance Related Disorders, Bipolar Affective

Disorders, Major Depressive Disorders, Anxiety Disorders and Personality Disorders). This was done to ease comparison with ICD-10 clinical diagnosis and for data analysis. The Suicidality module section of the instrument also enable assessment of suicide risk of the participant

3. Global Assessment of Functions (GAF); Global Assessment of Functions (GAF) was introduced in DSM-IV and is a revised version of the Global Assessment Scale (GAS). It is a 100-point scale on which the clinician rates the overall functioning of the patient. Each decile has a brief description of psychological, social and occupational performance²² which is operationally defined and represents a level of global severity. The two highest interval ranges (81 - 100) are used for individuals without significant psychopathology who also exhibit traits of positive mental health. The next interval range (71 -80) applies to individuals in which psychopathology is minimal. It has good reliability with intraclass correlation coefficient of 0.91 and has been used previously in Nigerian studies^{23,24}. Consecutive deciles were regrouped into a single category in this study to ease data analysis.

Data Management

Data of 406 out of the 414 cases that were recruited for the study were analysed, using the Statistical Package for Social Sciences (SPSS) version 20. Results were displayed in tables as appropriate. All variables were expressed in categorical terms and chi square test was used to compare the differences in variables between participants that exhibited absconding behaviours and those who did not. To avoid overloading of the



logistic regression models only the factors that were found to be significantly related to absconding behaviour were entered into the stepwise binary logistic regression model to determine the predictors of absconding behaviour amidst participants.

Results

30 out of the 406 cases were cases of readmission, while 12 participants were responsible for the 13 cases of abscond behaviour found in this study (one of the participants escaped in his two admissions during the study period).

The mean age of the respondents was 36.46years (± 10.11), about two-third (272, 67.00%) of the participants were male, most were single (260, 64.04%), reside in urban settlement (313, 77.10%), had minimum of secondary education (239, 58.90%) and were unemployed (183, 45.10%),

The modal indication for admission was violence / aggression (risk to others, 142, and 35.22%). Only about one tenth (43, 10.60%) of the participants consented to be admitted prior to hospital admission (voluntary admission). Over half of the participants (243, 59.85%) were considered to be at the lowest level of functionality as at the period of hospital admission when assessed with Global Assessment of Function (GAF) score.

Schizophrenia and related disorders (165, 40.64%), psychoactive substance related (120, 29.56%) and bipolar disorders (102, 25.12%) were the leading psychiatric diagnosis when assessed with Mini International Neuropsychiatric Interview (MINI). Only 16 (3.94%) of the participants

were reported to have escaped in previous inpatient care setting, while 13 (3.21%) exhibited absconding behaviour during the index period of hospital admission (see Table 1).

Table 1a: Sociodemographic and Clinical Features of Participants

Variable	Frequency	Percentage
Gender		
Male	272	67.00
Female	134	33.00
Age (mean = 36.46 \pm 10.11)		
< mean	230	56.70
\geq mean	176	43.30
Settlement		
Rural	93	22.90
Urban	313	77.10
Education		
< Secondary	55	13.50
Secondary	239	58.90
>Secondary	112	27.60
Employment Status		
Unemployed	183	45.10
Schooling	36	8.90
Vocational Training	8	2.00
Employed	166	40.90
Retired	13	3.20
Marital Status		
Single	260	64.00
Married/Cohabiting	84	20.70
Separated/Divorced /Widowed	62	15.30
Indication for Admission		
unclear	26	.640
Self Neglect	122	30.05
Suicidality/Self harm	8	1.97
Risk to others	143	35.22
Destructive	44	10.84
Relief of Carers Burden	5	1.23
Addiction Rehabilitation	35	8.62
Treatment of Comorbid illness	23	5.67

Table 1b: Sociodemographic and Clinical Features of participants (Continued)



Variable	Frequency	Percentage
Legal Status		
Involuntary Admission	363	89.41
Voluntary Admission	43	10.59
Suicidality		
No Risk	395	97.29
Low Risk	4	0.99
Moderate Risk	2	0.49
High Risk	5	1.23
Past History Abscond		
Previously Absconded	16	3.94
Never Absconded	390	96.06
Absconding Behaviour		
Non Absconder	393	96.79
Attempted Escape	4	0.99
Escaped But Was Brought Back/Returned	3	0.74
Escaped Without Being Brought Back/Returning	6	1.48

Features of participants (Continued)

Variable	Frequency	Percentage
Psychiatric Diagnosis		
No Psychiatric Diagnosis	2	0.49
Psychoactive Substance Related Disorders	120	29.56
Schizophrenia & Related Disorders	165	40.64
Bipolar Disorders	102	25.12
Major Depressive Disorders	17	4.19
Global Assessment of Functions (GAF)		
1-20	243	59.85
21-40	138	33.99
41-60	19	4.68
61-80	6	1.48

Masculine genders, psychiatric diagnosis of psychoactive substance related disorder and history of abscond during previous inpatient care treatment were the only factors that were significantly associated with absconding behaviour in the study participants (Table 2).

Table 2a: Sociodemographic and Clinical Determinants of Absconding Behaviour

Variable	Absconding Behaviour Nil	Absconding Behaviour	df	X ²	P value
Age Group					
< Mean	221 (96.09)	9 (3.91)	1	0.866	0.262
≥ Mean	172 (97.72)	4 (2.28)			
Gender					
Female	133 (99.25)	1 (0.75)	1	3.882	0.049
Male	260 (95.59)	12 (4.41)			
Settlement					
Rural	88 (94.62)	5 (5.38)	1	1.84	0.175
Urban	305 (97.44)	8 (2.56)			
Marital Status					
Single	252 (96.92)	8 (3.08)	2	1.204	0.548
Married/Cohabiting	80 (95.24)	4 (4.76)			
Widowed/Divorced/Separated	61 (98.39)	1 (1.61)			
Education					
< secondary	54 (98.18)	1 (1.82)	2	0.738	0.691
Secondary	230 (96.23)	9 (3.77)			
> Secondary	109 (97.32)	3 (2.68)			
Employment Status					
Unemployed	177 (96.72)	6 (3.28)	4	1.480	0.830
Schooling	35 (97.22)	1 (2.78)			
Vocational Training	8 (100.00)	0 (0.00)			
Employed	160 (96.39)	6 (3.61)			
Retired	13 (100.00)	0 (0.00)			

Table 2b: Sociodemographic and Clinical Determinants of Abscinding Behaviour (continued)

Variable	Abscinding Behaviour (N=406)		df	X ²	P value
	Nil Abscinding Behaviour n (%)	Abscinding Behaviour n (%)			
Suicidality					
Non-Suicidal	382 (96.71)	13 (3.29)	1	0.374	1.000
Suicidal	11 (100.00)	0 (0.00)			
Past History of Abscond					
Never Abscond	381 (97.69)	9 (2.31)	1	25.535	0.001
Previously abscond	12 (75.00)	4 (25.00)			
Legal Status					
Involuntary	350 (96.42)	13 (3.58)	1	1.587	0.208
Voluntary	43 (100.00)	0 (0.00)			
Global Assessment of Functions (GAF)					
1-20	237 (97.53)	6 (2.47)	2	2.806	0.246
21-40	131 (94.93)	7 (5.07)			
41-80	25 (100.00)	0 (0.00)			
Psychiatric Diagnosis					
No Diagnosis	2 (100.00)	0 (0.00)	4	9.894	0.042
Psychoactive Substance Related Disorders	111 (92.50)	9 (7.50)			
Schizophrenia and Related Disorders	162 (98.18)	3 (1.82)			
Bipolar Disorders	101 (99.02)	1 (0.98)			
Major Depressive Disorders	17 (100.00)	0 (0.00)			
Indications for Admission					
Unclear	23 (95.83)	1 (4.17)	9	13.041	0.110
Self neglect	120 (98.36)	2 (1.64)			
Suicidality/Self Harm	8 (100.00)	0 (0.00)			
Risk to Others	141 (98.60)	2 (1.40)			
Destructive	41 (93.18)	3 (6.81)			
Failed Outpatient Care	5 (100.00)	0 (0.00)			
Relief of Caregiver Burden	34 (97.14)	1 (2.86)			
Addiction Rehabilitation	19 (82.61)	4 (17.39)			
Treatment of Co-morbid illness	2 (100.00)	0 (0.00)			

Past history of abscond emerged as the most important predictor of absconding behaviour amidst participants when all the three significant factors were entered into a binary logistic regression model (Table 3).

Table 3: Variables in Binary logistic Equation

	B	S.E.	Wald	df	p-value	Odd ratio	95% C.I. for EXP(B)	
							Lower	Upper
Gender	1.120	1.095	1.045	1	0.307	3.065	0.358	26.238
Psychiatric Diagnosis	-0.762	0.426	3.196	1	0.074	0.467	0.202	1.076
History of Abscond	2.264	0.704	10.356	1	0.001	9.624	2.424	38.222
Constant	-6.686	2.483	7.253	1	0.007	0.001		

Discussion

Abscond behaviour was exhibited by 3.21% of the participants in this study. This is similar to the value of 3.30% recorded by John et al in India¹⁵, 4.24% reported by Sheikhmoonemi *et al* in Iran¹⁰, and relatively close to 7.83% reported by Feroza in South Africa, but lower than abscond rate of 20.82% reported by Muir-Cochrane in Australia. The lower abscond rate in our study may be due to African conservative culture which is similar to what is obtainable in Asian countries (like India and Iran) compared to Western and more liberalized nations like Australia. Conservative cultures seem to favour traditional sameness, rigidity and are more restrictive in child rearing pattern as well as on their subordinates. The liberalists on the other hand allow a great range of behaviours, they are more relaxed, freedom oriented, less restrictive in child control and are more permissive for themselves as well as their subsidiaries²⁵.

Male gender, psychoactive substance related disorder and past history of abscond were found to be significantly related to absconding behaviours amidst the respondents in this study with the latter factor being the most predictive.

Significance of male gender as an important factor for abscond in psychiatric setting has been reiterated in several studies^{15,2,27}. Males were also found to abscond more than females even in general hospital/non-psychiatric setting⁹. Only one of the females in this study exhibit absconding behaviour. This may be because of the cultural restriction on female gender ingrained in African culture²⁸.



Sheikhmoonesi *et al*¹⁰ reported higher proportion of patients with bipolar disorders among absconding patients and attributed it to their overactivity symptoms in a study conducted in Iran, John *et al*¹⁵ also reported significantly higher preponderance of people with mania and schizophrenia in a study of absconding patients conducted in India. Positive symptoms like delusional thought and command hallucination in patients with schizophrenia makes them more likely to abscond as reported in the review conducted by Emmanuel *et al*⁵ in Ontario, Canada. This study found a significant association between psychoactive substances related disorders and absconding behaviour. This has been reported in some studies^{5,29} and may be a part of the drug seeking behaviour when the person is craving or experiencing withdrawal symptoms of the drug.

Past history of abscond is the significant factor and the best predictor of absconding behaviour in this study. This is similar to what was reported by Beer *et al*²⁹ in a retrospective case control study and the finding of Muir-Cochrane *et al*¹⁷ in a retrospective descriptive study conducted in Australia. It is possible that absconding patients have typical personality traits that make them to be uncooperative with inpatient care plan. Personality disorders have been reported to be significantly associated with absconding behaviour in literature review conducted by Stewart *et al*⁴, though none of the respondents in this study had a main diagnosis of personality disorder.

Most studies^{4,15,17} on this subject consider young age as a significant factor in patients abscond. This contrast with our study that found no significant relationship between

absconding and age of participants. This difference may be due to the age group classification approach¹⁵ employed by different researchers and the case-mix effects due to inclusion of extremes of ages (elderly and paediatric age group). Only adult participants in the age range of 18-64 years were recruited in this study.

Isolation from relatives and friends (including spouses), lack of meaningful recreation and leisure, and perceived household responsibilities were part of the numerous reason usually stated by patients when asked about the reason for abscond. The urge for sexual gratification may make an individual to want to leave the inpatient treatment setting¹⁰. 47% of male absconders and 88% of female absconders were married as reported in a retrospective study⁵. Married and cohabiting participants were in higher proportion amidst absconding participants than the unmarried (single, widowed, divorced and separated) in this study, though this did not reach a level of statistical significance. A retrospective review conducted by Feroza in South Africa however²⁷ reported being single as a factor in abscondment

High order of literacy¹⁵, unemployment⁵ were found to be associated with absconding in studies though such was not replicated in this study. Living in urban or rural settlement has no relationship with absconding behaviour.

It is argued in the conceptual definition of abscond that the definition should not include patients that were admitted against their will, since they did not consent to be on admission in the first instance⁵. The legal status of admission (voluntary or



involuntary) is not related to absconding behaviour in the study despite the fact that all the patients that absconded in this study were compulsorily (involuntarily) admitted. However, the proper exploration of this fact in this study is limited by under-implementation and updating of Mental Health Act (MHA) in Nigeria³⁰.

Interview with some absconded patients that returned to hospital revealed that they usually cite reasons like boredom, and the need to attend to some social, official, family and occupational responsibilities^{5,14}. Such was not demonstrated in this study as our finding indicated no relationship between absconding behaviour and preadmission functionality assessed with GAF score.

Suicide risk has been quoted in several literatures as one of the consequence of abscond in mental health setting¹¹, though this was not replicated in our study upon exploration of suicide risk with suicidality module of MIINI. It is an established fact that suicide is less common in African setting than western world³¹.

The exploration of effects of other indications for admission like property aggression risk of violence to other people which are known consequences of abscond¹¹ were not significantly related to abscond behaviour in this study.

CONCLUSION

Rate of Abscond behaviour of 3.2% is very low in our setting compared to western world. Male gender, psychoactive substance use and past history of abscond were the significant determining factor for absconding behaviour in this study.

As it is for most other behaviours that we study in psychiatry (eg violence, suicide risk) the best predictor of abscond is past history of abscond.

Patients with high risk of abscond should be identified and special preventive strategies should be in place. A practice in the study centre is the tagging and labelling case files of young male previous absconders with psychotic and substance use disorders as "potential escapee". However ethical furore was raised by some professionals against such practice. A better option will be to have an escape register in the hospital electronic record which will flag patient as a potential absconder during subsequent inpatient care and the managing team will be aware and conscious of this without necessarily labelling patient's file.

There is need to develop abscond risk assessment tool which may be composed from the several factors that has been found to be significantly related to absconding behaviour in literatures.

Recreational drug use may be a maladaptive coping technique employed by the users during boredom, frustration and other strenuous situation of life which patients will not have access to during involuntary admission.

Effort should be made in creating and enabling adaptive coping technique during inpatient care. This can be attained by proper and spacious ward design, boredom prevention, leisure and recreation, occupational therapy, good patients relationship, and encouraging visitation by caregivers.



Limitation of the Study

Inquiring about the reasons for abscond from those who returned should have enabled designation of appropriate preventive strategies which could be tested in a prospective study to enable exploration of the effects of other interventions suggested in literatures.

Acknowledgement

The management and staff of psychiatric hospital Uselu were all appreciated for granting of ethical approval and their cooperation during the conduct of this study.

Conflict of Interest

None declared

REFERENCES

1. Alfandre D, Brenner J, Onukwugha E. Against Medical Advice Discharges. *J Hosp Med*. 2017;**12**:843-5.
2. Oleribe OO, Ezieme IP, Oladipo O, Akinola EP, Udofia D, Taylor-robinson SD. Industrial action by healthcare workers in Nigeria in 2013 - 2015?: an inquiry into causes , consequences and control - a cross-sectional descriptive study. *Hum Resour Health [Internet]*. 2016;**14**(46):1-10. Available from: <http://dx.doi.org/10.1186/s12960-016-0142-7>
3. Ayed I Al. What Makes Patients Leave Against Medical Advice? *J Taibah Univ Med Sci*. 2009;**4**:16-22.
4. Absconding from psychiatric hospitals?: a literature review. 2010;(November).
5. LI E, Taylor L, Hain A, Jr C, Mj H, Karsh B, et al. Mental Health Care?: Preventing and Responding to Absconding and Missing Patients. 2013.
6. Cullen AE, Jewell A, Tully J, Coghlan S, Dean K. A Prospective Cohort Study of Absconion Incidents in Forensic Psychiatric Settings?: Can We Identify Those at High-Risk? *PLoS One*. 2015;**10**:1-16.
7. Mahaye S, Mayime T, Nkosi S, Mahomed FN, Pramlal J, Setlhabana O, et al. Medication adherence of psychiatric patients in an outpatient setting. *African J Pharm Pharmacol [Internet]*. 2012 Mar 8 [cited 2013 Sep 24];**6**(9):608-12. Available from : [http://www.academicjournals.org/ajpp/abstracts/abstracts/abstract_2012/8_Mar/Mahaye et al.htm](http://www.academicjournals.org/ajpp/abstracts/abstracts/abstract_2012/8_Mar/Mahaye%20et%20al.htm)
8. Exworthy T, Wilson S. Escapes and absconds from secure psychiatric units Escapes and absconding from secure psychiatric units. *Psychiatrist*. 2010;**34**(January):81-2.
9. Khammarnia M, Kassani A, Amiresmaili M, Sadeghi A, Jaber ZK. Study of patients absconding behavior in a general hospital at southern region of Iran. *Int J Heal Policy Manag [Internet]*. 2015;**4**(3):137-41. Available from: <http://dx.doi.org/10.15171/ijhpm.2014.110>
10. Sheikhmoonesi F, Kabirzadeh A, Yahyavi ST, Mohseni B. A prospective study of patients absconding from a psychiatric hospital in Iran. *Med Glas Ljek komore Zenicko-dobojskantonu*. 2012;**9338**(August):86-90.
11. Anisi S, Zarei E, Kariman H, Kazemi MK, Chehrazi M. Patient Absconding and Its Predictors: A 5-Year Retrospective Analysis in a General Teaching Hospital in Tehran, Iran. *Shiraz-E Med J*. 2017;**16**(12).
12. Malgas FN. Exploration of Nurses' Experiences of the Assessment and



- Management of Patients at Risk of Absconding from an Acute Psychiatric Ward in the Western Cape. A mini-thesis Submitt Partial fulfilment Requir a degree Magister Curationis Sch Nursing, Fac Community Heal Sci Univ West Cape. 2017;(September).
13. Andoh B. The Consequences of Absconding from Mental Hospitals. *Mountbatt J Leg Stud.* 1991;70-92.
 14. Bower I, Jarret M, Clark N, Kiyimba F, LMF. Absconding: why patients leave. *J Psychiatr Ment Health Nurs.* 1999;6:199-205.
 15. Gangadhar BN. Phenomenology of Escape from A Mental Hospital in India. *Indian J Psychiatry.* 1980;22:247-50.
 16. Dr K.V.Rami Reddy, Dr G.Suresh Kumar D. V. A Study on Reasons of Absconds From Inpatient Ward in Government Hospital for Mental Care Visakhapatnam. *IOSR J Dent Med Sci [Internet].* 2015;14(2):12-4. Available from : <http://www.iosrjournals.org/iosr-jdms/papers/Vol14-issue2/Version-1/D014211214.pdf>
 17. Muir-Cochrane E, Mosel K, Gerace A, Esterman A, Bowers L. The profile of absconding psychiatric inpatients in Australia. *Journal Clin Nurs.* 2011;20:706-13.
 18. Marais B, Bch MB, Sa D, Sa F, Psychiatry M. Forensic state patients at Sterkfontein Hospital?: A 3-year follow-up study. *South African J Psychiatry.* 2015;21:86-92.
 19. Sheehan D., Lecrubier Y, Sheehan K, Amorn P, Janavs J, Weiller E, et al. The MINI International Neuropsychiatric Interview (MINI); the Development and Validation of a Structured Clinical Diagnostic Psychiatric Interview for DSM -IV and ICD-10. *J Clin Psychiatry.* 1998;59(20).
 20. Ogebe O, AbdulMalik J, Bello-Mojeed M, Holder N, Jones H, O.O O, et al. Comparison of the Prevalence of Dysphoric Disorders and Comorbidity among Adolescents in the United State of America and Nigeria. *J Paediatr Adolesc Gynaecol.* 2011;24:397-483.
 21. Okunrinboye H. The Relationship Between Depression and Medication Adherence Among Patients With Hypertension Attending Medical Out-Patient Clinic of Federal Medical Centre, Owo. A Dissertation Submitted to National Postgraduate Medical College of Nigeria. 2013.
 22. Hilsenroth M, Ackerman S, Blagys M, Baumann B, Baity M, Smith S, et al. Reliability and Validity of DSM-IV axis V. *Am J Psychiatry.* 2000;157:1858-63.
 23. Lasebikan VO. Validation of Yoruba Version of Family Burden Interview Schedule (Y-FBIS) on Caregivers of Schizophrenia Patients. *ISRN Psychiatry [Internet].* 2012;2012:165179. Available from : <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3658491&tool=pmcentrez&rendertype=abstract>
 24. Ajiboye PO, Adelekan M. A Prospective Analysis of In-patient Consultation-Liason Psychiatry In a Nigerian Teaching Hospital. *East Afr Med J.* 2004;81:620-5.
 25. Eisenman R, Sirgo HB. Liberals versus Conservatives?: Personality , Child-rearing Attitudes , and Birth Order / Sex Differences. *Bull Psychon Soc.* 1991;29:240-2.
 26. Nurjannah I. Absconding from a Psychiatric Setting in Indonesia: A Case Study. Master Nurs Res Thesis, James



- Cook Univ. 2007;
27. Arbee F. A Retrospective Review of Mental Health Care Users who Abscond from Psychiatric Hospital. A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry. 2014.
 28. Odiaka NO. The Concept of Gender Justice and Women's Rights in Nigeria?: Addressing the Missing Link. *J Sustain Dev Law Policy*. 2013;**2**:190-205.
 29. Beer MD, Anandamurugan Muthukumaraswamy, Khan AA, Musabbir MA. Clinical predictors and patterns of absconding in a low secure challenging behaviour mental health unit _ Journal of Psychiatric Intensive Care _ Cambridge Core. *J Psychiatr Intensive Care*. 2009;**5**:81-7.
 30. Westbrook AH. Mental Health Legislation and Involuntary Commitment in Nigeria?: A Call for Reform. *Washingt Univ Glob Study Law Rev*. 2011;**10**(2).
 31. Maharajh HD, Abdool PS. Cultural Aspects of Suicide. *Sci World J*. 2005;**5**:736-46.