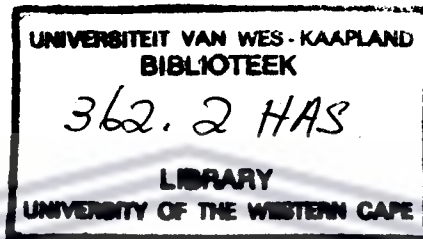


**A DESCRIPTIVE STUDY OF PATIENTS GOING 'ABSENT WITHOUT
LEAVE' FROM LENTEGEUR HOSPITAL**

(April 1992 - November 1992)



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ABSTRACT

This study provides a descriptive profile of psychiatric patients who had gone 'Absent Without Leave' (AWOL) from Lentegur Hospital over an 8-month period from April to November 1992. The clinical sample comprised 93 in-patients (83 males, 10 females) ranging in age from 14-57 years. A survey was conducted in order to gather standardised information. Results revealed that the majority of patients who had gone AWOL were young, single, unemployed, urban males with a low level of education. Most of them had been admitted involuntarily, and sported a history of several previous admissions coupled with a history of AWOL. Many had requested discharge prior to leaving, whilst only a few were due for discharge. The Police were more often than not involved in returning these patients to hospital. Of the majority diagnosed with Schizophrenia, most received oral neuroleptic medication and many were given depot neuroleptics. It is clear that treatment is still largely rooted in the medical model, and that patients derive no lasting benefit from their admission(s) to a mental hospital. The paper attempts to locate mental illness in context, and to this effect employs the Societal-Reaction Model as a substrate from which to consider the process of going AWOL. It further argues for 'deinstitutionalisation' coupled with increased community integration of the 'mentally ill', and provides some guidelines to this effect. These findings could serve as a basis for future studies, and also as a spring-board for the reconstruction and development of appropriate social services.

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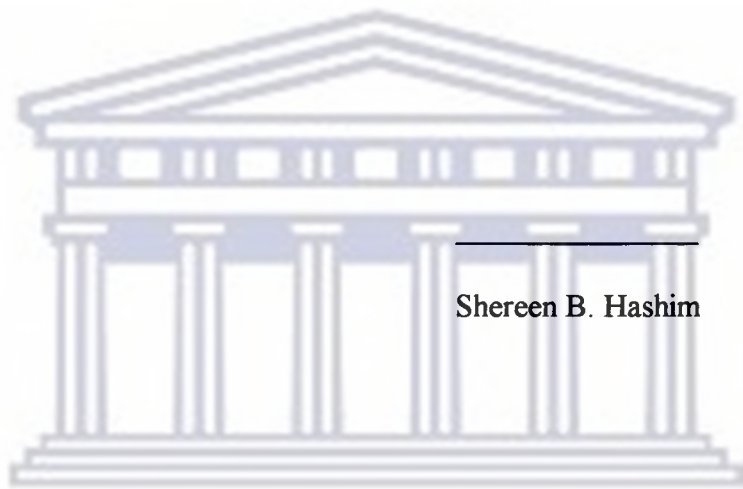
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DECLARATION

I declare that *A Descriptive Study of Patients Going 'Absent Without Leave (AWOL) from Lentegour Hospital'* is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.



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CHAPTER 1 : INTRODUCTION

A patient going "absent without leave" (AWOL) produces considerable anxiety on the part of hospital staff, relatives, and the lay public. This phenomenon is considered a disruptive crisis on a psychiatric ward and involves, among other things, a great deal of staff time in notification, search and inquiry.

The origin of this problem is associated with the "open door" policy which has become generally adopted in many psychiatric hospitals.

Although AWOL is considered a considerable problem in mental institutions, there is a paucity of research statistics pertaining to this phenomenon. South African statistics are virtually non-existent.

The problem of AWOL, though complex, deserves further investigation in view of its magnitude in many institutions (for example, 7-10 cases per week at Lentegeur Hospital), its burden on the economy in terms of time and money, the lack of research, and because it is at present virtually impossible to assess the far-reaching effects of this problem upon the individuals involved, the institution, and the community. In terms of practical management, there is a need for better recording of incidents of AWOL in psychiatric institutions.

The aim of this study is to provide a description of the phenomenon of AWOL amongst psychiatric inpatients at Lentegeur Hospital, Cape Town, South Africa. The study will

not attempt to ferret out cause-and-effect relationships. Instead, it will attempt to provide a local profile on the incidence of AWOL, to identify variables that exist in the given situation, and to describe the relationship that exists between these variables. The knowledge derived from this study could be used to formulate hypotheses which could, in turn, provide the basis for further studies.

Chapters 2-5 comprise the literature review. Chapter two provides a historical overview of perspectives on mental illness. The emergence and growth of the asylum in Europe, America and South Africa is discussed, with special attention to the South African context. This serves to acquaint the reader with the ways in which the mentally ill have been viewed over time. It further provides a backdrop against which to view two contrasting approaches to mental illness, namely, the Medical Model and the Societal-Reaction Model.

Chapter three examines some of the organisational problems experienced by the mental hospital. It generally focuses on the influence of the external environment (society) and treatment technology upon the internal structure and processes of life inside the mental hospital. More specifically, it deals with issues such as power and autonomy, hospital structure, technology and treatment goals, and patient adaptations/adjustments. The chapter attempts to illustrate that life inside the hospital has its own tensions and demands, similar to that outside.

Chapter four deals with the release process. It provides a description of both the patient's release ideology and the process of requesting discharge from hospital. Some

hypotheses regarding the type of patients, and the conditions most likely to result in discharge are presented.

Chapter five provides a review of some of the findings of previous studies. It also deals with some salient definitions in an attempt to clarify the concept of AWOL.

Chapter six provides a detailed summary of the methodology employed in this study. Information pertaining to the subjects, context, instrument/measures, procedure, and statistical analyses are recorded.

A summary of the results of this study is recorded in chapter seven. Tables and figures have been employed in an attempt to summarise the data and facilitate ease of reading.

A detailed discussion of the results is presented in chapter eight. Perceived limitations of the study are pointed out.

Chapter nine provides a summary of the thesis. Shortcomings and limitations of the present study are also noted here. Finally, conclusions are stated and recommendations offered.

LITERATURE REVIEW

CHAPTER 2 : HISTORICAL PERSPECTIVES

When one examines how the mentally ill have been viewed and treated historically, it becomes clear that 'the treatment is intimately related to the paradigm of the time as well as to the prevailing social attitudes.' (Braginsky et al., 1969, p.177).

This chapter traces the emergence and growth of the asylum in Europe, America, and South Africa. The historical overview serves to acquaint the reader with the ways in which the mentally ill have been viewed over time. It further provides a backdrop against which to view two contrasting approaches to mental illness, namely, the Medical Model and the Societal-Reaction Model.

2.1 Premodern Conceptions

Prior to the advent of 'modern psychiatry', and particularly during the Middle Ages, persons who exhibited deviant behaviour were thought to be possessed by the devil. The treatment of these persons involved exorcising the demons either by prayer or torture. A revolt ensued in reaction to these inhumane practices, followed by the search for a more rational, humane paradigm. As a result, theologians formulated the "wild beast" theory which viewed deviant behaviour as a reversion to man's primitive animal nature. Treatment of this condition involved beating the afflicted person until he rose again to

human sensibilities. This theological view was not received well by the medical profession. They, in turn, adopted a radical view, declaring that insanity was the result of a diseased brain. Because the afflicted were thought to be insensitive to and unaware of their surroundings, they were often subjected to 'violent' forms of medical treatment. The earlier forms of torture were replaced by 'blood-letting' and emetics.

By the end of the eighteenth century, an enlightened public demanded an end to these oppressive practices, and a respect for the dignity of every individual, including the insane. In response, physicians modified their paradigm of mental illness by shifting the emphasis from organic to functional. For the first time, mental illness was seen to be induced by situational factors external to the individual. Treatment thus involved placing the insane in a 'pleasant' environment so as to restore and develop their 'inner harmony and power of reason.' Integral to this "moral treatment" was the respect for the rights of the insane as human beings. The task of both the physician and the institution was to foster the development of patients as human beings. The physician thus perceived himself as a figurehead in a family of which his patients were members who had to be treated with kindness and sensitivity.

Respect for the dignity of the individual underwent a marked change shortly after the Civil War in America. This change was, in turn, reflected in the treatment of the mentally ill. The medical paradigm at this time reverted to the disease hypothesis. They further asserted that insanity was a degenerative illness afflicting persons with an inferior constitutional heredity. Doctors viewed mental illness as nature's way of eliminating the unfit of the species. Since religious and philosophical principles of the time did not

accommodate these natural processes, society had to assume the responsibility for the survival of the insane. Rehabilitation was not considered possible, and therefore treatment was never considered. The only intervention involved locking the insane away, so that the benevolent doctor thus became a keeper of inmates, and the institution represented a prison rather than an asylum. This practice marked the formal expulsion of the mentally ill insane from society.

Shortly after World War I, these custodial institutions began to be replaced by therapeutic ones. Unlike previous times, however, this revolution in the treatment of the mentally ill was not accompanied by any notable revolution in psychiatric conceptions. On the contrary, the dominant psychiatric conception today is strikingly similar to some of the earlier ones. For example, patients with schizophrenia are viewed as something less than human. Their illness is regarded as a disintegrative disease process that may result in almost total psychic dysfunction if not treated appropriately and promptly. It is furthermore, maintained that they are 'pawns of fate' with little or no control over their intra psychic and external processes (Braginsky et al., 1969).

This shift from custodial to therapeutic management of the insane was thus the result of a synthesis and elaboration of old paradigms rather than of a new one.

2.2 The Beginnings of Confinement

The seventeenth and early eighteenth century in Europe is depicted by Foucault as a period of the "great confinement" (Foucault, 1988, p.38). During this time, the insane could be confined in houses with the poor, the unemployed, and even with criminals.

Although this practice of confining persons spread throughout Europe and served as one of the answers to prevailing economic conditions, it also, for the very first time, focused public attention on the mentally ill as a special problem.

For the first time, purely negative measures of exclusion were replaced by a measure of confinement; the unemployed person was no longer driven away or punished; he was taken in charge, at the expense of the nation but at the cost of his individual liberty. Between him and society, an implicit system of obligation was established: he had the right to be fed, but he must accept the physical and moral constraint of confinement (Foucault, 1988, p.48).

The mentally ill were thus confined to special institutions simply because 'one aspect of madness - unemployment - coincided with the plight of the poor, unemployed, and other casualties of the economic crisis that affected Europe during this time' (Perucci, 1974, p.8).

Foucault (1988) thus asserts that 'it was in a certain experience of labour that the indissociably economic and moral demand for confinement was formulated' (p.57).

(This) isolation of madness and its location in a special institution had two profound effects: first, it made the physician the central and ultimate authority for the care and treatment of the mentally ill; and second, although it liberated the insane from physical constraints, it produced a total mastery of madness by making it an object, not only to be studied and controlled by others, but subject also to the madman's self-examination (Perucci, 1974, p.9).

2.3 Growth of the Asylum in America

The American experience in understanding and responding to mental illness parallels the European pattern described by Foucault in one important respect. In both societies,

insanity was dealt with as part of normal, everyday life. The insane remained in families and were, for the most part, free to roam the streets. Similarly, in both societies, the insane ultimately found themselves objectified. They were accordingly viewed as special problems which required special care and treatment dispensed by specialists, in institutions constructed or organized with their special problems in mind (Perucci, 1974, p.11).

Throughout the eighteenth century, the insane remained outside confinement. By the early nineteenth century, however, asylums flourished in America.

In spite of the medical conceptualisation of mental illness, a segment of the medical community that was involved with mental disorder - medical superintendents - embraced a European notion that insanity was linked to civilisation. According to them, unrestrained ambition, the pursuit of success, and the increasing complexity of life were those features of society thought to be responsible for mental disorders. The American pursuit of wealth, power and knowledge was identified as a source of great personal stress.

According to Perucci (1974), the medical superintendents were providing a critique of nineteenth-century America. Their critique was based on the belief that the danger inherent in the new social order was the disruption of a stable, established order without the provision of new bases of stability and cohesion.

A further concern was the fact that institutions that should have been providing stability

(the school, family and church) were in fact not moderating the dangers inherent in the social order. They were, instead, perceived to be encouraging the excessive concern with success.

Although the medical superintendents located the causes of mental illness in the social organisation of society, they failed to follow through and suggest that there should be changes in society. Instead, they proposed that the insane be placed in a setting that would eliminate the stress and strain of social life, and provide them with the order and stability lacking in the larger society.

2.4 The Case of South Africa

The social control of deviance in South Africa has followed a similar pattern to that in Europe, with a few differences.

Developments in South Africa were substantially later than at other locations. The first asylum in South Africa only appeared in 1846, and other asylums appeared nearly 40 years later. The new approach to mental defectives did not lag by the same degree, but at each historical stage, local events followed similar processes elsewhere.

The process was never as extensive or thorough in South Africa in comparison to Western countries. By the turn of the 20th century there were still relatively few asylums. Although numbers increased quite rapidly after Union, trebling between 1916 and 1932, in legal and psychiatric terms many more could have been incarcerated, that is, the effectiveness of control agencies appeared to be less pervasive.

Most relevantly, the 'race issue' permeated South African developments and produced different turns. Black people, perhaps surprisingly, were not brought into the control orbits as extensively as whites. One could simply claim that numerous other forms of controls were introduced from the late 19th century onwards to 'position' black persons in the racial order of South Africa. Regarding mental health, the perceived 'otherness' of blacks, cast into the classic racist discourse of superior versus inferior, rendered them outside the orbit of 'treatment', but incorporated them when they were potentially dangerous.

The rate of differentiation between categories of deviants appeared to take place more slowly and less extensively in South Africa, perhaps due to the slower development of universities and training institutions for 'specialists'. Racial divisions operated here too - whites were more rapidly differentiated than blacks, possibly because white deviants posed a stronger threat to everyday civil ordering (eg schools, factories) than blacks, who could be commonly classed as basic criminals (Lea and Foster, 1990, p.64).

Despite the apparent differences, the general pattern seems to parallel that proposed by the 'social control' theorists.

With regards to the more recent period characterised by the 'destructuring movement', Lea and Foster (1990) point out:

In many respects the 'radical' arguments regarding 'normalisation', anti-psychiatry, advocacy, decarceration and the like hardly surfaced at all in South Africa, or are only beginning to appear in recent years. There are many and varied reasons for this which cannot be dealt with here. It is sufficient to say that where there was evidence of an outward, more community-oriented shift, it applied more to whites (with greater facilities) than blacks. Such a shift was couched in far more conservative, cautionary terms and took place in a substantially more uneven fashion (across different sites of deviance, and even within the field of mental handicap) than was the case elsewhere (p.65).

Whilst it is difficult to explain the South African pattern, it is, nevertheless, possible to trace the correlations between broad social processes and changes in deviance control. According to Lea and Foster (1990), these changes occurred over three major historical periods.

The first historical period of legal and medical developments in South Africa seems to correspond with the rise of mining and agricultural capitalism. This occurred between

the 1880s and the turn of the century. Although treatment technology pertaining to 'lunatics' was largely imported from abroad, it still remains unclear why these practices spread throughout South Africa at this particular time (1880s and 1890s), and not sooner. Lea and Foster (1990) suggest that it may be related to the beginnings of major upheavals in the country's social formation.

The second historical period overlaps significantly with the developments in mining, manufacturing capitalism and urbanisation. In an attempt to create a privileged white working-class, the State introduced a policy of job-reservation to protect white working-class interests. This period was thus characterised by an intense class struggle. The 'lifting out' of white persons with mental defects could thus be seen as part of this process of social class ordering, with its associated concern for the well-being of whites.

The third historical period is somewhat difficult to characterise. By 1965, apartheid laws were firmly entrenched, black resistance had been suppressed by the state, and economic growth was on the rise. Once apartheid dominance had been established, there was a renewed trend towards mental health issues. With the emphasis on social ordering and social control, there was a growing concern over 'social misfits'. This concern led to inquiries into various forms of deviant behaviour. As a result, potential 'controlling agencies' were established including the Criminal Procedure Act, the Health Act and the Mental Health Act.

2.5 Models of Mental Illness

According to Perucci (1974), the influence of medical superintendents weakened when it became evident that confinement in the asylum did little to eradicate insanity. The general theory of causation presented by them was thus also discredited. At this juncture, medical practitioners put forth the disease theory which they had up until this point embraced silently. Mental illness was thus, once again, viewed as a disease. Conceptions of the nature, cause, and treatment of mental illness was located within a framework called the Medical Model.

2.5.1 The Medical Model

The medical model emphasises the individual nature of madness, and views the mentally ill as carriers of a disease that leads them to become patients.

Mental illness is something that a person has, like cancer or heart disease. A person with mental illness exhibits peculiar, unusual, or problematic behaviour which is related to some underlying cause that resides in the human organism. These behaviors are seen as "pathological symptoms" of a disease, and as such are subject to "diagnosis" and "treatment" (Perucci, 1974, p.14).

This model even incorporates the language of physical medicine. The supporters of this model include those segments of the medical community who view brain pathology as the basis of psychological symptoms, and also those who propagate strictly medical treatment (as opposed to psychotherapy). The model also gains support from members of the medical and mental health communities who believe that mental illness is similar to physical illness, even though they may not support the disease theory. This has two consequences: Firstly, those concerned about mental illness are able to utilise the resources of the medical community and its allies, and secondly, it could be seen as an

attempt to remove the stigma of mental illness by giving it the same status as physical illness (Ausubel cited in Perucci, 1974, p.15).

2.5.2 The Behavioural Model

The Behavioural Model may be viewed as a modification of the Medical Model.

The Behavioural Model embraces diverse practices and procedures. According to Kazdin, there are five characteristics that unify the heterogenous approaches in this model.

1. The present influences behaviour, as opposed to historical determinants.
2. Observation of overt behaviour change is the main criterion by which treatment should be evaluated.
3. Treatment goals are concrete and objective in order to make replication of treatment possible.
4. Basic research is a source of hypotheses about treatment and specific therapy techniques.
5. Target problems in therapy are specifically defined, so that treatment and measurement are possible. (Kazdin cited in Baruth and Huber, 1985, p.58).

According to this model, the human personality develops from consistent patterns of action.

Individuals are neither inherently self-actualizing nor: They have equal potential for proceeding in either direction in their lives. Persons become what and who they are through the skills they have learned or not learned (Baruth and Huber, 1985, pp.59-60).

Individuals are thus viewed as a product of their experience. The essential therapeutic goals of the model constitute specific and objectively stated learning objectives.

2.5.3 Common Factors Between Medical and Behavioural Models:

- a Both models view the "individual system" as an entity to be diagnosed, studied, and treated.
- b Dysfunctional behaviour of individuals is observed, diagnosed, and categorised according to a descriptive classification system that informs treatment.
- c Treatment, whether it comprises behaviour control, individual or group therapy, drugs or electroshock, is administered to individuals who are assumed to be ill with the aim of alleviating symptoms.

2.5.4 The Societal Reaction Model

This social model emphasises the communal nature of madness, and views the mentally ill as victims of external forces which lead them to the mental hospital.

The Societal Reaction Model is a relatively recent set of ideas proposed mainly by sociologists. A central feature of this model is the shift of attention from individuals to the social group. There is a shift from individuals who allegedly have a mental illness to the social group that is believed to create mental illness via the application of social rules of conduct in judging what comprises "normal behaviour".

According to this model, many behaviors viewed as mental illness by current medical and lay views, are actually reactions to labelling in an attempt to cope with their situation.

Thus, persons called mentally ill are not seen as patients, but as victims. They are victims of situational contingencies such that in one case an act of rule breaking will be transformed into a psychiatric symptom, whereas in

another case the very same act may be ignored or dealt with in other than a psychiatric framework. They are victims of their vulnerable status in society which makes them less able to defend against more powerful family members or heavily credentialed experts whose job it is to pass judgement on the mental health of others. In addition, they are victims of their own humanness, which makes them responsive to the judgements of significant others whereby they take the view of others and internalize them as their own. In short, the social role of mental illness can be created by collective judgements, imposed upon those who are socially vulnerable, and voluntarily adopted by persons as a defensive strategy. The end result is not a patient with a disease, but a victim of a socially constructed reality (Perucci, 1974, pp.17-18).

2.5.5 Models Applied To The Mental Hospital

According to both the Medical and Behavioural models, the reasons for hospitalisation are two-fold. In the first instance, hospitalisation alleviates the stresses and demands of "normal", daily living. Obligations (in various social roles) are thus temporarily suspended. This, in turn, is believed to eliminate a source of the illness or demands that may impede the therapeutic process. Secondly, it is assumed that hospitalisation facilitates the administration, monitoring and evaluation of treatment. The Societal Reaction Model, on the other hand, offers markedly different reasons for hospitalisation. Firstly, it views hospitalisation as an extension of the initial act of defining a person "outside" of the normal role boundaries of the family. Since society approves of the family's right to usurp ("define away") the rights of its members, it thus accepts responsibility for excluding the deviant from "normal" social life. Secondly, hospitalisation may be seen as an attempt to "stabilize the deviant role and reinforce the deviant identity of the victim" (Perucci, 1974, p.18).

This paper adopts the general view that madness is a "communal affair". The remaining chapters concern the way in which life in the mental hospital, for both patients and staff, is affected by the communal nature of madness.

CHAPTER 3 : ADAPTATION TO THE MENTAL INSTITUTION

This chapter will examine some of the organisational problems unique to the mental hospital. A few of the characteristics that mental hospitals share with other organisations are also considered. Special attention is given to the influence of the external environment (i.e. society) and treatment technology upon the internal structure and processes of life inside the hospital.

3.1 The Mental Hospital As Social Organisation

Perucci (1974) describes the mental hospital as 'that social organization in which society places persons who are defined as being mentally ill' (p.21). A close working relationship is fostered between the hospital, the community, and the family. This liaison is supposedly designed to facilitate a speedy discharge of the patient from hospital.

According to Perucci (1974), statements which describe the official goals of a mental hospital incorporate three features:

First there is the nature of the relationship that exists between the community and the hospital, and the steps that are being taken to ensure community cooperation and support. Second, there is the internal structure of the hospital in terms of the distribution of authority and responsibility. The third feature is the particular treatment technology that is being used to change patients, and hopefully, to effect their early release from the hospital (p.22).

Knowledge of these three central features of mental hospitals can serve to facilitate an understanding of the daily lives of patients and staff alike. These elements are, however, in a perpetual state of flux, 'reflecting shifting definitions of mental illness, the changing

power of hospitals vis-a-vis the larger society, and the availability of new ideas about hospital organization and procedures' (Perucci, 1974, p.22).

The mental hospital may thus be viewed as a 'historically evolving social organization which is constantly attempting both to adapt and to control its internal and external environment' (Perucci, 1974, p.22).

3.2 Organisation and Environment : Power and Autonomy

It is clear that every organisation exists within a particular social and cultural context. This social and cultural environment is to a greater or lesser degree supportive of, and conducive to, the existence of the organisation. Thus, social values, legal institutions, and class structure create conducive or unconducive climates for an organisation. Similarly, every organisation attempts to exercise influence and control over its external environment in order to facilitate the pursuit of organisational goals. In a general sense, the relationship between organisation and environment concerns the nature of and control over the "inputs" needed for effective (organisational) functioning, such as money, raw materials, workers, physical activities, and "outputs", whether consumer goods or "cured" ex-patients.

It follows then, that favourable reception of "output" will provide a favourable position for obtaining "inputs", thereby ensuring continued existence of the organisation. There is thus a balance of power between an organisation and its environment. This balance, however, is never really fixed. Rather, it continually shifts in a manner that reflects an organisation's relative adaptation to its environment.

Since an environment is perpetually changing, so must an organisation. Unless the latter changes in response to the environment, it may possibly face extinction.

Szasz (1987) regards the psychiatrist and the mental patient as adversaries, and comments on the nature of the power relationship between the two. He offers an important insight with respect to this 'legitimate' power:

An important feature of legitimate power is that its very existence induces people to submit to it voluntarily - that is, because they believe that the behaviour prescribed is right or because they fear punishment for deviating from it... This is why the standard psychiatric argument that since only a minority of the persons in mental hospitals is detained involuntarily, involuntary mental hospitalization is not an important issue, is specious and unpersuasive. Actually, so long as incarceration in a mental hospital is a legally legitimate and socially approved procedure, we cannot meaningfully speak of anyone entering or remaining in a mental hospital voluntarily. We must keep this always in mind when we consider the controversy concerning commitment and other coerced psychiatric interventions (Szasz, 1987, pp. 129-130).

If one views the mental hospital historically, it becomes apparent that there are periods of relative autonomy and power in relation to the larger society (with respect to both "inputs" and "outputs" of the hospital).

Both Foucault and Rothman suggest that mental hospitals exercised considerable control over all the activities when they first emerged (Foucault and Rothman cited in Perucci, 1974, pp 23-24). It is believed that during the nineteenth century, medical superintendents in the United States had sufficient influence with state legislatures to enable them to exercise autonomy with regard to design, cost, location, and internal structure of asylums. They also determined entrance of patients into the hospital (admission), visitation and release of patients back into society (discharge).

Professional staff thus exercised considerable power and autonomy in the early nineteenth century. There was, however, a reversed trend towards the end of the nineteenth century. This process is partly attributable to two problems faced by the mental hospital and medical superintendents. Firstly, state legislatures became concerned about rising costs incurred for construction and maintenance of asylums, and thus began to reduce appropriations. Secondly, criticism regarding success of these new institutions in "curing" the mentally ill came from medical professionals outside the asylum (including neurologists, research psychiatrists, and psychiatrists in private practice).

This decline in power and autonomy of the medical superintendents resulted in a loss of control over determining who should enter the hospital (admissions), and the type of patients to be admitted. Local officials and non-hospital professionals were now allowed to make such decisions. For the first time, mental hospitals were forced to admit chronic cases in addition to those patients who had a high potential for recovery (good prognosis).

This loss of control over "input" which began in the late nineteenth century, continues to be reflected in current hospital - society relationships. Currently, there are many different routes of admission (referral procedures). These include emergency admissions, made on the evaluation of a single physician, admissions made on the evaluation of more than one physician, temporary or long-term commitment (admissions) made with or without court-appointed lawyers, etc. In the case of these involuntary admissions, the decision is made by persons and/or bodies outside the institution. Another major form of commitment is "voluntary admission". The latter also reduces the hospital's control

in that the hospital cannot hold the patient against his or her will. If the need arises for a change in status of admission (from voluntary to involuntary), then the hospital has to apply for initiation of such a process via an external body.

In spite of diminished control of psychiatrists with regard to admission of persons to hospital, they do, however, have considerable autonomy over life inside the hospital. This social structure of the mental hospital will be discussed further in the next section.

3.3 Hospital Structure (See Appendix I)

The mental hospital represents a well-organised bureaucratic structure with the superintendent at the apex. This structure is divided into two hierarchies - clinical (medical) and business (administrative). The clinical hierarchy is further subdivided into organised services and wards on a functional basis. Each of these services and wards reflects the patients' stage and clinical needs. Positions within this hierarchical structure are clearly demarcated with little internal mobility. Spatial separation, occupational separation, prescribed (and proscribed) activities, etc. all serve to maintain the "caste-type" structure. This feature of the hospital structure is difficult to reconcile with therapeutic goals.

A second feature of the hospital which has implications for internal structure is the fact that caregivers (staff members) share some of the stigma placed on patients by society. This shared stigmatisation of staff, in turn, could have implications not only for the issue of authority, but also for bureaucratic and therapeutic functioning/effectiveness.

A third feature of the hospital with implications for internal structure is that its "raw materials" are human beings who are active participants in their own transformation (Etzioni cited in Perucci, 1974, p.27).

It is thus inevitable that patients in such a situation will have difficulty reconciling the needs of the bureaucratic, caste-like structure with the behaviour of a normal, active person.

3.4 Technology and Treatment Goals

Organisational Theory discussed earlier provides a general hypothesis to explain:

- a why mental hospitals have diminished power in relation to society, and
- b why hospital structure, staff, and goals appear to be relatively unsuccessful in the treatment of mental illness.

Perrow asserts that unsuccessful change in the structure and goals of a mental hospital requires a change in technology. (Perrow cited in Perucci, 1974, p.28).

He further asserts that mental hospitals lack the treatment technology suited to the large number of patients they house. In Perrow's view, "milieu therapy", often described by staff as a treatment technique, is not a new technology, but rather a "humanizing influence".

Perucci's extension of the logic of the technology hypothesis leads to the following interpretations:

First, the limited power and autonomy of the hospital to determine its "inputs" (i.e., patients) is a result of its inability to demonstrate to society that it can "cure" mental patients. Power and autonomy flow from ability to produce a marketable product, in this case a "cured" patient whom society is once again willing to accept. When and if the hospital has a technology that produces such a product, it will have more influence than it now commands. Second, the stigma attached to hospital medical staff and their marginal status within both the hospital and their profession are also results of their inability to demonstrate competence and expertise in their work (Perucci, 1974, p.29).

Whilst he believes that the technology hypothesis is useful for understanding the internal structure of the hospital in terms of authority and power relations, he also cautions against overstating the influence of technology.

Perucci provides a central criticism of the technology hypothesis and proposes an alternative view of mental hospitals.

According to him, if one argues that an effective treatment technology is required to produce changes in hospital structure and goals, then one basically assumes that patients have something called a mental illness and require a specific treatment in order to get "better" or cured. It is thus assumed that the medical model (discussed earlier), best explains why people are committed to mental hospitals. If, however, one adopts the view of the societal reaction model (as discussed earlier) for commitment to hospital, then there is little connection between effective treatment technology, treatment received, and chances of release or discharge from hospital. It follows then that if one is in hospital as a result of rejection by society, then the chances of returning to society are slim. It would seem, in this case, as if the purpose of the mental hospital is to ensure that one does not return to society.

3.5 The Mentally Ill : Patients or Victims ?

Szasz (1987), in discussing the social anatomy of mental illness, draws a parallel between crime and mental illness. In both instances, there is an 'offender, a victim, and a social authority with legitimacy to validate or invalidate the complaint and with power to coerce the offender' (p.113).

The parallels between crime and mental illness could thus hardly be more perfect. In each case: (1) claimants advance conflicting claims concerning each other and themselves; (2) representatives of social authority judge the validity of the conflicting claims and decide in favour of one or other party; (3) the person adjudicated as properly accused (of crime or mental illness) is detained for further investigation (trial, mental examination); (4) if the accused is confirmed in the suspected role (guilty, psychotic), he is incarcerated (in prison or mental hospital). As a rule, the person imprisoned or hospitalized in a mental institution is the individual accused of crime or mental illness... However, the situation of the prison inmate and mental hospital inmate differ in the ways in which complaints against them are perceived and adjudicated. Briefly put, Americans see merit in the principle that a person accused of crime should be considered innocent until proven guilty... In the case of the person accused of mental illness, Americans see merit in exactly the opposite principle: namely that such a person should be considered mentally sick until proven otherwise, and that it is better to hospitalize a thousand persons who do not need treatment than to deprive a single person of the treatment he needs for his mental illness (Szasz, 1987, p.115).

Perucci asserts that in order to understand the way a mental hospital is organised and the way it operates, one needs an understanding of why people are hospitalised in the first place. He adopts the societal reaction model to facilitate such an understanding.

According to Perucci, this model views patients as victims of their social networks.

They are victims of families and communities who can no longer tolerate rule-breaking and problematic behaviour. They are victims of poverty, powerlessness, and discrimination and the resulting individual-psychological explanations for their plight as people with a mental illness. They, moreover, are often willing victims insofar as they accept and adopt the roles of madness in order to "solve" the problems of living

which they are experiencing. In short, they are not in the hospital because they are mad, but because they have been rejected by society and have no suitable place in it (Perucci, 1974, p.30).

The view of mental patients as victims is difficult to accept by individuals and families responsible for commitment, and by society that permits this. In order to cope, individual and collective defence mechanisms are employed.

An example of an individual defence mechanism is 'the belief that mental illness is a disease' (Perucci, 1974, p.31). This belief makes it less difficult for people to have a family member institutionalised.

An example of a collective defence mechanism, on the other hand, is:

the existence of a mental hospital as a social organization, which reinforces the belief in mental illness and espouses the noble goal of treatment and return of people to society, but which, in fact, functions in large part as a dumping ground for societal rejects (Perucci, 1974, p.31).

It is thus apparent that the purpose of the asylum is that of 'isolating the deviant person from his neighbours at the request of his neighbours regardless of the rationale given for the cause of such strangeness by the society'. (Magaro et al., 1978, p.142).

In summary, changes in both medical and social models were embraced in the hope of reversing the trend of increased hospitalisation of mental patients. Symptomatology was markedly reduced by the use of new medications, thus eliminating the need for physical restraint. At the same time, the patient's social environment (values, roles and social structures) were recognised as contributing factors in the formation and management of

symptoms. The sociological perspective, furthermore, provided a useful framework for the formulation of administrative policies which had since emphasised a positive bias towards discharge, a shorter period of hospitalisation and minimising iatrogenic conditions, that is, side-effects caused by treatment. (Magaro et al., 1978, pp.142-143).

The above perspective on mental illness and mental hospitals serves to illuminate some of the features of hospital organisation discussed earlier.

The sections which follow entail more detailed examinations of some of the themes, hypotheses, and processes which have been elicited thus far.

3.6 Patient Adaptations

It is assumed that the loss of freedom as a result of hospitalisation leads to certain strains, and the consequent emergence of normative patterns as a response. According to Perucci (1974), the patient world can be considered a world of 'unfreedom'. Almost every aspect of life for the patient is subject to scrutiny, comment, or control by others. In many respects, the mental hospital resembles the prison. Erving Goffman (1961) regards both as 'total institutions', a concept that reflects Perucci's description 'unfreedom'. Goffman, however, considers an additional element. He asserts that in both institutions, there is a conscious attempt to destroy the patient's self that existed prior to institutionalisation. Since it is assumed that this self that existed prior to hospitalisation is in some way responsible for the patient's present condition, it follows that the old self must be destroyed, and a new self incorporated through a process of resocialisation.

Goffman (1961) differentiates between primary and secondary adjustments. Both of these, he claims, are 'matters of social definition' (p.176).

Primary adjustments are characterised by their contribution to institutional stability. Thus, 'the participant who adapts to the organization in this way is likely to keep on participating as long as the organization wants him to' (Goffman, 1961, p.180).

Secondary adjustments, on the other hand, can be divided into two types - 'disruptive' and 'contained' ones. In the case of the former, 'the realistic intentions of the participants are to abandon the organization or radically alter its structure' (Ibid.,p.180). This, in turn, leads to a breakdown in organizational functioning. The opposite holds true for 'contained' adjustments, where patients elect to fit into institutional structures without changing them. Goffman (1961), furthermore, makes two important comments regarding patient adaptations. Firstly, everything a patient is caused to do can be described as part of his treatment or custodial management; (whilst) everything a patient does on his own can be defined as symptomatic of his disorder or of his convalescence' (p.186). Secondly, 'a patient who settles down in the hospital, making a good thing of it, may be felt not to be abusing a place of treatment but to be really still ill' (Goffman, 1961, p.186).

3.7 Patient Adjustments

This section describes four typical adjustments which patients make to their social environment. The four adjustments according to Perucci (1974), are withdrawal, accommodation, conversion, and resistance.

3.7.1 Withdrawal

Withdrawal essentially involves a flight from the situation. Patients in this category are almost entirely asocial. They neither initiate interaction with others, nor respond to interaction directed at them. These patients are not necessarily psychologically withdrawn. While they isolate themselves from patients and staff, they remain cooperative with respect to hospital and ward rules. Their compliance is, further, not related to any expectation of special privileges.

3.7.2 Accommodation

Accommodation is found with patients who accommodate both staff and other patients. They thus conform to the expectations of both. This usually involves a moderately active patient. Although they initiate little interaction, they make 'good listeners'. These patients neither attack nor defend things said to them by patients or staff. They tend to be supportive in their relations with others.

3.7.3 Conversion

Conversion is found with patients who display a strong identification with the staff. They imitate the staff in much of their behaviour. These patients will "bend over backwards" to help staff members on the ward. There is thus a relatively marked amount of contact between these patients and staff members. The latter, however, have ambivalent feelings about this. On the one hand, they appreciate their support, but at the same time they resent "status advances" made by these patients. Many patients are (understandably) hostile towards conversion patients.

3.7.4 Resistance

Resistance includes a broad spectrum of behaviour, ranging from a "questioning of the shortcomings of hospital procedures and facilities to an outright rejection of the authority, motives, and competence of ward staff personnel." (Perucci, 1974, p.64).

Resistant patients are particularly concerned with preserving their self-respect and dignity. They thus resist all efforts to categorise them as patients. Although they comply with formal ward rules, they view them as artificially imposed and in need of change.

Resistant patients also tend to maintain clear boundaries between themselves and ward staff.

It becomes clear at this point that the act of patients' going 'absent without leave' may be viewed on some level as yet another adjustment to their condition of 'unfreedom'.

Another interesting phenomenon has been observed among patients who have been hospitalised. Russel Barton (1966) provided a systematic presentation of marked mental changes that may result from institutional life. He confined his attention to material available to him in mental hospitals, where, unfortunately, there was a tendency to assume that these mental changes were the result of mental illness. Barton labelled this condition "Institutional Neurosis" and likened it to "a mental bed-sore" (Barton, 1966, p.7). These mental changes, he believed, resulted from factors other than the patients' original presenting problem(s). The concept of "Institutional Neurosis" will be discussed further in the next section.

3.8 Institutional Neurosis

According to Barton (1966), institutional neurosis is a disease which is characterised by apathy, lack of initiative, loss of interest (especially in things of an impersonal nature), submissiveness, apparent inability to make plans for the future, lack of individuality, and sometimes also a characteristic posture and gait.

A number of differential diagnoses exist for this condition. Institutional neurosis may coexist with features of Schizophrenia such as delusions and hallucinations. Distinction from the later stages of Schizophrenia can sometimes be made by observing the response to treatment.

Depression has common symptoms, but the gloominess, sadness, and guilt are absent in the case of Institutional Neurosis. Organic Dementias may be complicated by the disorder. In this case rehabilitation is necessary to decide which symptoms are attributable to what. Myxoedema may be recognised by symptoms such as hair loss, croaking voice, constipation, and raised serum cholesterol. The Posture and gait must be distinguished from that of Parkinsonism, especially that due to reserpine and chlorpromazine (anti-psychotic medication).

Barton (1966) asserts that after two years in a mental hospital, most patients suffer from two illnesses, namely, Schizophrenia and Institutional Neurosis.

According to him, Institutional Neurosis should be considered a disease in its own right for the following reasons:

1. It occurs in institutions whether mental hospitals or otherwise, e.g., prisoner-of-war camps, orphanages, prisons, tuberculosis sanatoria, displaced persons camps.
2. It can hardly be argued that mental illness, regardless of its type, produces an end state similar to institutionalization.
3. Rehabilitation resolves these symptoms.
4. Hospitals run by a staff aware of the neurosis are ceasing to produce it.
5. A schizophrenic whose relations are prepared to look after him in his own home does not deteriorate or regress to the same extent as the schizophrenic in the mental hospital, particularly if he is kept in a large ward. (p.62).

The aetiology of the disease is uncertain. There are a number of probable causes including:

1. Loss of contact with the outside world.
2. Enforced idleness and loss of responsibility.
3. Bossiness of medical and nursing staff.
4. Loss of personal friends, possessions, and personal events.
5. Drugs.
6. Ward atmosphere.
7. Loss of prospects outside the institution. (Barton, 1966, p.63).

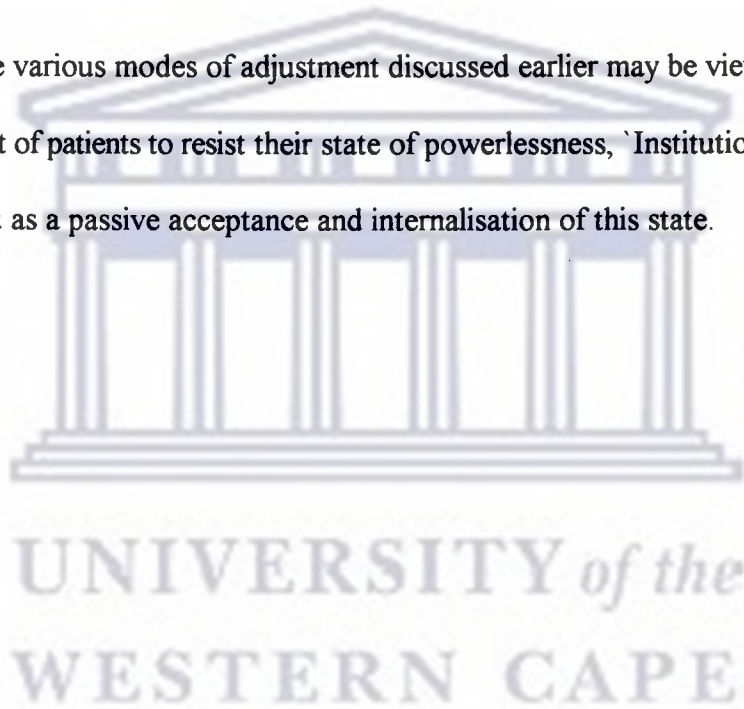
In terms of prognosis, whilst the schizophrenic episode or depression may clear up, institutional neurosis will generally persist for the duration of the patient's hospitalisation.

The treatment for this condition follows from its aetiology. Each of the aetiological factors as outlined above are targeted respectively with a view to eliminating symptoms.

The main thrust of treatment is to re-establish contact with the family and community and to facilitate both social and occupational reintegration of patients. Encouraging patients to participate in activities, allowing friends and relatives to visit, altering the attitudes of staff (if necessary), reducing medication where possible and producing a friendly, permissive ward atmosphere are all considered essential aspects of the rehabilitation process.

It is clear from this chapter that hospitalisation does not provide patients with freedom from the stress and strain of daily life. Instead, patients continue to experience certain demands in relation to their state of relative powerlessness. In addition to providing a general review of adaptation to the mental institution, the chapter has also described the phenomenon of 'Institutional Neurosis', a condition which develops as a result of institutionalisation.

Whilst the various modes of adjustment discussed earlier may be viewed as an attempt on the part of patients to resist their state of powerlessness, 'Institutional Neurosis' may be viewed as a passive acceptance and internalisation of this state.



CHAPTER 4 : THE RELEASE PROCESS

If, as suggested earlier, the main purpose of mental hospitals is to provide custody for society's rejects rather than return patients to society, then it is likely that both patients and staff will find ways to accommodate to that fact. This chapter will be concerned firstly with the patient's conception of what constitutes the release process, and secondly, with some of the ways in which staff view this process.

Many patients, during their present and past hospitalisations, have been exposed to one or more of the various therapies available in psychiatric practice. Given the amount of treatment already received by many patients, not much more can be provided in the way of a therapeutic programme. The responsibility for getting 'well' would thus seem to rest on the patient. The latter has to utilise his own resources in order to estimate progress. In this regard, patients become sensitive to subtle nuances of staff behaviour which they interpret as important signs of their therapeutic position. In this situation, we find the emergence of a 'release ideology', that is, 'a collection of beliefs referring to available means of obtaining a release from the hospital.' (Perucci, 1974, p.117).

4.1 Release Ideology

In constructing a 'release ideology', patients tend to view previously discharged patients as role models. They attempt to emulate these role models in an attempt to obtain release from hospital. More specifically, they interpret the by-products of the recovery process (for example, coming off medication, becoming a patient leader, and maintaining good relations with staff) as 'things to be done in order to get better' (Perucci, 1974, p.119).

This 'release ideology' thus allows patients to maintain the belief that there is a way to 'get better' and be released from hospital.

4.2 Release Criteria

The mental hospital does not have clear, objective standards for evaluating its "product".

A particular problem faced by hospital staff is that of judging the relative "wellness" of a patient who requests a release from hospital.

Are the standards used relevant to the patient in the hospital setting, or in the larger society as well? That is, is the patient who "gets on" well according to hospital standards the patient who will "fall apart" in the outside world? or is the particular patient who develops a bit of an "institutional neurosis" the one who "makes it" in the larger society? (Perucci, 1974, p.136).

These are, no doubt, pertinent questions that those considering the granting of leave or discharges are faced with. It is clear that certain ground rules need to be established in this regard.

This section concerns itself with these ground rules as suggested by Perucci (1974). It will attempt to describe the functions of disposition staff, as well as the process and meaning of approaching staff with a request for discharge.

4.2.1 Disposition Staff

Disposition staff comprise all the physicians having ward responsibilities within a particular treatment service in the hospital. Staff meet with patients on a weekly basis.

These meetings are attended by the ward physicians, psychologist, social worker, and

some nursing staff. Although there is participation from the nonmedical staff, it is the medical staff who are responsible for the final decision-making process.

Disposition staff are thus responsible for granting or denying patients requests for leaves of absence, convalescent leaves, work placements, and discharges. Seeking leave usually comes from the patient, the social worker, or the family. No matter who initiates the process, the formal request generally comes from the family. The formal request thus primarily serves to indicate that the family wishes to have the patient home, and is prepared to care for the patient at home. With a request for discharge, however, proceedings are generally initiated by the patient or ward doctor.

Once the patient becomes aware of the fact that (s)he will be meeting with staff, a preparation phase begins. According to Perucci (1974), this preparation is an attempt by the patient 'to present her best "self" to the staff' (p.138).

4.2.2 Staff Meetings

At Lentegeur Hospital, staff meetings take place in a room (usually the same room in which ward rounds occur). Several chairs are arranged along the walls, in a circle of sorts. The chairs are occupied by the attending physicians, psychologists, social worker, nursing staff, and, sometimes, the priest. A chair is also reserved for the patient. Staff are furnished with record folders for each of the patients to be interviewed that day. Patients wait in the lounge area before being called into the meeting individually. Because all patients on the staff list assemble at the same time, some may have to wait for as long as two or three hours before being interviewed. Thereafter, the patient

returns to ward activities and awaits feedback from the ward doctor concerning the staff's decision.

The decision to grant leave is generally considered less serious than that of discharge for several reasons. Firstly, granting of leave does not imply that the patient is fully recovered, or ready to resume life in the larger society. Secondly, leave is granted with the understanding that significant others will substitute the role of the hospital in providing continued supervision and patient care. Responsibility is thus shifted from the hospital to the family (or significant others) for the duration of leave. A third and important aspect of leave is that the request comes from outside the system. Staff members thus run no risk of 'laying (themselves) on the line' by requesting a patient's leave.

The staff decision is much more pronounced on the issue of discharge. Such a decision serves to verify both the condition of the patient and the effectiveness of the treatment programme. It, in a way, guarantees society that the patient is ready to 'fit in'.

Discharge requests often provoke disagreement among staff members. This is understandable in view of the consequences of errors in judgement.

4.2.3 A Need For Structure In The Decision-Making Process

Staff clearly need to operate within some framework which lends structure to the decision-making process. These standards must, furthermore, have some credibility. In an attempt to answer the pertinent question, namely, 'Is the patient well enough to leave

the hospital?', staff apply both 'relevant knowledge' and '"masking beliefs"' (Perucci, 1974, p.150).

Additional sources from which structure emerges are:

- (1) the potential complexity of the decision - i.e., how much additional work or problems the decision will generate and (2) the strength of the resistance to, or support for, the request by an individual or group in the hospital. (Perucci, 1974, p.150).

Often, the decision is shaped in terms of its 'conformability to external conditions'. The behaviour and mental status of the patient, however, remain an important criterion. The main purpose of this staff interview is to elicit the pathology of the unwell patient. The '"unwell"' patient will thus remain in hospital while the '"well"' patient will be discharged.

Perucci (1974), however, suggests an alternative hypothesis; namely that 'under certain limited conditions, the relatively "unwell" patient (as measured by performance at staff) will be more likely to get a discharge than the relatively "well" patient.' (p.152). The explanation for this 'organizational paradox' follows below.

4.3 Discharge : An 'Organizational Paradox'

Attending a staff meeting to decide upon discharge is a situation that can produce considerable anxiety for both patients and staff alike. Patients are expected to present their "best self" in order to ensure a favourable decision from the staff. This anticipatory anxiety often serves to undermine the patient's performance. Physicians are expected to make decisions with considerable implications for patients, the hospital, and the community. In exercising their "quality control" function, physicians must base their

situation may substantiate or qualify his decision by drawing on two sources. The first source is the external structure mentioned earlier. Here the decision was influenced by factors such as the amount of staff support for the decision, the legal complications, the extent of family pressure, and so forth. In the absence of external structure, however, the physician has to rely on his own resources. Essentially, he must utilise his knowledge of the dynamics of pathology, and apply his clinical skills to make a decision regarding discharge. Staff physicians thus depend upon an available series of questions which are designed to elicit pertinent information from the patient so as to facilitate appropriate decision-making. An interesting aspect of this questioning process is that staff actually depend on patients to indicate whether or not they are well enough to be discharged. Decisions are based upon an analysis of the patient's responses. It thus seems that all the physician has to work with are his own questions, and the responses of the patient to these questions. In this situation where the physician must rely upon his own resources, Perucci applies the hypothesis that the relatively "unwell" patient is more likely to get a discharge than the relatively "well" patient.

His rationale is that during the questioning process, the "unwell" patient will provide structure with his responses. The "well" patient, on the other hand, only increases the anxiety of the staff.

According to Perucci, the relatively "unwell" patient, when confronted with the standard questions of the physicians, will provide some "pathological content" in his answers. This "pathological content" provides staff members with a "foothold", thus allowing them to exercise their "quality control" function. The anxiety that is inherent in the

discussion presented, criteria identified were related to matters such as 'the source of and support for the release request, the locus of responsibility for "errors" in staff decisions, and the degree of anxiety generated by staff's inability to find criteria within the staffing situation itself.' (Perucci, 1974, p.159). In each of these cases, the criteria seem to be relatively unrelated to the salient issue, namely, the degree of illness of the patient. Instead, these criteria are closely related to certain social conditions. This phenomenon, once again, indicates that psychiatric decisions (in this case pertaining to release from hospital) are made within a social context rather than a social vacuum.



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CHAPTER 5 : REVIEW OF PREVIOUS STUDIES

The literature review up to this point, has covered a broad spectrum of issues including, historical perspectives, the growth of the asylum, theories of causation, adaptation to the mental institution, and aspects of the release process. The following section will review some of the findings of previous studies, including some relevant definitions.

5.1 Some Definitions

ELOPEMENT has been defined as an inpatient's running away from hospital without proper authorisation.

ABSCONDMENT has been defined as an inpatient's leaving the hospital grounds without permission and/or without notifying a staff member of his/her intention to do so.

It also refers to a patient not returning from leave at the appropriate time.

It follows that both elopement and abscondment are phenomena which involve being ABSENT WITHOUT LEAVE (AWOL).

Leaving the hospital AGAINST MEDICAL ADVICE (AMA) ordinarily requires the patient to confront the staff with his/her wish to leave and to sign papers to that effect.

Before (s)he is permitted to depart, (s)he must wait a variable period during which the staff attempt to persuade the patient to stay. The patient must exhibit open communication and a capacity to tolerate confrontation and delay goal gratification.

It may be that the patient who goes AMA will have a significantly higher number of unauthorised absences from the hospital. This becomes increasingly significant when one considers that in many instances the number of unauthorised absences will have the effect of leaving against medical advice.

Absence without leave, as defined here, thus accounts for only a proportion of those patients who leave hospital treatment prematurely.

For the purpose of this study, patients discharged against medical advice will be excluded.

5.2 Previous Studies

Whilst the phenomenon of AMA has been researched fairly extensively, little research has been conducted with regard to AWOL. Certain findings pertaining to AMA may, however, shed some light on the AWOL process.

STEINGLAS et al. (1980) reported findings from a prospective study. Data from a brief structured interview of patients at the time of admission were used to predict subsequent AMA behaviour with an 80% accuracy. Critical variables were related to the "treatment contract" as the patient perceived it. It was found that AMA patients had never intended to stay in hospital for longer than a few days. They view the hospital as a temporary "way station", rather than a treatment resource which could help them deal with psychological and practical life problems. It would thus be erroneous to assume that the patient's willingness to sign a voluntary admission form always reflects an interest in

receiving treatment. It would also not be realistic to assume that an agreement to hospitalisation implied a request for ongoing psychological treatment and pharmacotherapy. One conclusion from the study was that such patients should be allowed to use hospitalisation a temporary relief from stressors in their life, and that it should not be expected of them to accept psychiatric treatment. An alternative view was that such identification of potential AMA patients at the time of admission could be used to tailor a short-term hospitalisation program which is in keeping with the patients needs.

STUEN and SOLBERG (1970) compared AMA patients with those leaving with maximum hospital benefit on the basis of 37 demographic and treatment variables. The study attempted to identify those characteristics which would distinguish between the two groups. It was found that the patient who went AMA stayed in hospital for a shorter period of time, was more aggressive than the average patient, less cooperative and less involved in the treatment program. There was also a likelihood of alcohol as part of the problem. Repeated hospitalisations coupled with repeated unauthorised absences were a common feature. The staff generally felt that the patient could have benefited from additional treatment. The study suggested that a significant number of patients who went AMA derived no lasting benefit from their hospital experience.

GREENWALD and BARTEMEIER (1963) explored some factors associated with premature discharge from a private psychiatric hospital. Two groups of patients were contrasted, namely, those discharged against medical advice (AMA), and those discharged with medical advice (WMA). In addition, the rate of AMA discharges was also compared with ratings of the therapeutic effectiveness of the resident staff. It was

found that patients discharged AMA averaged one-third less time in hospital and twice as many prior hospitalisations as those discharged with medical advice. More sociopathic diagnoses were found among the AMA group, but no other significant diagnostic differences were noted. Their hypothesis that rate of AMA discharges varies inversely with the therapeutic effectiveness of the resident was confirmed.

DANIELS et al. (1963) undertook a two-year study in the hope that the information and understanding pertaining to the origins and outcome of patients leaving AMA would suggest administrative policies and therapeutic techniques that would be effective in decreasing the rate of such discharges. For the purpose of their study, AMA included patients who had presented a formal request to their doctor or the hospital administration as well as patients who eloped or ran away. It was found that most patients who had left AMA were acutely disturbed and had been admitted under emergency conditions. Their stays were brief and turbulent. The presenting symptoms in most of these cases had been marked anxiety, motor agitation, delusions and hallucinations (frequently involving persecution), and somatic complaints. In the majority of cases, psychiatric evaluation revealed isolation of thought and affect, lack of insight, lack of motivation, and an inability to communicate effectively. The immediate crisis precipitating the patient's departure was found to be influenced by many factors. The most important of these factors were summarised in 4 broad categories, namely, inadequate preparation and referral of patients and/or their families; threatening aspects of the ward environment; difficulties in the patient-therapist and/or therapist-supervisor relationship; and interference from family members. The most important single factor in patients leaving AMA was found to be the preparation and referral process.

MEYER et al. (1967) investigated the incidence, dynamics and consequences of elopement behaviour over a two-year period (between January 1, 1962 and December 31, 1963) with the ultimate goal of formulating policies and devising techniques to control its incidence. During this period, 42 individuals accounted for 124 elopements. Elopers were found to be considerably younger than non-elopers on the ward. They were typically young adults or late adolescents of either sex. No differences were found between eloping patients and other patients with regards to sex, religion, race, or socioeconomic status. Elopers were hospitalised longer (a mean of 68.21 days) than controls (a mean of 40.12 days). There was also a tendency for the former to abscond more frequently as the duration of their hospitalisation increased. A higher incidence of psychotic disorders and a lower incidence of non-psychotic disorders (neuroses, character disorders, and situational reactions) was revealed. The results of categorising elopements according to primary precipitating factors revealed that internal factors had predominated in 55% of patients; ward-patient conflicts accounted for 25%; therapist-patient relationships for 11%; and outside interfering factors for 4% of cases. These were not found to be mutually exclusive since elopement behaviour is complex and multifactorial.

GYNTHER et al. (1963) compared attitudes of patients of markedly different educational and socioeconomic levels toward treatment, psychiatrists and hospitals. They also looked at the relationship between attitudes and various demographic variables such as marital status, age, sex and race in a public hospital sample. A Multiple Choice Attitudes Questionnaire was administered to 121 patients shortly after admission to Malcolm Bliss Mental Health Centre and later readministered to 65 of the same patients.

On average, there were 25 days between test and retest. Data was also available on 187 patients tested shortly after admission to the Institute of Living. No significant differences were found between the private and public hospital samples with regard to initial scores. The test-retest analysis of data obtained from the public hospital sample revealed no significant changes in attitude over time. It was found from the Malcolm Bliss sample that readmissions had more favourable attitudes than first admissions, and that married patients had more positive feelings about treatment, psychiatrists and hospitals than do those who are not married. Furthermore, older patients tended to have more positive perceptions of the psychiatric milieu than younger patients.

JONES et al. (1963) conducted a study that was directed toward the development of a method for describing a reliable consensus of patients' attitudes toward aspects of mental illness, hospitalisation and treatment. Fifty-seven items from a questionnaire were administered to the total population (62 patients) of a small psychiatric hospital. These items met the criterion for high reliability and low variance. The statements were clustered into groups of attitudes and interpretations were made regarding consensus of the patient population in the following areas: conception of illness, stigma of hospitalisation or illness, conceptions of hospitalisation and treatment, patient's view of staff role and interest, expectation of control, attitude toward hospital activities, and length of stay. It was found that in a number of attitude dimensions, patients' consensus reflected the actuality of the hospital in respect to length of stay, a therapeutic community approach, and psychological orientation. These attitudes seemed to reflect that patients generally accepted the values and goals of the hospital. It was believed that patient attitudes on these dimensions might have differed considerably from hospital to

hospital depending on a particular hospital's orientation. In other areas patients seemed to have had less opportunity to develop attitudes about the hospital model. It was believed that attitudes held regarding stigmatisation were more likely formed prior to hospitalisation. The "psychological mindedness" of this patient population might have been linked to the public education campaigns about mental illness which were widespread at the time. The study offered a promising procedure for describing patients' views and for comparing patients' attitudes with the hospital goals.

ANTEBI (1967), in an attempt to identify some characteristics of mental hospital absconders, conducted a survey of 166 patients who absconded 284 times from All Saint's Hospital (Birmingham) over a 12-month period. Different aspects such as diagnosis, legal status, age, criminal record, monthly incidence, the pattern of visits to patients prior to absconding, and the periods at large of these occurrences were studied in detail. These results were discussed mainly with reference to the significantly high percentage of male absconders (39%) with a criminal record. Alternative future management and facilities for these patients were also outlined. Antebi posits that the motivation for absconding is multi-factorial. He suggested three major variables worthy of consideration in undertaking a study of this nature: 1) the Community, 2) the Institution, and 3) the Patient.

Moreover, he suggested that the interaction between these factors will be important in the prediction of the patient's behaviour. It is believed that a study of the inter-relation of the patient and the community, as well as that between the patient and the hospital, might well shed more light on the absconder's motivation. Other obscure factors, such

as tensions occurring within the patient resulting from his/her personality, particular illness, and conflicts, may affect his/her behaviour unpredictably. These tensions may resolve themselves when the patient absconds. In addition, geographical factors, distances, mechanical barriers, and financial aspects were taken into account in evaluation of abscondence, since it was felt that the resultant of all these factors would determine whether the patient is likely to abscond or not.

Although a number of studies have been conducted of irregular discharges over the past few decades, none have compared AMA and AWOL groups from the same hospital caseload.

ATKINSON in his 1971 report presents a comparison based on a retrospective survey of 2529 consecutive discharges of all types, from first admissions, over a six-year period between 1961 and 1967. The data covered adolescents and adults who were admitted to the adult in-patient service of the Neuropsychiatric Institute of the University of California at Los Angeles.

Of the 2529 patients discharged, 1117 were men and 1412 were women; 2008 were adults and 521 were adolescents.

Irregular discharges accounted for 312 or 12.3% of all discharges - 223 AMA (8.8%) and 89 AWOL (3.5%). Of the 312, a total of 72% were AMA and 28% AWOL. The overall distribution of characteristics of sex, race, religion and ward assignment for the AMA and AWOL groups did not differ significantly, and in those characteristics both groups were similar to the regularly discharged groups. Statistically significant

differences between the AMA and AWOL groups were found for age at admission, sex by specific age group, primary psychiatric diagnosis at discharge, duration of hospitalisation, and time of year that the patient was discharged.

The study reiterates the view that there are many factors which influence a patient's decision to opt for irregular discharge, including the patient's psychodynamics, preparation for hospitalisation, current relations with family and hospital staff, and also various institutional policies.

In their paper, "Prediction of Unauthorized Absence", ALTMAN et al. (1972) discuss their derivation of a multivariate equation for predicting unauthorised absence from hospital. The equation was derived from 3383 psychiatric inpatients, and cross-validated with another sample, using mental status, diagnostic and demographic data. The rate of correctly predicting elopement was 72%, yielding a high-risk group with a one-in-ten chance of eloping and a low-risk group with a one-in-forty chance. The authors presented correlation co-efficients of individual predictors of elopement, and discussed these in terms of their theoretical implications. A finding of special interest in their study was that the diagnosis of "Chronic Brain Syndrome", or the presence of findings on mental status items that are consistent with such a diagnosis, was associated with a decreased likelihood of elopement. They refer to their previously formulated theory, namely, that elopement could be explained on the basis of three causal factors:

- 1) impulsivity, 2) disregard for, or inability to, follow rules and regulations, and
- 3) a tendency to act-out under stress. While their findings were generally consistent with this theory, the finding regarding Chronic Brain Syndrome suggests a fourth causal factor, or perhaps more accurately, a necessary prerequisite for elopement, that is, a level

of psychomotor competence sufficiently high to make possible the act of departing from the hospital on one's own. The low rate of elopement reported in young children is also consistent with this prerequisite. Schizophrenics have been reported to elope more frequently than non-schizophrenics. Although they did not find that a diagnosis of schizophrenia was significantly correlated with elopement, several mental status items such as "flat affect", that are usually associated with a diagnosis of schizophrenia, were significantly correlated with elopement.

TOMISON (1989) conducted a prospective study of all patients reported AWOL from Barrow Hospital (UK) during one calendar year. Numbers were small (95 AWOL incidents involving 35 patients during the year of study) as those patients discharged against medical advice and those failing to return from leave were excluded. It was found that absconders were predominantly male, young, compulsorily admitted, and discharged with a diagnosis of "schizophrenia". They tended to be single and had many previous admissions, with a longer total length of stay. The police were more often than not involved in their admission.

In summary, the literature review has spanned chapters 2-5 and has attempted to deal with a broad spectrum of issues in order to contextualise the phenomenon of AWOL in mental hospitals. More specifically, it has provided an overview of historical perspectives on mental illness, examined some of the organisational problems experienced by the mental hospital, summarised theories of causation, reviewed patient adaptations to the institution, and attempted to describe aspects of the release process. Finally, it has provided a review of the previous findings, and has further attempted to clarify the concept of AWOL by way of some definitions.

CHAPTER 6 : METHODOLOGY

6.1.1 Subjects

The sample consisted of 93 inpatients at Lentegeur Hospital who had gone "absent without leave" (AWOL) over an eight-month period between April 1992 and November 1992. Subjects included adolescents and adults of both sexes. Young children were excluded from the study. There were 83 males and 10 females. The sample ranged in age from 14 to 57 years. All adult and adolescent psychiatric wards were included in the study.

6.1.2 Context

This section provides a general picture of the formal structure of Lentegeur Hospital in terms of treatment sections, ward arrangements, staff locations, and the like. Lentegeur Hospital first opened its doors on 1 April 1986. Its Mission Statement:

To provide a client-centred, community-oriented mental health service which is relevant, accessible, comprehensive and efficient. This service utilises the skills of suitably trained and appropriately motivated staff and recognises that patients are a special need group with the same inalienable rights as every individual (Lentegeur Hospital, Annual Report, 1989/1990, p.3).

It is accepted that "every staff member is committed to and guided by this statement" (Lentegeur Hospital, Annual Report, 1989/1990, p.3).

The hospital renders in-patient, out-patient, and community mental health services, adopting a multidisciplinary team approach.

The team comprises psychiatrists, medical officers, clinical psychologists, social workers, nurses, occupational therapists, physiotherapists, and pharmacists. Being a teaching hospital, graduate and post-graduate training is offered to students of the various disciplines. These professional activities are supported by an administrative and auxiliary service.

The policy of sectorisation was introduced to facilitate the co-ordination of in-patient and community services, and to provide for continuity of care. Each of the eight acute units is responsible for a specific catchment area.

Other special units include a substance abuse (drug) unit, three neuroclinics, a psychogeriatric unit, rehabilitation wards, a child and family unit and an adolescent unit.

Two short-term, high-care units (one male, one female) provide specialised care for high-risk patients.

The hospital aims for increased family involvement in the care of the patient, and claims to be committed to discharging as many so-called long-term patients back into the community. Whilst acknowledging specific responsibilities to the community, Lentegeur Hospital is of the opinion that both Hospital and Community share responsibility for the mentally ill.

6.2 Instruments/Measures

The survey, a widely used descriptive research technique, was employed in the study as a method of gathering standardised information.

The final instrument was constructed by George Savage, Senior Clinical Psychologist at Lentegeur Hospital. This instrument was based on that used by him in the pilot study.

The Questionnaire (Appendix II)

Since the motivation for "absence without leave" is multifactorial, the three major categories investigated are: 1) the Patient, 2) the Institution, and 3) the Community.

The questionnaire is further divided into roughly four sections, namely, Identifying Data, Psychiatric History, Abscond Information, and Ward Information. It consists of a total of 55 items.

The rationale for the inclusion of specific items under each of the above sections follows here.

The Identifying Data category includes the items: Surname, First Name, Hometown, Sex (Gender), Age, Folder Number, Date of Admission, Section of the Mental Health Act, Religion, Educational Level, Employment Status, and who the patient was living with (prior to admission).

The Ward Number is significant in that it gives an indication of whether the patient had been in a short-term, long-term, acute, chronic, "open" or "closed" unit. These units, in turn, vary in the degree of mobility afforded to the patients.

The Surname, First Name and Folder Number is essential for accurate identification of the patient and for record-keeping. In an attempt to preserve the confidentiality of the subjects, these items are neither reported nor discussed in the study.

The Date of Admission gives an indication of the length of stay in hospital prior to going AWOL. In a broader sense, it also suggests the time of year in the context of social events (for example, school holidays, advent of Christmas, etc.).

The Section of the M.H. Act indicates the condition of the commitment, for example, voluntary or involuntary. This is very likely to influence the way that the subject perceives his/her stay at the hospital.

Marital Status, Religion, and information about who the subject lives with, are all indicative of the subject's social support network.

Educational Level offers some measure of intellectual development, and the subject's degree of insight into his/her situation.

The Psychiatric History category includes the items: Provisional Diagnosis (on Axes 1, 2 and 3), Medication at time of absconding (going AWOL), Side-Effects, and Number of Previous Admissions.

The Provisional Diagnosis item is significant since it was found, in previous studies, that certain diagnoses (e.g. Schizophrenia) were associated with a higher likelihood of going AWOL. Provisional Diagnoses are recorded on three axes in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Axis 1 indicates the Primary Clinical Diagnosis, Axis 2 indicates Personality Disorders, and Axis 3 indicates Physical/Organic problems.

Medication at time of absconding (going AWOL) indicates whether the subject was on medication for a specific diagnosed problem. This is important since treatment is abruptly interrupted when the subject goes AWOL. Also, medication may cause an alleviation of symptoms, resulting in a temporary feeling of well-being on the part of the subject.

The recording of side-effects is important in that subjects may experience considerable discomfort as a result of side-effects of medication, and may wish to escape this discomfort by going AWOL. In other instances, certain side-effects may reduce mobility (e.g. "stiffness" due to medication) thus reducing the chances of going AWOL.

The Number of Previous Admissions is an important item for a number of reasons. Firstly, it may suggest the incidence of relapse. Secondly, it may indicate poor "compliance" with treatment. Thirdly, it may be suggestive of previous incidences of AWOL.

Whether the subject was involved in an argument or fight provides information regarding whether the act of AWOL was in any way provoked. It may further provide information about the way in which the subject deals with conflict and aggressive impulses (such as "running away"/going AWOL).

Whether the subject was due for any special treatment may also be indicative of his/her way of dealing with anxiety and fear of the unknown. The act of going AWOL may further suggest a rejection of such treatment on the part of the subject.

The number of nursing staff on the ward at the time of going AWOL is important in view of the hypothesis that the incidence of AWOL is likely to increase with fewer staff members on duty. As is the case with the number of patients on the ward, the incident is more likely to go unnoticed if there are fewer staff members present at the time.

6.3 Procedure

A briefing session was held together with the Head of the Nursing Department and the psychiatric sisters in charge of all the wards included in the study. The sisters in charge had agreed to complete the questionnaires for patients going AWOL since they were in close proximity and amongst the first to be informed of such incidents. Since they had been assigned the task of completing the questionnaires, this briefing session was regarded as crucial. The purpose of the session was to define the task, direct attention, develop a mental set, and motivate the staff members to participate diligently and enthusiastically. Instructions included a clear, unambiguous description of the task that they were to perform.

Each item on the questionnaire was explained to the sisters in detail. The importance of completing all the categories was emphasised. The sisters were given an opportunity to seek clarification where necessary.

A number of questionnaire forms were issued to each of the sisters present to take to their respective wards. They were told to obtain more forms from myself if the need arose. Completed questionnaire forms were collected from the wards by myself on a weekly basis. The data was codified and entered onto computer promptly. A debriefing session followed after the eight-month period. Sisters and nursing staff involved were thanked for their co-operation and role in the study.

6.4 Statistical Analyses

Appropriate descriptive statistical procedures were employed in line with the aim of the study. Frequencies were computed for each of the items. Cross-tabulations were computed across a number of variables.

Table 7.1.1 indicates the Hometown, Gender and Age of the patients who went AWOL.

Table 7.1.1

ID Data : Hometown, Gender and Age

Variable	N	%
Hometown:		
Urban	53	84.1
Rural	10	15.9
Gender:		
Male	83	89.2
Female	10	10.8
Age:		
14-21	10	11.0
22-34	61	66.3
36-57	14	15.4

Most patients who went AWOL (84.1%) hailed from urban areas, whilst only 15.9% were of rural origin. The highest incidence of AWOL occurred amongst male patients. Ages ranged from 14 to 57 years. The highest frequencies (66.3%) occurred in the range from 22 to 34 years; the lower frequencies (15.4%) in the 36-57 years range; and the lowest frequencies (11.0%) in the 14-21 years range.

Table 7.1.2 indicates the date of admission of those patients who went AWOL.

Table 7.1.2

ID Data : Date of Admission

D.O.A	N	%
First Quarter	10	10.8
Second Quarter	40	43.1
Third Quarter	36	38.7
Fourth Quarter	05	5.4

Of those patients who went AWOL, 43.1% were admitted during the second quarter (April, May, June); 38.7% during the second quarter (July, August, September); 10.8% during the first quarter (January, February, March); and only 5.4% during the fourth quarter (October, November).

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Table 7.1.4 indicates the level of education of the patients who went AWOL, as well as their employment status.

Table 7.1.4

Level of Education and Employment Status

Variable	N	%
Education:		
None	5	5.6
A - 4	21	23.6
5 - 6	3	25.8
7 - 10	21	23.6
Post Matric	2	2.5
Unknown	17	19.1
Employment:		
Unemployed	55	60.4
Employed	12	13.2
Disability Grant	21	23.1
Unknown	2	2.2

Of those who went AWOL, 25.8% had a Std 5-6 education; 23.6% Sub A-Std 4; 23.6% Std 7-10; 19.1% had an unknown level of education; 5.6% had no formal education; and only 2.5% had a post-matric education.

In terms of employment, 60.4% were unemployed; 23.1% received a disability grant; and 13.2% were employed. The employment status of 2.2% patients was unknown.

Table 7.1.5 indicates who the patient was living with prior to hospitalisation.

Table 7.1.5

Living arrangements of the Patient

Patient Living With:	N	%
Parental Family	60	66.7
Marital Family	15	13.2
Foster Care	1	1.1
Friend	4	4.4
Boarding	3	3.3
Alone	0	0.0
Unknown	6	6.7
Elsewhere	1	1.1

*90 valid cases

Of the patients who went AWOL, 66.7% were living with the parental family; 13.2% with the marital family; the living arrangements of 6.7% was unknown; 4.4% lived with a friend; 3.3% were boarding with someone; 1.1% was in foster care; and 1.1% lived elsewhere.

7.2 Psychiatric History

This section includes the following variables: Ward, Section of the Mental Health Act, Provisional Diagnosis (on Axis 1, Axis 2 and Axis 3), Medication at the time of going AWOL, Side-effects of medication, and Number of Previous Admissions.

Table 7.2.1 indicates the frequency of reported cases of AWOL in the various wards, as well as the section of the Mental Health Act under which these patients had been admitted.

Table 7.2.1

Ward and Section of the Mental Health Act

Variable	N	%
Ward:		
Admission Units	78	84.0
Neuroclinics	11	11.8
Closed Wards	2	2.2
Long-Term Ward	1	1.1
Adolescent Unit	1	1.1
Mental Health Act:		
Section 3	6	6.5
Section 4	64	69.6
Section 9	19	20.7
Section 12	3	3.2

The highest frequencies (84.0%) occurred in the admission units, with lower frequencies (11.8%) in the neuroclinics. The incidence of AWOL was markedly low (2.2%) in the closed wards, and only 1.1% each was reported in the long-term and adolescent unit.

Table 7.2.2 indicates the Provisional Diagnosis on Axis 1.

Table 7.2.2

Provisional Diagnosis (Axis 1)

Axis 1	N	%
Schizophrenia (various subtypes)	50	58.2
Schizophreniform Psychosis	2	2.3
Bipolar Mood Disorder	8	9.3
Toxic Psychosis	5	5.8
Substance Abuse	4	4.7
Organic Brain Syndrome	2	2.3
Paranoid Delusional Disorder	1	1.2
Major Depression (psychotic fs)	1	1.2
Organic Hallucinations	1	1.2
Posttraumatic Stress Disorder	1	1.2
V-Codes: (P-Child ; Malingering)	2	2.4
Alcohol Dependence	1	1.2
Major Depressive Episode	1	1.2
Deferred	7	8.1

* 86 valid cases

Of the patients who went AWOL, 58.2% had an Axis 1 diagnosis of one or other subtype of Schizophrenia; 9.3% Bipolar Mood Disorder; 5.8% Toxic Psychosis; 4.7% Substance Abuse; 2.3% Schizophreniform Psychosis; 2.3% Organic Brain Syndrome; 2.4% was diagnosed with a V-Code (1.2% each with Parent-Child Problem and Malingering); and 1.2% each with Paranoid Delusional Disorder, Major Depression (with Psychotic features), Organic Hallucinations, Posttraumatic Stress Disorder, Alcohol Dependence, and Major Depressive Episode. In 8.1% of the cases, the Axis 1 diagnosis was deferred.

Table 7.2.3 indicates the Provisional Diagnosis on Axis 2.

Table 7.2.2

Personality Disorder (Axis 2)

Axis 2	N	%
Anti-Social traits	7	36.8
Anti-Social PD	1	5.3
Borderline traits	2	10.5
Dependent traits	2	10.5
Passive-Aggressive traits	1	5.3
Deferred	3	15.8

* 19 valid cases

* PD : Personality Disorder

Of the patients who went AWOL, 36.8% had an Axis 2 diagnosis of Anti-Social traits; 10.5% each were diagnosed with Borderline Personality Disorder, Borderline traits, and Dependent traits; and 5.3% each with Anti-Social Personality Disorder and Passive-Aggressive traits. In 15.8% of the cases, the Axis 2 diagnosis was deferred.

Table 7.2.4 indicates the Provisional Diagnosis on Axis 3.

Table 7.2.4

Provisional Diagnosis (Axis 3)

Axis 3	N	%
Nil	5	35.7
Head Injury	2	14.3
Self-inflicted injury	1	7.1
Urinary Tract Infection	1	7.1
Hypertension	1	7.1
Scabies	1	7.1
Epilepsy	1	7.1
Amenorrhoea	1	7.1
Deferred	1	7.1

* 14 valid cases

Of the patients who went AWOL, 35.7% had no Axis 3 diagnosis; 14.3% were diagnosed with Head Injuries; and 7.1% each with Self-Inflicted Injury, recurrent Urinary Tract Infection, Hypertension, Scabies, Epilepsy, and Amenorrhoea. In 7.1 of the cases, the Axis 3 diagnosis was deferred.

Table 7.2.5 indicates the type of medication which formed part of the patients' treatment.

Table 7.2.5

Medication at time of going AWOL

Medication	N	%
Oral Neuroleptic	68	86.1 (79)
Depot Neuroleptic	30	52.6 (57)
Anti-Depressant	5	10.2 (49)
Anti-Epileptic	1	2.3 (44)
Anxiolytic	2	4.4 (45)
Anti-Parkinsonism	14	29.8 (47)
Lithium	3	6.7 (45)
Other	8	80.0 (10)
Not on Medication	4	4.6 (87)

* See brackets for valid cases

Of the patients who went AWOL, 86.1% were on oral neuroleptic medication; 52.6% were on a depot neuroleptic; 10.2% were on an anti-depressant; 2.3% were on an anti-epileptic; 4.4% were on an anxiolytic; 29.8% were on anti-parkinsonism medication; 6.7% were on lithium; 80.0% were on some other medication; and only 4.6% were on no medication at all.

Table 7.2.6 indicates the various side-effects as a result of medication.

Table 7.2.6

Side-effects from Medication

Side-effects	N	%
Acute Dyskinesia	0	0.0 (85)
Dystonia	2	2.4 (84)
Parkinsonism	3	3.5 (86)
Akathisia	0	0.0 (85)
Tardive Dyskinesia	0	0.0 (85)
No. of complaints	8	9.1 (88)

* See brackets for valid cases

Of the patients who went AWOL, 9.1% complained of side-effects. None complained of acute dyskinesia; 2.4% complained of dystonia; 3.5% complained of parkinsonism; none complained of Akathisia; and none complained of tardive dyskinesia.

Table 7.2.7 indicates the number of previous admissions.

Table 7.2.7

Number of Previous Admissions

Prev. Admissions	N	%
Nil	16	18.2
1	12	13.6
2	16	18.2
3	18	20.5
4 or more	26	29.5

* 88 valid cases

Of the patients who went AWOL, there were 29.5% with 4 or more previous admissions; 20.5% with 3 previous admissions; 18.2% with 2 previous admissions; 18.2% with no previous admissions; and 13.6% with 1 previous admission.

7.3 Abscond Information

This section includes items such as whether the patient was admitted directly to the ward or transferred from another ward, date of transfer, date of AWOL, previous history of AWOL, who was informed, date of last entry in the folder, who made the latter, when the patient went AWOL, date of return, who brought the patient back, how the absence was discovered, where the patient was found, and route of departure.

Table 7.3.1 indicates the route of admission into the ward, as well as the route of transfer where applicable.

Table 7.3.1

Route of Admission and Route of Transfer

Variable	N	%
Admission: (90)		
Direct	63	70.0
Transferred	27	30.0
Transfer: (26)		
Ward 2	19	73.1
Ward 4	4	15.4
Ward 5	2	7.7
Ward 5B	1	3.8

* See valid cases in brackets

Of the patients who went AWOL, 70% were admitted directly to the ward, and 30% were transferred from elsewhere. Of the latter, 73.1% were transferred from ward 2; 15.4% from ward 4; 7.7% from ward 5; and 3.8% from ward 5B.

Table 7.3.2 indicates the date of transfer and date of AWOL.

Table 7.3.2

Date of Transfer and Date of going AWOL

Variable	N	%
Transfer: (93)		
1st Quarter	2	2.2
2nd Quarter	16	17.2
3rd Quarter	9	9.7
4th Quarter	2	2.2
Unknown	63	67.7
AWOL: (93)		
2nd Quarter	42	45.2
3rd Quarter	38	40.9
4th Quarter	8	8.6
Unknown	4	4.3

* See valid cases in brackets

Of those who went AWOL, 2.2% were transferred during the first quarter; 17.2% the second; 9.7% the third; 2.2% and during the fourth quarter. In the case of 67.7%, the date of transfer was not indicated.

Furthermore, 45.2% went AWOL during the second quarter; 40.9% during the third; 8.6% during the fourth quarter; and 4.3% during an unknown time.

Table 7.3.3 indicates whether there was a previous history of AWOL, as well as the number of previous incidents.

Table 7.3.3

Previous History of AWOL and Number of Previous Incidents

Variable	N	%
Previous History: (90)		
Yes	55	61.1
No	35	38.9
Previous Incidents: (88)		
1	33	37.5
2	12	13.6
3	12	13.6
4	3	3.4
More than 4	3	3.4
Unknown	25	28.4

* See valid cases in brackets

Of the patients who went AWOL, 61.1% had gone AWOL before, whilst 38.9% had no previous history. Of those with a previous history, 37.5% had a record of one previous incident; 13.6% each had two and three previous incidents; 3.4% each had four and more; and 28.4% had an unknown number of previous incidents.

Table 7.3.4 indicates who had been informed about the patient's absence.

Table 7.3.4

Who was informed about the patient's absence

Reported to:	N	%
Med. Supt.	35	38.9
S.A.P.	71	78.9
Family	66	73.3
Friend	03	3.3

* 90 valid cases

Of the total cases of AWOL, 38.9% were reported to the medical superintendent; 78.9% to the S.A. Police; 73.3% to the family; and 3.3% to a friend.



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Table 7.3.5 indicates the date of the last entry in the patient's folder, and also the staff member who made it.

Table 7.3.5

Date of last entry and Staff Member

Variable	N	%
Date of Last Entry:		
2nd Quarter	43	46.2 (93)
3rd Quarter	35	37.7 (93)
4th Quarter	8	8.6 (93)
Staff Member:		
Doctor	68	77.3 (88)
Psychologist	5	5.7 (88)
Nursing Staff	31	35.2 (88)
Social Worker	3	3.4 (87)
Occ. Therapist	1	1.1 (88)
Other (Unspecified)	2	100.0 (2)

* See valid cases in brackets

Most of the last entries (46.2%) were made during the second quarter; 37.7% during the third; and 8.6% during the fourth. In 77.3% of the cases, the last entry was made by the doctor; 35.2% by the nurse; 5.7% by the psychologist; and 3.4% by the social worker. In two instances, the last entry was made by an unspecified person.

Table 7.3.6 indicates period of day when the patient left the ward.

Table 7.3.6

Time of going AWOL

Time	N	%
Night (6pm -7am)	19	20.7 (92)
Before Breakfast	3	3.3 (92)
Between:		
Breakfast & Morning Tea	12	13.0 (92)
Morning Tea & Lunch	20	21.7 (92)
Lunch & Afternoon Tea	17	18.5 (92)
Afternoon Tea & Supper	16	17.6 (91)
After Supper	7	7.7 (91)

* See valid cases in brackets

Of those who went AWOL, 21.7% left between morning tea and lunch; 20.7% during the night; 18.5% between lunch and afternoon tea; 17.6% between afternoon tea and supper; 13.0% between breakfast and morning tea; 7.7% after supper; and 3.3% before breakfast.

Table 7.3.7 indicates when the patients returned to hospital, and who brought the patient back.

Table 7.3.7

Date of Return and Who brought patient back

Variable	N	%
Date of Return: (93)		
2nd Quarter	9	9.7
3rd Quarter	15	16.2
4th Quarter	1	1.1
Unknown	64	68.8
Brought back by: (60)		
S.A.P.	19	31.7
Family	6	10.0
Staff	3	5.0
Returned on own	10	16.7
Had not returned	22	36.7

* See valid cases in brackets

The date of return of 68.8% was unknown; 9.7% returned during the second quarter; 16.2% during the third; and 1.1% during the fourth quarter. In 36.7% of the cases, patients had not returned; 31.7% were brought back by the Police; 10.0% by family; 5.0% by staff; and 16.7% returned on their own.

Table 7.3.8 indicates how the various incidents of AWOL was discovered, and where the patient was found.

Table 7.3.8

How AWOL was discovered and Where Patient was Found

Variable	N	%
Means of Discovery:		
Observed	24	27.3 (88)
During routine check	57	65.5 (87)
Informed by fellow patient	11	12.5 (88)
Where Found:		
At home	40	56.3 (71)
At a friend's house	5	7.1 (70)
On hospital grounds	1	1.4 (70)
On the street	5	7.1 (70)
Elsewhere	12	100.0 (12)
Unknown	17	21.5 (79)

* See valid cases in brackets

Most incidents (65.5%) were discovered during a routine check; 27.3% were directly observed, and in 12.5% the staff was informed by another patient. Also, 56.3% were found at home; 7.1% at a friend's; 7.1% on the street; 1.4% at hospital; 12 elsewhere, and the whereabouts of 21.5% was unknown.

Table 7.3.9 indicates how the patient left the ward.

Table 7.3.9

How patient left the ward

Route	N	%
Bedroom window	30	39.0 (77)
Front door	11	14.3 (77)
Back door	2	2.6 (77)
Yard	10	13.0 (77)
Broke window / door	2	2.6 (77)
Unknown	31	36.0 (86)

* See valid cases in brackets

Of those who went AWOL, 39.0% left the ward via the bedroom window; 36.0% left via an unknown route; 14.3% via the front door; 2.6% via the back door; 13.0% through the yard; and 2.6% broke a window or door.

Table 7.3.10 indicates whether the patient had threatened to go AWOL prior to doing so, whether the patient requested discharge, and whether the patient was due for discharge.

Table 7.3.10

Threats, Request Discharge and Due for Discharge

Variable	N	%
Threats: (77)		
Yes	24	31.2
No	53	68.8
Request: (79)		
Yes	43	54.4
No	34	43.0
Unknown	2	2.5
Due for Discharge: (78)		
Yes	11	14.1
No	67	85.9

* See valid cases in brackets

Of those who went AWOL, 31.2% had threatened to do so, whilst 68.8% had made no such threats; 54.4% requested discharge, whilst 43.0% did not. In 2.5% of the cases, it was not known whether the patient had requested discharge. Only 14.1% were due for discharge, whilst the remaining 85.9% were not.

Table 7.3.11 indicates whether the staff were particularly concerned about the 'missing' patients, and whether the patients received visitors whilst on the ward.

Table 7.3.11
Staff Concern and Visitors

Variable	N	%
Staff Concern: (86)		
Yes	61	70.9
No	25	29.1
Visitors: (84)		
Yes	36	42.9
No	48	57.1

* See valid cases in brackets

From the table it is evident that the staff was particularly worried about 70.9% of the patients who had gone AWOL, and not particularly worried about the other 29.1%. Of those who went AWOL, 42.9% received visitors whilst 57.1% did not receive any visitors prior to leaving.

7.4 Ward Information

This section includes information regarding the number of patients in the ward at the time of going AWOL, whether the patient had argued with fellow patients, was involved in a fight, participated in an activity group, or was due for any special treatment. The number of nursing staff on duty at the time of going AWOL is also recorded.

Table 7.4.1 indicates the number of patients on the ward (density of patient population) at the time of going AWOL.

Table 7.4.1

No. of Patients in ward at time of going AWOL

No. of Patients	N	%
01 - 10	8	8.8
11 - 20	46	50.5
21 - 30	36	39.9
30 +	1	1.1

* 91 valid cases

Most of the incidents of AWOL (50.5%) occurred when there were 11-20 patients in the ward; 39.6% with 21-30 patients; 8.8% with 1-10 patients; and 1.1% with 30+ patients in the ward.

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Table 7.4.2 indicates whether the patients who went AWOL had argued with fellow patients prior to doing so, whether they were involved in a fight, whether they were involved in an activity group, and whether they were due for any special form of treatment.

Table 7.4.2
Argue, Fight, Activity Group, and Special Treatment

Variable	N	%
Argue: (85)		
Yes	3	3.5
No	82	96.5
Fight: (85)		
Yes	2	2.4
No	83	97.6
Activity Group: (84)		
Yes	24	28.6
No	60	71.4
Special Treatment: (84)		
Yes	3	3.6
No	81	96.4

* See valid cases in brackets

In 96.5% of the cases, they did not argue with fellow patients, whilst 3.5% had been involved in an argument with fellow patients. In 97.6% of the cases, they had not been involved in a fight, whilst 2.4% had been in a fight prior to going AWOL. Most of the patients (71.4%) had not been involved in an activity group. Only 28.6% had been in an activity group prior to going AWOL. The majority (96.4%) were not due for any special treatment, whilst 3.6% were due for some kind of special treatment prior to going AWOL.

Table 7.4.3 indicates the number of nursing staff on the ward at the time of the incident.

Table 7.4.3

No. of Nursing Staff on duty at time of AWOL

Nursing Staff	N	%
1	22	23.9
2	11	12.0
3	23	25.0
4	21	22.8
5	10	10.9
6	1	1.1
7	1	1.1
8	2	2.2
9	1	1.1

* 92 valid cases

Of all the recorded incidents of AWOL, 25.0% occurred with 3 nursing staff members on duty; 23.9% with 1 on duty; 22.8% with 4 on duty; 12.0% with 2 on duty; 10.9% with 5 on duty; 2.2% with 8 on duty; and 1.1% each with 6, 7, and 9 nurses on duty.

7.5 Cross-Tabulations

This section describes the relationship(s) between certain variables in the study. More specifically, it examines the relationship between date of admission and date of going AWOL; date of AWOL and date of return; medication and side-effects; who was informed about the incident and who brought the patient back to hospital; where the

patient was living and where the patient was found after going AWOL; whether the patient had requested discharge and whether the patient was due for discharge. It also looks at the relationship between the number of nursing staff and the number of patients on the ward at the time of the incident. These relationships between variables are recorded in the tables which follow.

Table 7.5.1 indicates the relationship between the date of admission and the date of going AWOL.

Table 7.5.1

Date of Admission by Date of AWOL

Date	Admission	AWOL
May	21.5	55.0 (35.0 ; 5.0)
June	14.0	76.9 (15.4)
July	17.2	62.5 (25.0 ; 12.5)
August	17.2	75.0 (12.5 ; 12.5)

* See brackets for AWOL % in following two months

In most cases, patients went AWOL within the same month of being admitted. In some cases, patients went AWOL within three months of admission (see brackets). Of the 21.5% of patients admitted in May, 55.0% went AWOL in the same month, 35.0% in June, and 5.0% in July. Of the 14.0% of patients admitted in June, 76.9% went AWOL in the same month, and 15.4% the following month. Of the 17.2% of patients admitted in July, 62.5% went AWOL in the same month, 25.0% in August, and 12.5% in September. Of the 17.2% of patients admitted in August, 75.0% went AWOL in the same month, and 12.5% each in September and October.

Table 7.5.2 indicates the relationship between the Date of AWOL and the Date of Return.

Table 7.5.2

Date of AWOL by Date of Return

Date	AWOL	Return
May	24.7	39.1 (8.7)
June	19.4	5.6 (5.6)
July	14.0	30.8 (7.7)
August	17.2	25.0
September	9.7	55.6
October	5.4	20.0

* See brackets for Return % in following month

In most cases, the time between Date of AWOL and Date of Return was not known. In many cases, the patient returned within a two-month period (see brackets). In some cases, the patient returned within the same month. Of the 24.7% who went AWOL in May, 39.1% returned in May and 8.7% in June. Of the 19.4% who went AWOL in June, 5.6% returned in June and 5.6% in July. Of the 14.0% who went AWOL in July, 30.8% returned in July and 7.7% in August. Of the 17.2% who went AWOL in August, 25.0% returned in August. Of the 9.7% who went AWOL in September, 55.6% returned in the same month. Of the 5.4% who went AWOL in October, 20.0% returned in the same month.

Table 7.5.3 indicates the relationship between certain medication and complaints of side-effects.

Table 7.5.3

Medication by Complaints of Side-Effects

Type of Medication	N	Side-Effects
Oral Neuroleptic	87.0	11.9
Depot Neuroleptic	51.9	14.3
Anti-Parkinsonism	31.1	21.4

Of the 87.0% of patients who were on Oral Neuroleptic medication, only 11.9% complained of side-effects. Of the 51.9% on Depot Neuroleptic medication, only 14.3% complained of side-effects. Of the 31.1% on Anti-Parkinsonism medication, only 21.4% complained of side-effects.

* Of the 29.5% of patients on Anti-Parkinsonism medication, none complained of Tardive Dyskinesia. See discussion in next chapter.

Table 7.5.4 indicates the relationship between who had been informed about the incident of AWOL and who brought the patient back to hospital.

Table 7.5.4

Who Informed by Who Brought Patient Back

Informed	SAP	Family	Own	Not Back	Staff
Fam. (77.6)	28.9	11.1	20.0	35.6	4.4
SAP (72.4)	38.1	2.4	16.7	38.1	4.8
Supt. (39.7)	21.7	8.7	17.4	39.1	13.0
Friend (3.4)	0.0	50.0	0.0	0.0	50.0

Of the 77.6% of cases reported to the family, 35.6% was not back, 28.9% was brought back by the S.A. Police, 20.0% returned on their own, 11.1% was brought back by family, and 4.4% by staff.

Of the 72.4% of cases reported to the Police, 38.1% was brought back by the SAP, 2.4% by the family, 4.8% by staff, 16.7% returned on their own, and 38.1% was not back.

Of the 39.7% of cases reported to the Superintendent, 39.1% were not back, 21.7% was brought back by the S.A. Police, 13.0% by staff, 8.7% by family, and 17.4% returned on their own. Of the 3.4% of cases reported to a friend, 50.0% was brought back by family and 50.0% by staff. None were brought back by a friend.

Table 7.5.5 indicates the relationship between where the patient was living (abode) and where the patient was found after having gone AWOL.

Table 7.5.5

Where Living by Where Found

Living	Home	Friend	Hospital	Street
P.Fam. (69.6)	58.3	6.4	2.1	6.4
M.Fam. (18.8)	61.5	7.7	0.0	0.0

Of the 69.6% of patients living with the Parental Family, 58.3% were found at home, 6.4% at a friend, 6.4% on the street, and only 2.1% on hospital grounds.

Of the 18.8% of patients living with the Marital Family, 61.5% were found at home and 7.7% at a friend. None were found on the street or on hospital grounds.

Table 7.5.6 indicates the relationship between whether the patient had requested discharge and whether the patient was due for discharge prior to going AWOL.

Table 7.5.6

Request Discharge by Due for Discharge

Request	Due	Not Due
52.6 (Y)	22.5	77.5
44.7 (N)	5.9	94.1

* Y - Yes; N - No

Of the 52.6% of patients who had requested discharge, only 22.5% was due for discharge. Of the 44.7% who had not requested discharge, only 5.9% was due for discharge.

Table 7.5.7 indicates the relationship between the number of nursing staff on duty and the number of patients on the ward at the time of incidents of AWOL.

Table 7.5.7

Number of Nursing Staff by Number of Patients

No. of Nurses	0-10	11-20	21-30	30+
1 (23.1)	14.3	57.1	28.6	0.0
2 (12.1)	9.1	36.4	54.5	0.0
3 (25.3)	17.4	52.2	30.4	0.0
4 (23.1)	0.0	57.1	38.1	4.8
5 (11.0)	0.0	40.0	60.0	0.0
6 (1.1)	0.0	0.0	100.0	0.0
7 (1.1)	0.0	0.0	100.0	0.0
8 (2.2)	0.0	50.0	50.0	0.0
9 (1.1)	0.0	100.0	0.0	0.0

Of the 23.1% of cases where there was 1 nurse on duty, 57.1% occurred with 11-20 patients on the ward and 28.6% with 30+ patients. Of the 12.1% of cases where there were 2 nurses on duty, 54.5% occurred with 21-30 patients on the ward and 36.4% with 11-20 patients. Of the 25.3% of cases where there were 3 nurses on duty, 52.2% occurred with 11-20 patients on the ward and 30.4% with 21-30. Of the 23.1% of cases where there were 4 nurses on duty, 57.1% occurred with 11-20 patients on the ward and 38.1% with 21-30 patients. Of the 11.0% of cases where there were 5 nurses on duty, 60.0% occurred with 21-30 patients on the ward and 40.0% with 11-20 patients. Of the 1.1% of cases where there were 6 nurses on duty, 100% occurred with 21-30 patients on the ward. Of the 1.1% of cases where there were 7 nurses on duty, 100% occurred with 21-30 patients on the ward. Of the 2.2% of cases where there were 8 nurses on duty, 50.0% occurred with 11-20 patients on the ward and 50.0% with 21-30 patients. Of the 1.1% of cases where there were 9 nurses on duty, 100% occurred with 11-20 patients on the ward.

7.6 Summary of Results

This section provides a summary profile of the research findings. These findings are summarised in terms of five sub-sections, namely, Identifying Data, Psychiatric History, Abscond/AWOL Information, Ward Information, and Relationships between Variables. The findings will be discussed in detail in the next chapter.

7.6.1 Identifying Data

It was found that most of the patients who went AWOL were from urban areas. Of these, the majority were males. The greatest number of incidents occurred amongst the 22-34 years age group. The majority were single, some were married and a few divorced. In terms of religious affiliation, most of the patients were Christian. Few had a post-matric education. Most had an education ranging from Sub A-Std 6. Only a small number had a Std 7-10 education. With regards to employment status, the majority were unemployed, many patients received a disability grant, and only a few held jobs. Most patients were living with their parental family prior to admission, others with their marital family, some were living with a friend or boarding, and still fewer were in foster care.

7.6.2 Psychiatric History

It was found that the majority of patients who went AWOL were admitted under Section 4 of the Mental Health Act, some under Section 9, a few under Section 3, and still fewer under Section 12. Most had a provisional Axis 1 diagnosis of one or other subtype of Schizophrenia. Of these, the greater number were diagnosed with Schizophrenia, many with Schizophrenia (Relapsed), some with Schizophrenia (Paranoid type), and a few with

Chronic Schizophrenia. In some cases, Bipolar Mood Disorder was diagnosed, and in a few Toxic Psychosis. In a small number of cases, Schizophreniform Psychosis was diagnosed. In a number of cases, the Axis 1 diagnosis was deferred. Most patients had an Axis 2 diagnosis of Anti-Social traits, and fewer each with Borderline traits and Dependent traits. In a number of cases, the Axis 2 diagnosis was deferred. In a substantial number of cases, there was no Axis 3 diagnosis. In some cases, there was a diagnosis of Head Injury. There were a few reported cases each with a diagnosis of Self-Inflicted Injury, Urinary Tract Infection, Hypertension, Scabies, Epilepsy, and Amenorrhoea. Of the patients who went AWOL, only a small minority were not on any medication. Most were on Oral Neuroleptics, many were on Depot Neuroleptics, and a substantial number were on Anti-Parkinsonism medication. A few were on Anti-Depressants. Not many of the patients complained of side-effects from medication. Of those who did complain, only some complained of Parkinsonism, and even fewer of Dystonia. Most patients who went AWOL had a history of previous admission(s) to the hospital. Of these, the majority had 4 or more previous admissions, many had 3 previous admissions, a substantial number had 2 previous admissions, and a some had 1 previous admission.

7.6.3 Abscond/AWOL Information

Most patients went AWOL during the period from May to September. The majority had a previous history of AWOL. In a large number of cases, the police were informed about the patients's absence, in many instances the family was informed, and in fewer cases the medical superintendent was informed. The highest incidence of AWOL occurred during the day, most of which took place between morning tea and lunch.

Fewer occurred between lunch and afternoon tea, and still fewer between afternoon tea and supper. In some cases, incidents occurred between breakfast and morning tea. In rare cases, patients left before breakfast. Of the incidents which occurred at night, most took place between 6pm and 7am, whilst only a few occurred after supper. In a vast number of cases, it was not known whether the patient had returned to hospital. Of those who did return, many were brought back by the police, some returned on their own, and a few were brought back by family. In most cases the patient's absence was discovered during a routine check, in some instances it was observed, and in fewer cases the staff were informed by fellow patients. Most patients who went AWOL were found at home. In some cases it was not known where the patient was found. There were instances where the patient was found either at a friend's house or on the street. Where the route of departure was known, most patients had left via a bedroom window, some left through the front door, and a few via the yard. In rare cases, the patient left via the back door. There were instances where the patient had broken a window or door. In most cases, the patient had never threatened to go AWOL. There were, however, cases where such threats had been made.

7.6.4 Ward Information

In most cases, staff were particularly concerned about the patients who had gone AWOL. More often than not, these patients did not receive any visitors in the ward prior to leaving. Most of the incidents occurred with a high patient population on the ward. A very small percentage had argued with fellow patients and even fewer has been involved in a fight prior to going AWOL. Most patients had not been involved in an activity group before leaving, and only a small number were due for some kind of special treatment.

7.6.5 Relationships between Variables

When comparing Date of Admission with Date of AWOL, it was found that more often than not, patients went AWOL within three months of admission. In most cases, they left within the same month. Often, the time between Date of AWOL and Date of Return was not known. In many cases, the patient returned within a two-month period, and in some cases within the same month. Few of the many patients on Neuroleptic Medication (both oral and depot) complained of side-effects. Of the lesser number of patients who were on Anti-Parkinsonism medication, only some complained of side-effects. Of the many cases reported to the Family, the SAP, and the Superintendent, most had not returned to hospital, many were brought back by the SAP, and some by the family. In a few instances, patients were brought back by staff. There was a marked tendency for patients to return to their place of abode. Of the many who lived with their Parental Family, most returned home after going AWOL. Some were found on the street or at a friend's place. Of those living with the Marital Family, the majority returned home, whilst a small number were found at a friend's place. In both cases, markedly few patients were found on hospital grounds. More than half of the patients who went AWOL had requested discharge prior to doing so. Of these, only a small minority were due for discharge. Even a smaller number of those who had not made such a request were due for discharge. There was an inverse relationship between the number of nurses on duty and the frequency of incidents of AWOL. Most incidents occurred with few nurses on duty. An inverse relationship was also found to exist between the patient population on the ward and the frequency of incidents of AWOL. Most incidents occurred when there was a high patient concentration on the ward. In summary, most incidents of AWOL occurred when there were few nurses on duty and many patients to attend to. This summary has served to sketch a profile of the patients who had gone AWOL from Lentegour Hospital during the study. These findings will be discussed in the next chapter.

CHAPTER 8 : DISCUSSION, CONCLUSION AND RECOMMENDATIONS

8.1 Discussion

The findings of this study are fairly consistent with those of previous studies conducted overseas. Similar results emerged with regards to mental status, diagnostic and demographic data. A particularly interesting and unique finding in this study was the high incidence of unemployment coupled with the low level of education amongst the patients who had gone AWOL.

The majority of patients who went AWOL during this study were young, single, unemployed urban males with a low level of education. These findings are consistent with that of Antebi (1967) and Tomison (1989) in terms of the significantly high percentage of male absconders. Meyer et al.(1967) also found that elopers were considerably younger than non-elopers, whilst Gynther et al. (1963) found that married patients had more positive attitudes about treatment than did single patients.

In most cases, patients were living with the parental family, and had been admitted to hospital involuntarily. The latter is consistent with the findings of Tomison (1989), and supports the belief that mental illness has its origins in the social organisation of society. The fact that most patients had been admitted to the hospital involuntarily is also evidence of the relative powerlessness of the mentally ill person in the face of the prevailing social order. That most patients who went AWOL did not receive any visitors further conveys a tone of social isolation and alienation from the community at large.

Consistent with the findings of Greenwald & Bartemeier (1963), Myer et al. (1967) and Tomison (1989), the most common diagnosis was found to be Schizophrenia. Many patients were also diagnosed as having anti-social traits. The latter is fitting in an ethos of gross socio-economic deprivation since the connection between poverty and crime is well-established.

Of the majority diagnosed with Schizophrenia, most received oral neuroleptic medication, and many were given depot neuroleptics. It is clear that treatment is largely rooted in the medical model which views the 'individual system' as an entity to be diagnosed, studied, and treated. This is the case despite clinical evidence to support the opinion that Schizophrenia is a process illness that is rooted in the patient's relationships with others as well as his/her relationship with society as a whole.

Results reveal that most patients who went AWOL had had several previous admissions to the hospital. Many had requested discharge, but only a small minority were due for discharge. The majority also had a previous history of AWOL.

Most incidents occurred within the first three months of hospitalisation. Of these, however, the majority left within the first month only to return within a two-month period. These findings are consistent with those of Daniels et al. (1963) and Stuen and Solberg (1970) in terms of brief, turbulent hospitalisations, less cooperation and involvement in the treatment program, and repeated hospitalisations coupled with repeated unauthorised absences. In view of this 'admission-discharge-readmission cycle' (Magaro et al., 1978, p.148), it is unlikely that patients derive any lasting benefits from hospital treatment.

The fact that the Police were more often than not involved in returning the patients to the institution is consistent with the findings of Tomison (1989), and reiterates the link between the organisation and the environment. From this, it is clear that the social context is supportive of the organisation (hospital), and that it relies on social structures and 'controlling agencies' such as the Police to control 'deviancy'.

The discussion thus far has dealt with findings which were largely consistent with those of previous studies. An important finding which is unique to this study and warrants discussion is that of the high incidence of unemployment coupled with a low level of education. In an ethos of gross socio-economic deprivation of the masses, as is the case in South Africa, it would appear that the mentally ill who are confined in institutions are more often than not casualties of the economic crisis who lack both the skills and resources to cope with the stress and strains of everyday life.

That most of the incidents occurred with few staff members and large patient numbers on the wards suggests that the situation is stressful for both mental health professionals and patients alike.

Though the reasons for leaving without authorisation is clearly multi-factorial, it is possible that (for the patient) these tensions resolve themselves temporarily when s/he leaves the hospital. This act could thus be viewed as a 'disruptive secondary adjustment' as far as the institution is concerned.

I would, however, like to suggest that the act of going AWOL - disruptive as it may seem - could be regarded as more adaptive than that of developing an 'Institutional Neurosis'.

One short-coming of the present study was the lack of a follow-up clinical interview with the subjects ('patients') who had returned from AWOL. It is my opinion that such an interview would have afforded both the subjects and the researcher an opportunity to explore the reason(s) for their unauthorised absence(s), thereby providing pertinent clinical data. Also, since it is evident that the reasons for going AWOL are complex and multi-factorial, future research must of necessity investigate Institutional, Individual ('patient') and Community variables more vigorously in order to better understand this phenomenon and facilitate efficient transformation of mental health services.

8.2 Conclusion and Recommendations

Since the aim of the study was to sketch a profile of the patients going AWOL from a local mental hospital, it remains essential to locate mental illness in context.

This paper has attempted to shed light on the social structure of the mental hospital in an attempt to better understand the process going 'absent without leave'.

To suggest that mental patients are 'victims' does not imply that they do not have 'personal problems'. On the contrary, they do experience numerous, and often severe life problems including interpersonal difficulties with family members, friends, and employers. Many patients also experience daily life under severe conditions of both

economic and emotional deprivation. This is especially true in the case of South Africa with its legacy of Apartheid and consequent deprivation of the masses, of whom the present sample is an example. Most mental patients have thus spent the greater part of their lives trying to cope with this deprivation. They begin life as victims of a social order with few resources and little prospect of improvement. It is obvious that they lack the resources to help them deal effectively with the problems of living, and consequently, their adaptations are often 'unhealthy'. Since family and friends find themselves in a similar position, little support is available for the patient. It would thus seem that commitment to a mental institution is closely linked to socio-economic deprivation with its lack of resources and life-skills. For this reason, it would be feasible to view mental illness as a social process rather than a strictly medical one. It becomes clear that the mental institution, rather than being a 'benevolent social structure' (Magaro et. al., 1978, p.148), may actually be detrimental to the health of 'patients' and 'mental health workers' alike. If one adopts this view, then the act of going AWOL may be considered adaptive rather than maladaptive.

The act of going AWOL indicates a certain resistance to confinement, and a resilience on the part of the 'patient' to embrace a society that has expelled him/her.

It is my opinion that society at large would benefit from 'deinstitutionalisation' coupled with adequate life-skills and occupational training. This trend has already begun, and finds expression in the 'community mental health' movement with its emphasis on preventative, community intervention. Though discussion of this modality is beyond the scope of this paper, it is necessary to point out that the community mental health

movement holds promise of reducing the sense of isolation of the mentally ill from their families and communities. Many people are allowed to remain within their communities whilst receiving medical-psychiatric treatment on an out-patient basis. This practice further has a tremendous economic advantage in terms of reducing the costs of supporting a hospital population, and enhancing the economically productive sector of the general population. It also has a therapeutic advantage in that a meaningful occupational contribution (work) essentially contributes to a person's sense of well-being, and would also facilitate reintegration into and acceptance by the community. This is a pertinent consideration in the South African context since these funds could be made available for community-based mental-hygiene and psycho education programmes with the emphasis on prevention rather than 'cure'.

One shortcoming of the present community mental health movement, however, is that it still lacks a clear, unambiguous theoretical basis which informs practical intervention. 'Treatment' is thus still very much rooted in the medical model.

The future of the mental health movement in post-apartheid South Africa poses a challenge for mental health workers and statesmen alike, since legislation will lend thrust to the 'reconstruction and development' of the current mental health structures.

I believe that as long as mental health institutions continue to function as they do presently, i.e. within a predominantly medical framework, the practice of patients going absent without leave will persist, and perhaps increase.

The process of 'deinstitutionalisation', however, is a challenging one, particularly in view of the stigma attached to mental illness and the historical expulsion of the mentally ill from society. Community education is thus clearly integral to this process.

The post-apartheid Government of South Africa has already recognised the legitimate concern about the availability of adequate community services for the mentally ill. It would therefore have to assume initiatives to ensure that both health and social care are more efficient and accessible to the masses. South Africans may benefit from some of the guidelines set forth by developed countries such as Great Britain. Below are some considerations for future community care which were presented to Parliament by command of Her Majesty (Caring for People : Community Care in the Next Decade and Beyond, 1989, pp 55-58).

The essential components of locally-based services should include community-based services for children and adolescents with psychological problems, coupled with access to professional support and hospital services (if necessary).

Adequate services for assessment and treatment of adults who require short term or longer term admission are also important. There should also be an effective networking between health and social services authorities, primary health care teams and voluntary agencies so as to facilitate the continuing care of those people with a mental illness who are residing in the community. This policy could offer a more effective service and simultaneously enhance the quality of life of the mentally ill.

An important prerequisite for 'deinstitutionalisation' is that adequate alternative structures have been developed. Unless this has been effected, the reduction of hospital beds and closure of mental hospitals could pose an even bigger problem.

Since capital for building new facilities is a problem, the Government may consider involving the private sector. Developers may, for example, build community resources with the appropriate facilities for the mentally ill, in return for all or part of the redundant hospital sites.

The Department of Health may further benefit from considering additional initiatives such as guidance to practitioners on compulsory admission, and also by recognising the contribution of the voluntary sector. Since the latter plays a major role, the Department could encourage an active, empowered voluntary sector through central funding.

These are but a few suggestions which may facilitate the process of deinstitutionalisation, and enhance community integration of those persons who are considered mentally ill.

Finally, it is considered that the present study has attained its objective, namely, to provide a descriptive profile on patients going AWOL at Lentegeur Hospital, Cape Town, South Africa. An adequate sample size was achieved and clear results were shown across a number of variables. These findings could form the basis for further studies pertaining specifically to the phenomenon of AWOL, and also to broader mental health issues. Moreover, it could serve as a springboard for local discussions regarding future policy-making and mental health practices. Interim measures for identifying potential AWOL patients and dealing with the phenomenon (for example, brief hospitalisations and devising appropriate and differential treatment methods) may also be generated.

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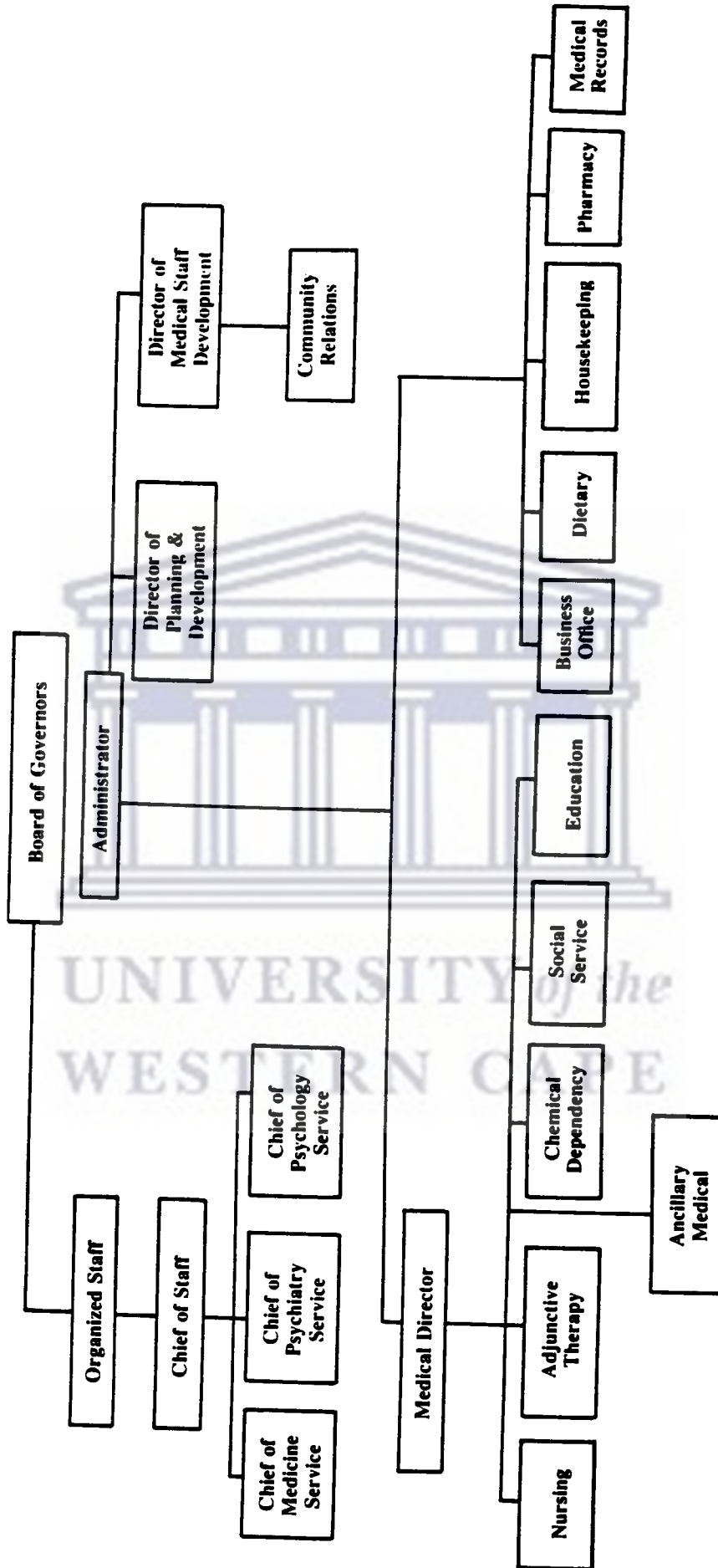
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APPENDIX I

Sample Hospital Organizational Chart



APPENDIX II.

SURVEY OF PATIENTS WHO ABSCONDED FROM LENTEGEUR HOSPITAL

PLEASE MARK WITH AN X WHERE APPROPRIATE OR ANSWER IN SPACE PROVIDED

IDENTIFYING DATA

WARD

SURNAME

FIRST NAME

SEX

MALE	FEMALE
------	--------

AGE

FOLDER NUMBER

DATE OF ADMISSION

DD	MM	YY

SECTION OF THE M.H. ACT

3	4	9	12	28	OTHER
---	---	---	----	----	-------

MARITAL STATUS

MARRIED	SINGLE	DIVORCED	SEPARATED
---------	--------	----------	-----------

WIDOW/ER	COM. LAW SPOUSE
----------	-----------------

RELIGION

CHRISTIAN	MOSLEM	OTHER
-----------	--------	-------

EDUCATIONAL LEVEL

NONE	A - 4	5 - 6	7 - 10	POST MATRIC
------	-------	-------	--------	-------------

UNKNOWN

EMPLOYMENT

UNEMPLOYED	EMPLOYED	D. GRANT	UNKNOWN
------------	----------	----------	---------

PATIENT LIVING WITH

PARENTAL FAM.	MARITAL FAM.	FOSTER CAS
---------------	--------------	------------

FRIEND	BOARDING	ALONE	UNKNOWN
--------	----------	-------	---------

PSYCHIATRIC HISTORY

PROVISIONAL DIAGNOSIS

AXIS 1

AXIS 2

AXIS 3

MEDICATION AT TIME OF
ABSCONDING

ORAL NEUROLEPTIC

YES	NO
-----	----

DEPOT NEUROLEPTIC

YES	NO
-----	----

ANTI-DEPRESSANT

YES	NO
-----	----

ANTI-EPILEPTIC

YES	NO
-----	----

ANXIOLYTIC

YES	NO
-----	----

ANTI-PARKINSONISM

YES	NO
-----	----

LITHIUM

YES	NO
-----	----

OTHER SPECIFY

NOT ON MEDICATION

YES

DID PATIENT COMPLAIN OF ANY
SIDE EFFECTS

YES	NO
-----	----

IF YES, DID PATIENT COMPLAIN OF

ACUTE DYSKINESIA

YES	NO
-----	----

DYSTONIA

YES	NO
-----	----

PARKINSONISM

YES	NO
-----	----

AKATHISIA

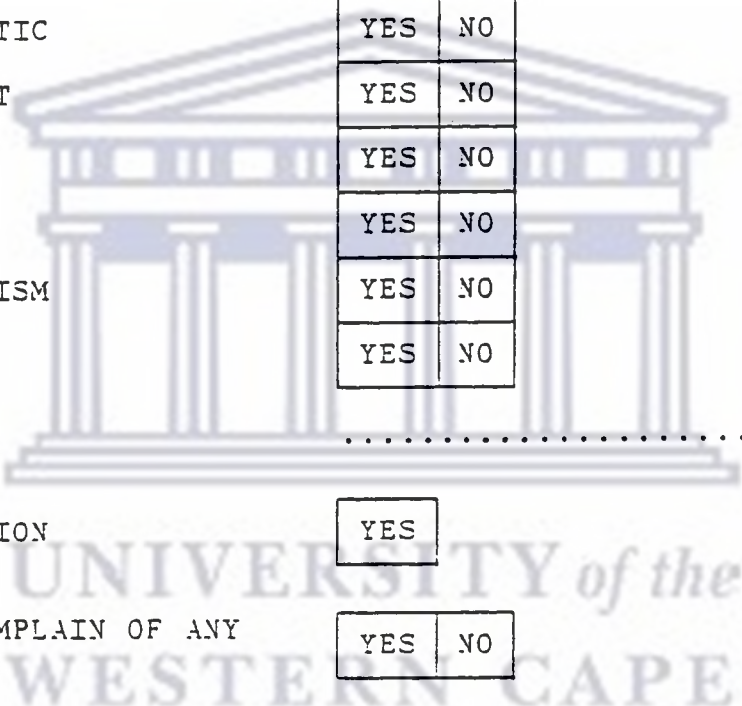
YES	NO
-----	----

TARDIVE DYSKENESIA

YES	NO
-----	----

NUMBER OF PREVIOUS ADMS.

1	2	3	MORE THAN 4
---	---	---	-------------



ABSCOND INFORMATION

WAS PT ADMT. TO WARD DIRECTLY

YES	NO
-----	----

IF NOT TRANSFD. FROM

DATE OF TRANSFER

DD	MM	YY

DATE OF ABSCONDMENT

DD	MM	YY

IS THERE A PREVIOUS HISTORY OF ABSCONDING

YES	NO
-----	----

NUMBER OF PREVIOUS ABSCONDS.

1	2	3	4	MORE THAN 4
---	---	---	---	-------------

WHO WAS INFORMED ABOUT ABSCONDMENT

MED. SUPT.	S.A.P.	FAMILY	FRIEND
------------	--------	--------	--------

DATE OF LAST ENTRY IN PATIENT'S FOLDER

DD	MM	YY

LAST ENTRY MADE BY :

DOCTOR

YES	NO
-----	----

PSYCHOLOGIST

YES	NO
-----	----

NURSING STAFF

YES	NO
-----	----

SOCIAL WORKER

YES	NO
-----	----

OCCUPATIONAL THERAPIST

YES	NO
-----	----

OTHER SPECIFY

WHEN DID PATIENT ABSCOND

DURING THE NIGHT 6pm - 7am

YES	NO
YES	NO

BEFORE BREAKFAST

BETWEEN :

BREAKFAST AND MORNING TEA

YES	NO
-----	----

MORNING TEA & LUNCH

YES	NO
-----	----

LUNCH & AFTERNOON TEA

YES	NO
-----	----

AFTERNOON TEA & SUPPER

YES	NO
-----	----

AFTER SUPPER

YES	NO
-----	----

DATE PATIENT RETURNED

DD	MM	YY

BROUGHT BACK BY

S.A.P.	FRIEND	FAMILY	RETURNED ON OWN
--------	--------	--------	-----------------

ABSCOND DISCOVERED

OBSERVED

YES	NO
-----	----

DURING ROUTINE CHECK

YES	NO
-----	----

INFORMED BY FELLOW PATIENT

YES	NO
-----	----

PATIENT FOUND

AT HOME

YES	NO
-----	----

AT FRIEND'S HOUSE

YES	NO
-----	----

ON HOSPITAL GROUNDS

YES	NO
-----	----

ON THE STREET

YES	NO
-----	----

UNKNOWN

YES	NO
-----	----

HOW DID PATIENT LEAVE WARD

BEDROOM WINDOW

YES	NO
-----	----

FRONT DOOR

YES	NO
-----	----

BACK DOOR

YES	NO
-----	----

FROM YARD

YES	NO
-----	----

BROKE WINDOW / DOOR

YES	NO
-----	----

UNKNOWN

YES	NO
-----	----

DID PATIENT REQUEST DISCHARGE

YES	NO	UNKNOWN
-----	----	---------

DID PATIENT THREATEN TO ABSCOND

YES	NO
-----	----

WAS PATIENT DUE FOR DISCHARGE

YES	NO
-----	----

WAS STAFF PARTICULARLY WORRIED ABOUT PATIENT WHILE PATIENT ON ABSCOND

YES	NO
-----	----

DID PATIENT RECEIVE VISITORS WHILE IN WARD

YES	NO
-----	----

WARD INFORMATION

NUMBER OF PATIENTS IN WARD AT TIME OF ABSCONDING

1 - 10	11 - 20	21 - 30	30+
--------	---------	---------	-----

PRIOR TO ABSCONDING DID PATIENT AS FAR AS YOU KNOW :

ARGUE WITH FELLOW PATIENTS

YES	NO
-----	----

INVOLVED IN A FIGHT

YES	NO
-----	----

IN AN ACTIVITY GROUP

YES	NO
-----	----

DUE FOR ANY SPECIAL TREATMENT

YES	NO
-----	----

NUMBER OF NURSING STAFF ON DUTY AT TIME PATIENT ABSCONDED

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----