

**A RETROSPECTIVE RECORD REVIEW OF MENTAL
HEALTH CARE USERS WHO ABSCOND FROM A
PSYCHIATRIC HOSPITAL**

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A research report submitted to the Faculty of Health Sciences, University of
the Witwatersrand, Johannesburg, in partial fulfilment of the requirements

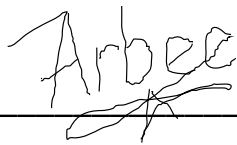
for the degree of

Master of Medicine in the branch of Psychiatry

Johannesburg, 2014

DECLARATION

I, Feroza Arbee declare that this research report is my own work. It is being submitted for the degree of Master of Medicine in the branch of Psychiatry in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

A handwritten signature in black ink, appearing to read 'Arbee', is written over a horizontal line.

14th day of May, 2014

For my parents, your eternal encouragement and optimism
is always appreciated

For my husband Yaseen

And children Fayaaz and Safiya Bibi,

Without your support and patience this would not have been possible

Most importantly, for my dearest grandmother

Your bravery and dynamism in the face of all difficulties

will never be forgotten

(1924 – 2014)

PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS STUDY

- ❖ Oral presentation – University of Witwatersrand, Department of Psychiatry, Annual Research Day, June 2010

ABSTRACT

Introduction

Absconding from psychiatric facilities has socioeconomic implications. The aetiology is multifactorial. Absconding patients are at higher risk of self-harm, violence, non-adherence, relapses, substance use and negative media attention. Identification of potential absconders would assist with risk assessment and prevention.

Methods

A retrospective record review was conducted of all absconds from a tertiary psychiatric hospital over one year. An abscond rate and a profile were formulated. In addition, trends were identified since the inception of democracy and deinstitutionalization.

Results

97 patients absconded 108 times during the study period, 7 having absconded more than once. The absconding rate was 7.83%. The typical absconder is: single, unemployed male, in his early 30's, known to psychiatric services, diagnosed with schizophrenia and co-morbid substance use. The typical absconder is more likely to be a forensic patient not returning from an official leave of absence.

Conclusion

The study defines the profile of the typical absconder. The abscond rate has decreased to half that of a previous study by Siwinska (1993). Mental health care users are being treated in a less restrictive manner and this results in less absconds and a change in the method of absconds. This has implications for clinical practice.

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GLOSSARY/ABBREVIATIONS/LEGAL REFERENCES

Abscond – when a patient /mental health care user leaves the hospital premises without being discharged. It also applies to patients on leave of absence (LOA) who do not return within the prescribed time. Thus the term abscond encompasses mental health care users who escape and those not returning from Leave of Absence

Escape – when a patient/mental health care user runs away or finds a way out of the ward/hospital without being given LOA or discharge

Health establishment – institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitative centres, clinics, hospitals and psychiatric hospitals

Involuntary care, treatment and rehabilitation – the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others

Leave of Absence (LOA) - leave from the health establishment that is approved and granted by the mental health care practitioner. Usually the duration of the LOA and terms and conditions are agreed upon prior to the mental health care user leaving and the user is usually signed over into the custody of a responsible family/community member

Mental Health Care Provider (MHCP) – a psychiatrist, registered medical practitioner, nurse, Occupational Therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitative services

Mental Health Care User (MHCU) – a person receiving care, treatment and rehabilitative services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner

Mental Health Review Board (MHRB) – a Review Board established in respect of every health establishment providing mental health care services in that province. Comprised of 3-5 South African citizens appointed by the Executive Council in each province (viz. a mental health care provider, a member of the community concerned and either a magistrate, attorney or an advocate)

Method of Abscond – whether a mental health care user fails to return from an official LOA or physically escapes while under custody of the health establishment

Observandus (plural *observandi*) – awaiting trial detainee/s referred by the court for the period of 30 days observation for inquiry into his/her mental status

SAPS – South African Police Service

State Patient - a person so classified by a court directive in terms of Section 77 or 78 of the Criminal Procedure Act. See below. Admission is usually to the forensic wards.

Mental Health Care Act 17 of 2002 (MHCA)

Section 18 – where a mental health care user does not present himself or herself for monitoring and review according to the conditions of LOA, and after the necessary measures have been taken by the health establishment concerned to locate such user, such user shall be deemed to have absconded in terms of Section 40 of the Act and in such case the health establishment concerned shall inform the SAPS in the form of MHCA

Section 29 – if a mental health care user has absconded or is deemed to have absconded, the head of the health establishment concerned may in terms of section 40, 44 or 57 of the Act and in the form of MHCA 25, notify and request the assistance from the SAPS to locate, apprehend and return the user to the health establishment concerned

Section 33 – application to obtain involuntary care, treatment and rehabilitation of a mental health care user, where two mental health care practitioners must assess the physical and mental health status of the user for a period of 72 hours

Section 34 – after the 72 hour assessment period, the mental status of the user warrants further involuntary care, treatment and rehabilitation services

Section 42 – the court orders the admission of state patients to designated health establishments for mental health treatment, care and rehabilitation under the Criminal Procedure Act

Section 44 - If a state patient has absconded, the health establishment concerned must

- a) Immediately notify and request the SAPS to locate, apprehend and return the patient to the health establishment
- b) notify the Registrar or Clerk of the Court concerned and the official *curator ad litem*, within 14 days of having notified the SAPS

Section 45 – the head of the health establishment may, in writing, grant Leave of Absence (LOA) to a state patient from a designated health establishment. If the state patient fails to return to the health establishment on the return date, he or she will be deemed to have absconded

Criminal Procedure Act No 51 of 1977 (CPA)

Section 77 – Capacity of the accused to understand proceedings - if it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the Court shall direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79

Section 78 - Mental illness or mental defect and criminal responsibility – a person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him incapable –

- a) of appreciating the wrongfulness of his act; or
- b) of acting in acting in accordance with such an appreciation of the wrongfulness of his act or omission, shall not be criminally responsible for such an act or omission

Section 79 – Panel for purposes of enquiry and report under Sections 77 and 78 – the court may for the purposes of the relevant enquiry commit the accused to a mental hospital or to any other place designated by the court, for such periods, not exceeding 30 days at a time

CHAPTER ONE

1.1 Introduction

The phenomenon of absconding from psychiatric facilities is a serious and costly health issue. It is associated with significant social, economic and emotional costs (Muir-Cochrane, Mosel & Gerace, et al., 2011) and valuable resources are spent in trying to eradicate this problem. There is no single definition for absconding and this makes comparison between studies difficult. The aetiology is multifactorial, with environmental, psychosocial and organic contributors (Muir-Cochrane & Mosel, 2008). The identification of the potential absconder and the circumstances surrounding the escape would help with risk assessment and inform effective clinical management.

1.2 Objectives

- 1.2.1 To determine the number of Mental Health Care Users who absconded from Sterkfontein Hospital for the period January 2008 to December 2008
- 1.2.2 To provide a descriptive analysis of Mental Health Care Users who absconded from Sterkfontein Hospital in 2008
- 1.2.3 To compare data obtained with that of Siwinska (1993) with a view to highlighting differences and similarities between the two studies

1.3 Hypothesis

We hypothesized that the descriptive profile of users who absconded would NOT be different to the previous study done by Siwinska at Sterkfontein Hospital in 1993. Siwinska's findings are in keeping with international trends viz: absconders are more likely to be young, single, unemployed males of Ethnic origin with a likely diagnosis of schizophrenia and a history of substance abuse.

CHAPTER TWO: LITERATURE REVIEW

2.1 Definition:

Research on absconding was pioneered in the 1960's. Since then several studies have been conducted. A standard definition of absconding remains elusive, making prevalence difficult to establish (Muir-Cochrane, 2008 and Mosel, Gerace & Muir-Cochrane, 2010) and comparison between studies difficult (Bowers, Jarrett & Clarke, et al., 2000). There are several definitions for the phenomenon of absconding. As cited by Bowers, Jarrett & Clark (1998), some include temporary short absences from the ward, failure to return from an official absence of leave (Yasini, Sedaghat & Ghasemi Esfe, et al., 2009), discharge AMA (Against Medical Advice) and unauthorised absence without leave (AWOL) (Pages, Russo & Wingerson, et al., 1998 and Meehan, Morrison & McDougall, 1999).

According to a literature review by Bowers, et al. (1998), the best and most popular definition seems to be that of Antebi (1967). He defined absconding as "leaving the hospital grounds without permission, or failing to return from leave". This is in keeping with the definition as understood in the Mental Health Care Act No. 17 of 2002, as well as that used in the policy of Sterkfontein Psychiatric Hospital.

2.2 Importance/Consequences

There are significant legal, administrative and therapeutic repercussions associated with absconding (Siwinska, 1993). Negative consequences include : harm to self or others, discontinuity of treatment, relapses, violent behaviour (Mosel, 2010 and Muir-Cochrane, 2011), substance abuse, being placed under constant special observation (Whitehead & Mason, 2006),

worse long term outcome, negative media attention and a negative portrayal of psychiatric services (Khisty, Raval & Dhadphale, et al., 2008 and Yasini, 2009).

Bowers, et al. (2000) predict that a patient with a previous history of absconding is 9 times more likely to abscond again. In addition, they compared absconding between wards under different consultant care; they postulated that the differing abscond rates could, in part, be influenced by the different styles employed by nursing staff and the multi-disciplinary teams involved. The introduction of therapeutic groups and increased patient involvement in their own care could reduce absconding.

Reporting of absconding sometimes only takes place when sufficient concern has been aroused by the staff involved. They may only take action if the patient is legally detained. Other absences may simply be “waited out” or the patient contacted telephonically, before officially reporting the incident.

Absconding tends to be a costly, disruptive event in which valuable resources are wasted. It is no wonder then that the phenomenon arouses genuine concern on the part of mental health care professionals.

2.3 Sociodemographic Profile

Bowers, et al. (1998) and Meehan, et al. (1999) postulated that the potential absconder was a young single male who suffered from schizophrenia and who came from a disadvantaged background. However, younger male schizophrenic patients are more likely to be admitted to in-patient psychiatric services (Janse van Rensburg, 2007 and Mabena, 2010). This can lead to an over-representation of patients with these characteristics. There is also a link to compulsory detention and patients referred by court (Muir-Cochrane, 2008 and Mosel, 2010). However, this

may be due to more efficient reporting of these cases due to the perception that they pose a higher risk.

Other associated factors include substance abuse, previous admissions, a history of previous absconds and a high-risk period shortly after admission. Most studies of gender effect and ethnicity have been found to have inconclusive and conflicting findings (Khisty, 2008 and Muir-Cochrane, 2008). However, even while finding that males were responsible for almost 75% of absconding events in their study, Muir-Cochrane, et al. (2011) calculated that this was not statistically significant. In short, males are NOT more likely to abscond, but due to larger numbers of male admissions, they ARE responsible for more absconds. Khisty, et al. (2008) cited an Indian study by John, et al. (1980) who found exceptionally low abscond rates from females and hypothesized that it was due to cultural restrictions imposed on Indian women.

2.4 Absconding Rates

Absconding rates vary widely because of the different definitions used (Yasini, et al., 2009). Up to 50% of absconds may not be reported, therefore the true extent is not known. Differences in the methods of calculating abscond rates have resulted in the wide range of 2.5% – 34% of all psychiatric admissions (Muir-Cochrane, et al., 2011). However, this excludes forensic and adolescent psychiatric services. Some studies calculated event-based rates. These tend to be higher because repeat absconds are included. Others only calculate patient-based rates. According to Muir-Cochrane, et al. (2011), inconsistencies lead to incomparability of results between studies and a lack of precision, due to differing methods of calculation.

2.5 Why patients abscond

Advances in understanding the reasons that patients abscond, as well as the methods used, may help health care professionals to reduce associated risks. Interventions to decrease absconding need to be designed and put in place. The reasons that patients abscond are many and varied. Some of the reasons are : boredom (Meehan, et al.,1999), going to see family, lack of visitors, unwell relatives, relationship problems, impulsivity, non-compliance, fashion/fad in ward, influenced by other patients, active symptomatology (e.g. command hallucinations), to obtain substances, stigmatization, dislike of staff, ward or food, lack of privacy (Falkowski, Watts & Falkowski, et al., 1990), feeling that their admission is unnecessary (Meehan, et al.,1999), feeling trapped and confined, unwelcome news about denial of leave or discharge (Yasini, et al.,2009).

Most patients abscond after being given permission to leave the ward unaccompanied. There is also some link to escape during the warmer seasons (Falkowski, 1990 and Bowers, 1998). In addition, Meehan, et al. (1999) found that up to one third of all incidents were repeat absconds by the same individuals and the first 7 days post-admission were a high-risk period. This may be the most potent predictor of the absconder.

2.6 Deinstitutionalization and the South African perspective

In 1994, South Africa inherited the Apartheid legislation of highly institutionalized and outdated custodial psychiatric services. With democracy, there has been a parallel move in psychiatry towards least restrictive and more accessible mental health care. This was propagated by the implementation of the new Mental Health Care Act No. 17 of 2002, which repealed and replaced the Mental Health Act No. 18 of 1973, which was widely considered to be outdated. The new Act was promulgated on the 15 December 2004 and is considered to be among the most progressive

mental health legislation in the world (Ramlall, 2012). It attempts to address the problems of stigmatization, discrimination, prolonged institutionalization, inaccessibility to appropriate care and exploitation of the rights of people living with mental disorders. Emphasis is placed on the treatment and protection of its users in the least restrictive environment i.e. deinstitutionalization, rather than the detention of the patient.

Globally, deinstitutionalization began some 60 years ago. To many, deinstitutionalization was the down-scaling of tertiary psychiatric services, with the placing of mental health care users into the care of a range of community-based services. The emergence of consumer and family advocacy groups also assists in the development of a more humanistic treatment system. Khisty, et al. (2008) suggests that findings from developed countries cannot be generalised to developing countries due to the differences in legislation, resources and culture. In India, most patients are accompanied by a family member throughout their admission (the authors do not specify the reasons for this) and are financially responsible for any use of psychiatric services. In many countries, including South Africa, this would not be feasible for many of our MHCUs and the needs of our most vulnerable population would not be met. Szabo (2006) pointed out that there are “inescapable commonalities” between developed nations and South Africa’s “developing nation” status i.e. limited resources, the need for integration between health and social services and for cohesion between hospital and community-based services.

Unfortunately, there has not been resounding evidence for the success of deinstitutionalization. From a local perspective, service integration has been hampered by infrastructure constraints, administrative challenges and limited political support (Lund, Petersen & Kleintjes, et al. 2011 and Ramlall, 2012). The phenomenon has been known to fail to acknowledge the changing clinical needs of the most disadvantaged members of our community. Potential negative outcomes have resulted in: premature discharge, frequent relapses, homelessness, substance abuse, social issues,

neglect and the “revolving door phenomenon” (i.e. the re-admission of MHCUs who relapse) (Hamden, Newton & McCauley-Elsom, et al., 2011 and Petersen & Lund, 2011). As progressive and well-meaning as the new South African legislation may be, due consideration was not given to infrastructure requirements and the absence of a supporting implementation plan has hampered progress (Szabo, 2006 and Ramlall, 2012).

A new Mental Health Act was introduced in Britain in 1983 and a study was conducted in 1990 by Falkowski, et al. They found that the majority of absconders were repeat absconders and were compulsorily detained at the time of absconding. However, despite the changes in psychiatric practice and the implementation of a new, less restrictive Mental Health Act of 1983, Falkowski, et al. (1990) found no major differences in absconding. Similarities included demographic details, diagnoses, duration of absence and legal status. The proportion of absconding patients was unchanged, despite fewer MHCUs being kept in locked wards. Falkowski, et al. (1990) also found in their review of many studies that few, if any, changes were made in patients’ management on their return. They suggested that specific policy be designed and implemented for returned absconded patients. With the above in mind, there was little to suggest that the situation in South Africa would be any different following the implementation of the new Mental Health Care Act and its accompanying shift towards deinstitutionalization. Kaliski (2013) points out that deinstitutionalization, with its enforced psychiatric bed reduction and increased turnover of patients, has resulted in a paradoxical increase in the number of involuntary admissions. This may imply that the population at risk of absconding is potentially larger.

To date there have been two studies on absconding in South Africa (Karani, 1986 and Siwinska, 1993). Both of these studies had findings in keeping with international findings. However, both studies were carried out more than 20 years ago and since then there have been many changes. Subsequent to the implementation of democracy in 1994, there has been major transformation in

legislation with the promulgation of the new MHCA of 2002. In addition, the study done by Siwinska (1993) did not examine an abscond rate as such, but rather was a descriptive profile of patients who absconded.

Siwinska's study at Sterkfontein Hospital in 1993 found that the abscond group was largely male, unemployed, single, non-white, in their thirties and suffered from schizophrenia. There was also a large proportion of absconders diagnosed with substance-induced psychosis. Approximately one third of the absconders were patients who did not return from official leave of absence. The patients who escaped tended to do so within a short time of their admission. These findings are in keeping with international trends (Bowers, 1998; Bowers, 2000; Muir-Cochrane, 2008).

There have been no recent South African studies on absconding. It is important therefore, that a systematic study be undertaken in order to compare a South African population with that of international studies. This is particularly important from a risk management perspective.

2.7 Risk Profile and Management Strategies

Pages, et al. (1998) suggest that if potential absconders could be identified, interventions could be implemented which could insure that these patients complete treatment, rather than repeatedly use high-cost inpatient services for crisis management. This would prevent multiple hospitalisations i.e. the "revolving door phenomenon". Hypothetically, it is possible to achieve a certain level of accuracy when predicting potential absconders. This would be helpful for service planning, quality assurance and evaluation of treatment. Interventions may then be targeted at these patients to prevent the event. This is particularly important in the case of potentially dangerous forensic patients.

Pages, et al. (1998) included absconded patients in their study on patients who were discharged Against Medical Advice (AMA). They found 6 significant predictors that could be used when identifying these patients: substance abuse, 2 or more previous psychiatric hospitalisations, ethnicity other than Caucasian, absence of physical impairment, male gender and mild to no suicidality at admission. They also found that the chances of rehospitalisation within one month were greater and these patients tend to have worse outcomes. Overall, these broad findings provide little guidance when trying to address the problem of absconding.

Gudeman, et al. (1985), as cited by Bowers, et al. (2000), implemented a set of changes that resulted in less restrictive care and found that this significantly decreased absconding. This coincides with findings by Khisty, et al. (2003) that absconding rates were higher from locked wards. Some of the suggestions made to decrease absconding were : locking wards, the introduction of group activities to give patients a chance to express themselves, regular checking by nurses, use of a sign-out book (Bowers, et al., 2005), patient involvement in treatment planning, contracting with patients about off-unit privileges, early discharges for patients who clearly intend to leave, appropriately skilled staff to provide sufficient attention and improved communication between staff and patients.

By identifying the interaction between factors and mechanisms contributing to the phenomenon of absconding, a framework for evidence-based intervention arises. Currently, there is a significant gap in the local knowledge base from both a risk assessment and quality of care perspective. We need to extend the current knowledge about the phenomenon of absconding, both nationally and internationally, to effectively inform management and best practice.

CHAPTER THREE: METHODOLOGY

3.1 Site of the study

Sterkfontein Hospital is a specialised psychiatric hospital that is situated outside of Krugersdorp. It provides tertiary level in-patient care for the population of Southern Gauteng. It is designated to treat patients under Section 34 of the MHCA i.e. for further involuntary care. Due to infrastructure constraints at referring hospital level, it also manages involuntary patients under Section 33 (i.e. for 72 hour observation).

At the time of the study, it provided forensic services for Southern Gauteng, as well as the North West Province (Appendix E). With regard to the forensic section, *observandi* (awaiting trial detainees) are admitted for a 30 day observation period. If, following this 30 day period, they are found not to be fit and/or not criminally responsible by virtue of mental illness or defect; and the crime was minor, they can be referred to the general section of the hospital under Chapter 5 of the MHCA for involuntary care and treatment. If the crime was major, they are admitted to the forensic unit as state patients under Section 42 of the MHCA. Frequently, there are lengthy delays between post-observation referral and admission. This leads to longer duration of untreated illness and this could possibly contribute to higher levels of treatment resistance and aggression. Sterkfontein Hospital also provides mental health services for forensic adolescent males (both for observation and as state patients).

Sterkfontein Hospital is located far away from the population it serves and is thus not easily accessible. This has negative implications both for visiting relatives and potential staff members. It has an inadequate number of beds for the population it serves. At the time of the study, it was running at approximately 72% occupancy because of infrastructure and human resource constraints. There were 820 approved beds, 638 of which were usable. Furthermore, the ratio of

beds at the time of the study was: general psychiatry (52%) and forensic psychiatry (48%). It caters for both male and female adults, as well as adolescent forensic male patients. The general psychiatry section has both open and closed wards. It also has a Dual Diagnosis Unit, for the rehabilitation of substance use disorders and an Integrated Living Unit (for rehabilitation and re-integration into society). Sterkfontein Hospital is affiliated to the University of Witwatersrand's Department of Psychiatry and is thus a teaching hospital.

3.2 Abscond and Escape Policy

Sterkfontein Hospital has a policy in keeping with the MHCA and the Criminal Procedure Act currently in use in South Africa. All MHCUs who leave the hospital premises without being discharged are considered as having absconded. This also applies to MHCUs on LOA who do not return within the prescribed time. An escaped MHCU is one who runs away or finds a way out of the hospital without being given LOA or discharge.

In the event of an escape or abscond, the ward manager must inform hospital security for assistance. All entrances must be locked and checked. All MHCUs in the ward must be gathered and a head count done. The premises must be searched, including wards and buildings not in use. If the MHCU is not found, he/she must be reported as having absconded. The ward manager must inform the assistant or operational manager, the ward doctor, hospital security services, the local SAPS and the MHCU's family or next-of-kin telephonically. If an *observandus* has absconded/escaped, the investigating officer will need to be notified.

The SAPS must receive a full description of the absconded MHCU, including clothes worn at the time of the abscond, as well as the mental and physical condition of the MHCU. They are also given a home address and telephone numbers to assist in locating the absconded MHCU.

The absconding event is recorded on the daily incident report, the MHCU's file and a notification of abscond/escape form is filled in. In accordance with the MHCA, the relevant form MHCA 25 is completed and submitted to the nursing administration who usually faxes a copy to the MHRB.

In the event of a MHCU not returning from an official LOA on the stipulated date, the family is contacted to establish the reasons. The family may be advised to seek assistance from the local SAPS if the MHCU is reluctant to return. Thereafter the above procedure is followed. The MHCU's file is usually kept in the ward and he/she is NOT discharged immediately. State patients are periodically followed up (i.e. contact with family members or SAPS) and further attempts made to return the patient to the hospital. A MHCU admitted to a general ward is usually discharged in absentia after 3 months. This is an internal policy at Sterkfontein Hospital, as patients cannot be kept on the hospital in-patient list indefinitely. The policy was developed to assist with logistical challenges with regard to bed numbers and administrative complications.

If the MHCU returns or is found, he/she is re-admitted and assessed by the ward doctor or doctor-on-call. The relevant MHCA 26 is completed and sent to the MHRB via management.

3.3 Study design

The study design was that of a retrospective record review of all mental health care users who absconded from Sterkfontein Hospital over a 12 month period, from January to December 2008. It was a descriptive cross-sectional study aimed at identifying the abscond rate and to provide a profile of absconders.

3.4 Sample

Data on all documented absconds was obtained from the daily incident reports, forensic administration department statistics, records of faxes sent to the MHRB, as well as patient files. These were cross-referenced with ward movement books for the year 2008.

All wards comprising Sterkfontein Hospital were investigated

i.e. 2 acute female general wards

3 acute male general wards

Admissions ward

1 male medical ward

1 chronic male ward

The Integrated Living Unit (ILU)

The Dual Diagnosis Unit (DDU)

1 adolescent forensic ward (observations and state patients)

4 male forensic wards (observations and state patients)

1 female forensic ward (observations and state patients)

In addition, the records of patients absconding from the forensic LOA Clinic were also reviewed.

All absconders between the 1st of January and the 31st of December 2008 were identified and included in this study. There were no exclusion criteria.

3.5 Data/Tools

Data on patient age, gender, relationship status, employment status, section of the MHCA or CPA under which admitted, general or forensic ward, open or closed ward, psychiatric diagnoses, substance use, factors that may have contributed to the abscond, presence of past psychiatric history, documented previous admissions, date of admission, date of abscond, method of abscond, previous absconds, length of hospital stay and whether returned or not were obtained from the above sources. A data collection sheet was utilised (Appendix D).

Contributing factors were any events/reasons reported by the patient or documented in the file that may have contributed to the absconding event. Some of these were documented in the notes either by doctors or nursing staff in the weeks preceding an escape. For those not returning from LOA, these were the reasons given either telephonically to ward staff or captured during re-admission interviews by the ward doctor. None of the sample was interviewed by the principle researcher.

Psychiatric diagnoses were subject to the accuracy and diagnostic skills of the training registrar and were not necessarily based on the Diagnostic and Statistical Manual of Mental Disorders, text revision, 4th Edition (DSM IV-TR) criteria. Sometimes the diagnosis changed during the course of admission. In these cases, the last documented diagnosis prior to the abscond was the preferred diagnosis. Psychiatric diagnoses were broadly categorised to eliminate diagnostic bias and to facilitate comparison.

The abscond rate was also calculated using the widely-accepted formula by Molnar and Pinchoff (1993)

$$Na / Npr \times 100$$

Na = number of patients absconding

Npr = number of patients at risk of absconding (i.e. total number of in-patients at the beginning of the study period plus patients admitted during the course of the study - Appendix A)

The abscond rate could be event-based or patient-based.

When calculating the event-based abscond rate, repeat absconding incidents by patients are distributed across the total number of patients, resulting in higher rates. The patient-based abscond rate takes into account the number of patients who have absconded, regardless of how many times they absconded. For the purposes of this study both rates were calculated.

3.6 Ethical considerations

Approval was obtained from the Human Research and Ethics Committee (HREC) and the Postgraduate Committee of the School of Medicine, Faculty of Health Sciences, University of Witwatersrand (Appendix B). Approval was also obtained from the hospital CEO (Appendix C) to conduct the research at Sterkfontein Hospital. No consent was required from the patients themselves as patient contact was not necessary, nor were any interventions made. Data was elicited retrospectively from patient files. To ensure confidentiality, no identifiers were evident on the data collection sheets and access to patient files was restricted to the principle researcher.

3.7 Statistical Analysis

Descriptive statistical and associational (Chi square and Fisher's exact tests) analyses were used to summarise the data and provide a measure of variability. The data was analysed using the Statistica 9.1 and Stata 11.0 Programs. Means, frequencies and percentages were used to describe the data. If more than one abscond was recorded for a patient, it was analysed separately. For the associational analysis, only the 1st absconding event was considered for repeat absconders.

The abscond rate was also calculated using the formula by Molnar and Pinchoff (1993). As a large proportion of the sample was made up of MHCUs not returning from LOA and the risk assessment and management of these MHCUs differ substantially from escaped MHCUs, it was decided to differentiate these in the statistical analysis.

CHAPTER FOUR: RESULTS

A total of 97 patients absconded during 2008. Of these, 7 patients absconded more than once, resulting in a total of 108 absconding events.

4.1 Abscond Rate

4.1.1 Event-based

The event-based absconding rate per 100 detained patients was 7.83%, with 108 events recorded.

4.1.2 Patient-based

The patient-based absconding rate per 100 detained patients was 7.03%, with 97 patients involved.

4.2 Sociodemographic profile

4.2.1 Age

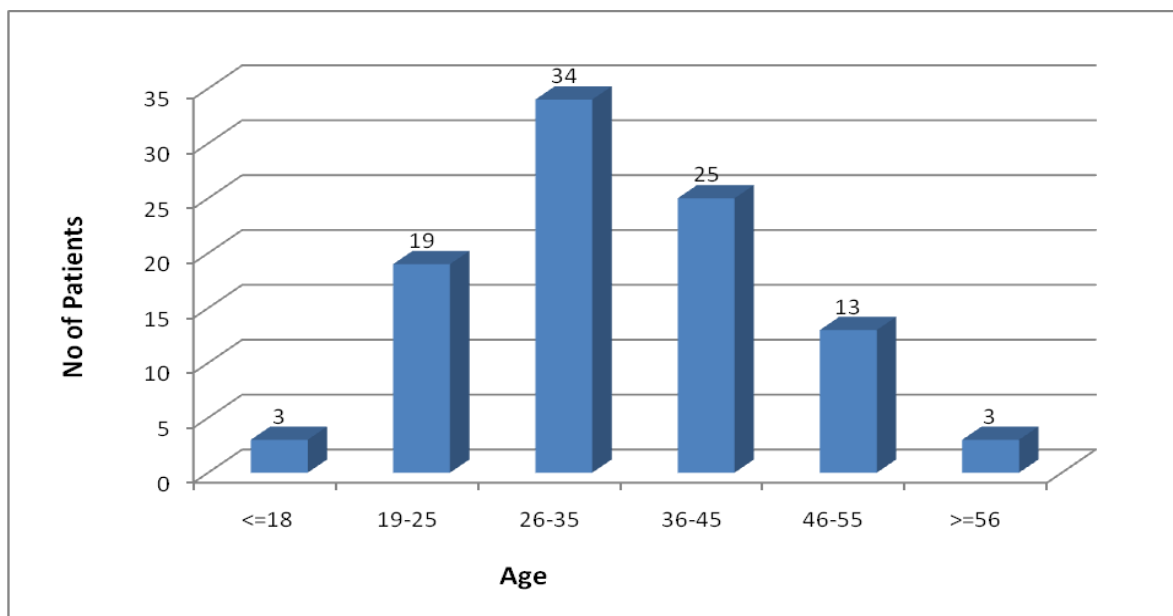


Fig 4.1 Age Distribution of Sample Population

Age was the first predictor to emerge. 60.82% (n = 59) of all absconding patients were between the ages of 26 – 45. The youngest patient to abscond was 15 years old and the oldest patient to abscond was 63 years old. The mean age of the abscond group was 33.8 years. If a distinction was made between escaped patients (n = 22) and those not returning from LOA, then the majority of the sample (11 out of 22) was in the 19-25 year age range and the mean age of the escape group was 26.2 years. There was a significant association between young adulthood (19-25) and escape (P = 0.00).

4.2.2 Gender

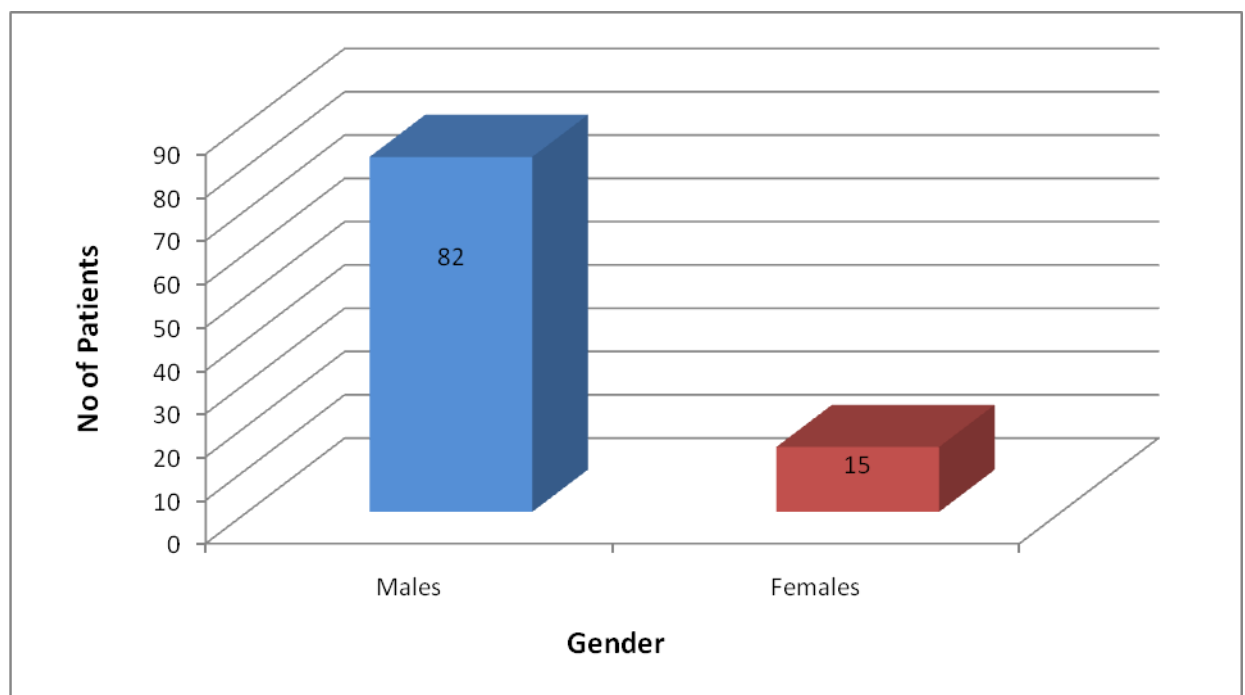


Fig 4.2 Gender Distribution of Sample Population

Gender was the second variable studied. 84.54% (n = 82) of all absconding patients were male and 15.46% (n = 15) were female. The escape sample consisted of 100% males (n = 22) and thus there was a statistically significant link between male gender and escaping (P = 0.02). Females were less likely to escape.

4.2.3 Employment status

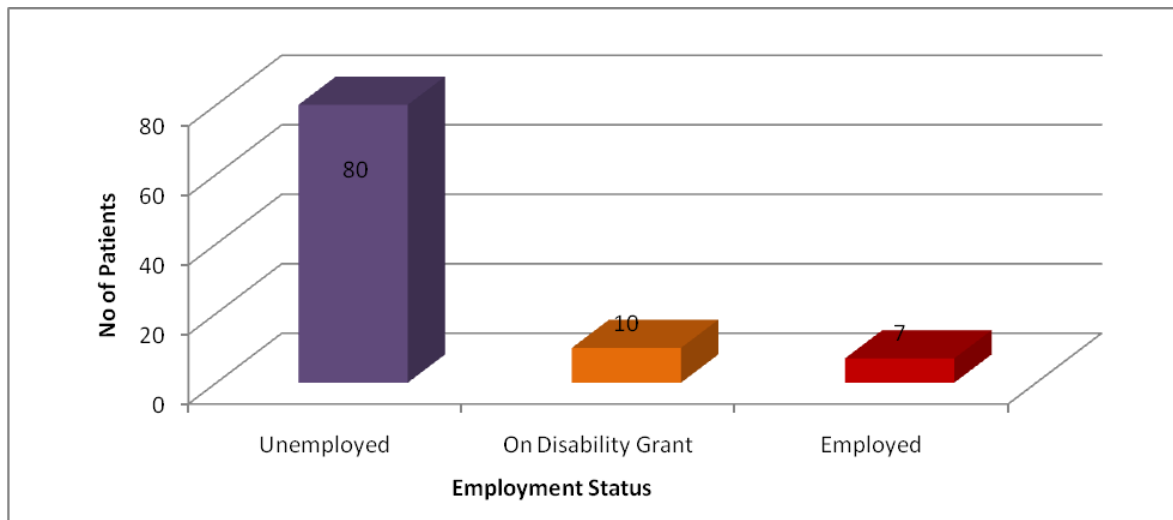


Fig 4.3 Employment Status of Sample Population

82.47% (n = 80) of all absconding patients were unemployed, 10.30% (n = 10) received a disability grant and only 7.22% (n = 7) were employed. There was no association found between employment status and method of abscond.

4.2.4 Relationship Status

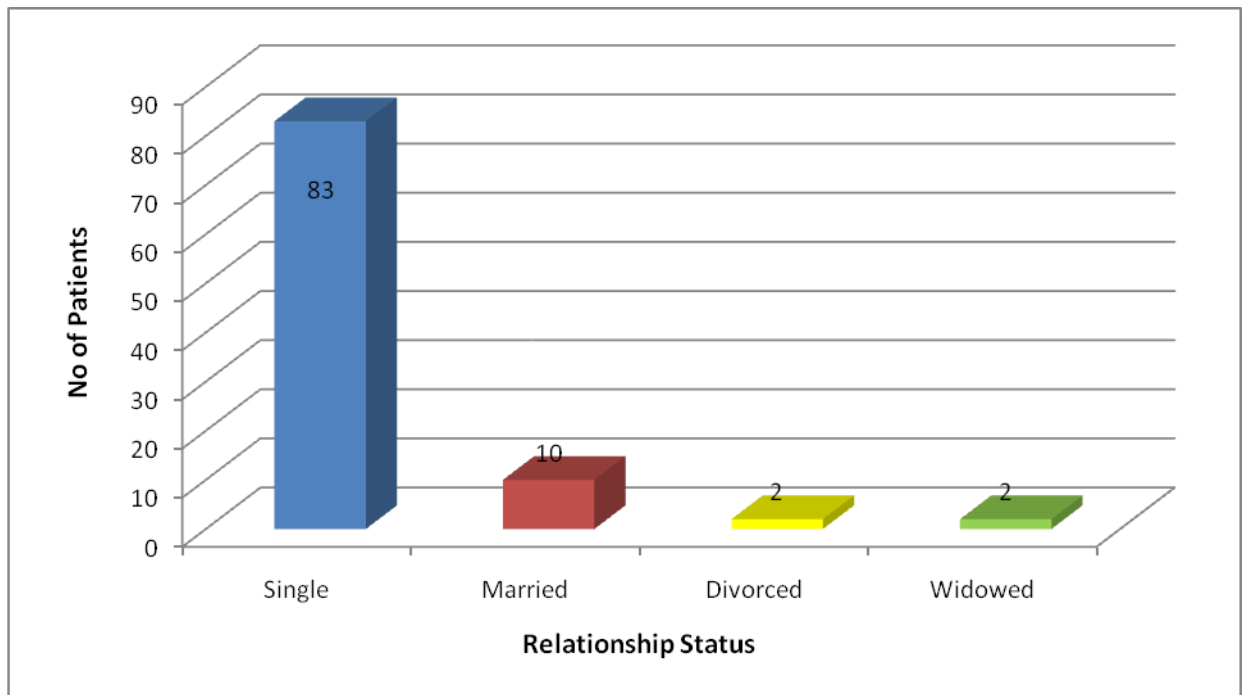


Fig 4.4 Relationship Status of Sample Population

85.57% (n = 83) of all absconding patients were single, 10.31% (n = 10) were married, 2.06% (n = 2) were divorced/separated and 2.06% (n = 2) were widowed. There was no clear association between relationship status and method of abscond.

4.2.5 Sociodemographics in Summary

Table 4.1 Summary of Sociodemographics of Sample Population

Variable	n (%)
<u>Age:</u>	
<= 180	3 (3.09)
19-25	19 (19.59)
26-35	34 (35.05)
36-45	25 (25.77)
46-55	13 (13.40)
>= 56	3 (3.09)
<u>Gender</u>	
Male	82 (84.54)
Female	15 (15.46)
<u>Employment Status</u>	
Unemployed	80 (82.47)
Receiving Disability Grant	10 (10.30)
Employed	7 (7.22)
<u>Relationship Status</u>	
Single	83 (85.57)
Married	10 (10.31)
Divorced/Separated	2 (2.06)
Widowed	2 (2.06)

4.3 Method of abscond

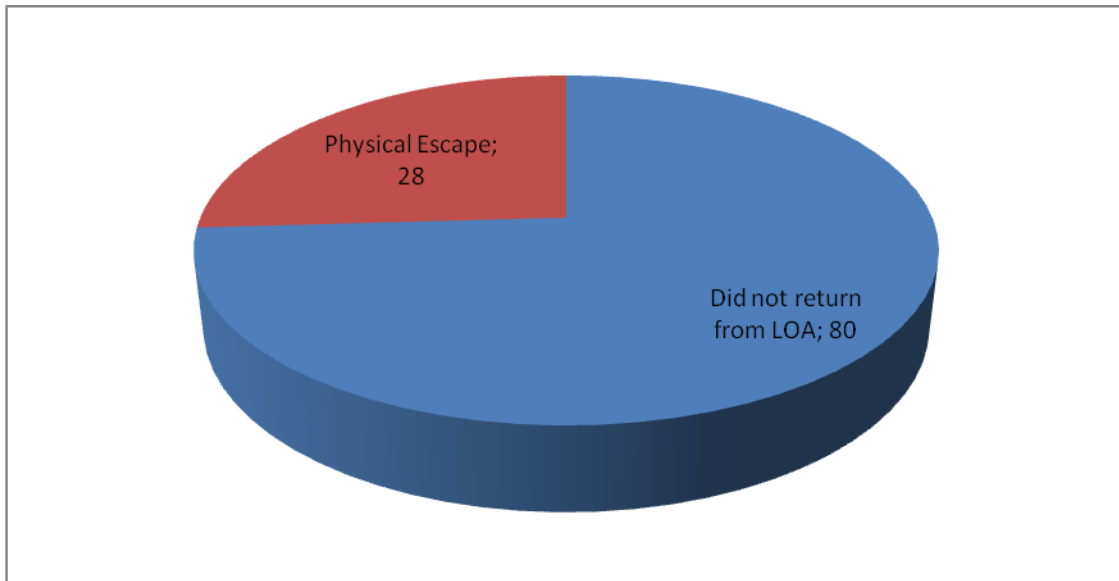


Fig 4.5 Method of Abscond of Sample Population

In total, there were 108 absconding events by 97 patients. During 80 (74.07%) of these events, the patient did not return from an official LOA. The remaining 28 (25.93%) events comprised of patients escaping while under direct hospital supervision.

Methods of escape included: breaking ward doors or windows, escaping through the roof, escaping from inadvertently open ward doors, escaping whilst on ground parole (i.e. OT, sports events, church, tuck-shop visits or other social events) and jumping the fence. Others escaped while receiving medical consultations or procedures at the neighbouring district hospitals (Yusuf Dadoo or Leratong Hospitals). Sterkfontein Hospital does not have the staffing capacity to provide a round-the-clock escort for these patients and relies on security at these hospitals. For *observandi* requiring medical intervention, the SAPS are obliged to provide a police escort.

4.4 Section of MHCA/CPA under which admitted

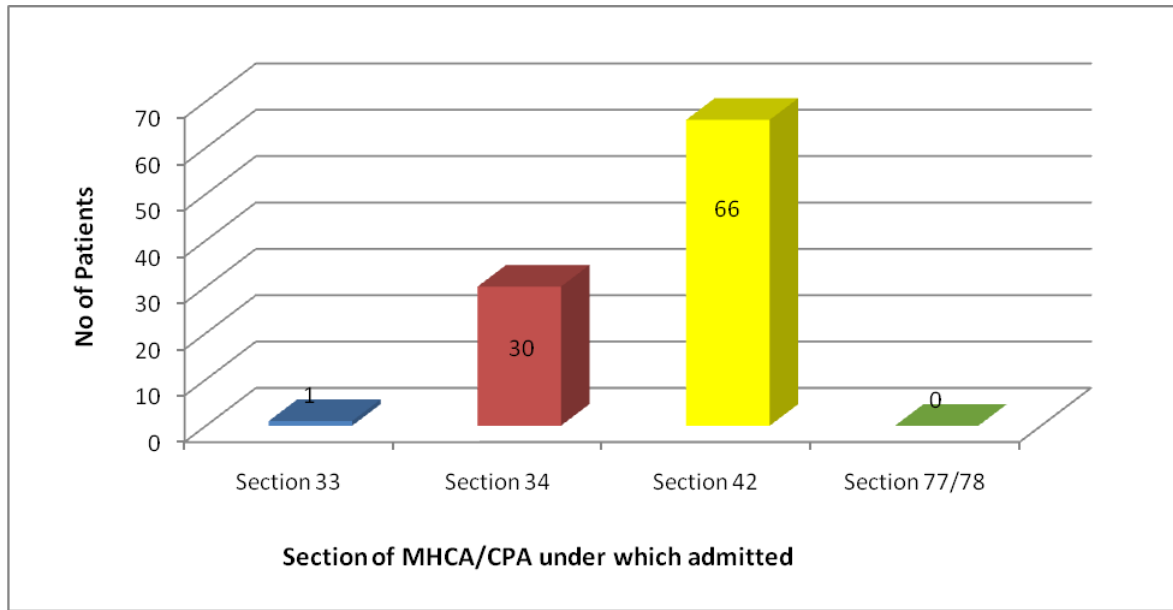


Fig 4.6 Section of MHCA/CPA under which admitted

Only 1 patient (1.03%) escaped under Section 33 (i.e. while undergoing 72 hour observation). 30.93% (n = 30) of patients absconded while under Section 34 (i.e. further involuntary care) and 68.04% (n = 66) patients who absconded were under Section 42 of the MHCA (i.e. state patients). No *observandi* absconded while under forensic observation (i.e. Section 77 or 78). If only escaped patients were considered, then 14 of the 22 (63.64%) were admitted under Section 34 (i.e. further involuntary care) and 7 of the 22 (31.82%) escaped under Section 42 (i.e. state patients). Chi-square analysis revealed that involuntarily admitted patients were more likely to escape than state patients ($P = 0.00$), while state patients were more likely to delay their return from LOA as their primary method of abscond.

4.5 Type of ward

Of the 97 patients who absconded, 66 (68.04%) absconded from the forensic wards and 31 (31.96%) absconded from the general wards. None of the forensic wards are open wards; however there are several general open wards. Only 11 (35.48%) of the 31 patients admitted to a general ward absconded from an open ward (i.e. 11.34% of the total sample). When only escaped patients ($n = 22$) are reviewed: 15 (68.18%) of these were from a general ward and only 4 (26.67%) patients escaped from an open ward. There was a statistically significant relationship between general wards and escapes ($P = 0.00$), however the patients in the open wards were not MORE likely to escape ($P = 0.32$).

4.6 Month of Abscond

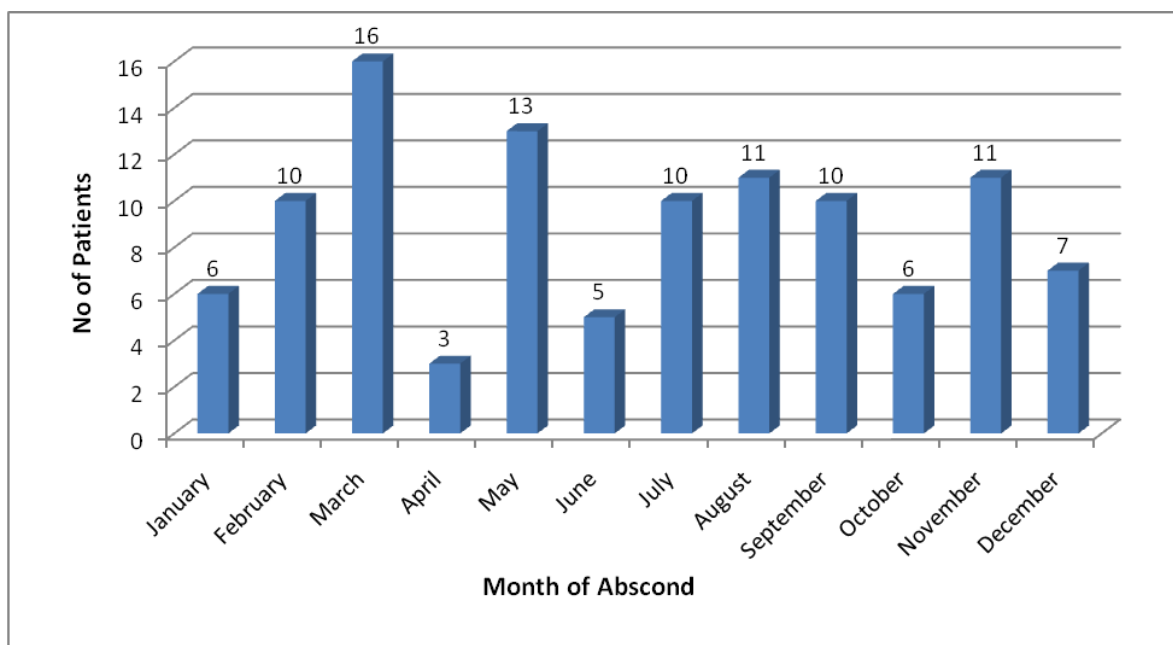


Fig 4.7 Monthly Distribution of Absconds

Most absconding events took place during March (n = 16), and the month with the least absconding incidents was April (n = 3).

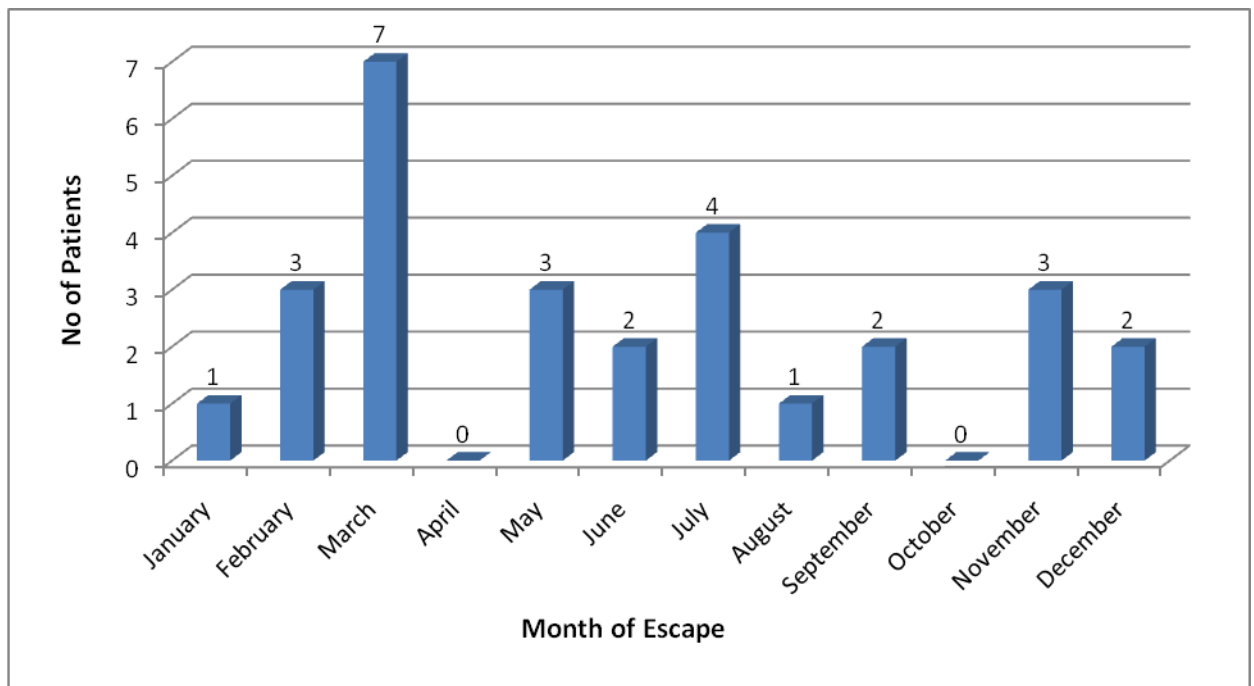


Fig 4.8 Monthly Distribution of Escapes

Investigating the escaped patients, the month with the most frequent escapes was March and no patients escaped during the months of April or October 2008. There was no significant link between escaping and seasonality or the festive season.

4.7 Length of Hospital Stay

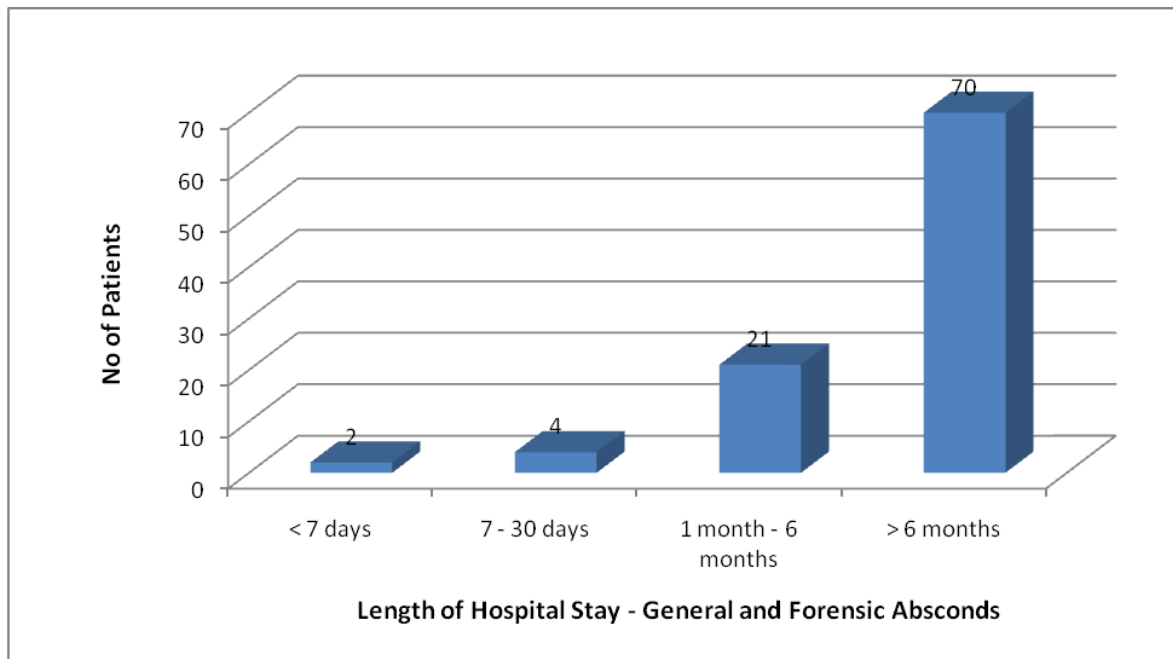


Fig 4.9 Distribution of Length of Hospital Stay for all Absconds (General and Forensic)

The mean length of hospital stay was 1531 days (i.e. 51 months). The minimum stay was 0 days (1 patient absconded from the Admissions ward) and the maximum stay was 7626 days (i.e. over 20 years!). 71.43% (n = 70) of patients had been admitted for longer than 6 months. There was a statistically significant link between length of hospital stay and escaping ($P = 0.00$), with patients (general and forensic admissions) more likely to escape if they had been admitted for less than 6 months.

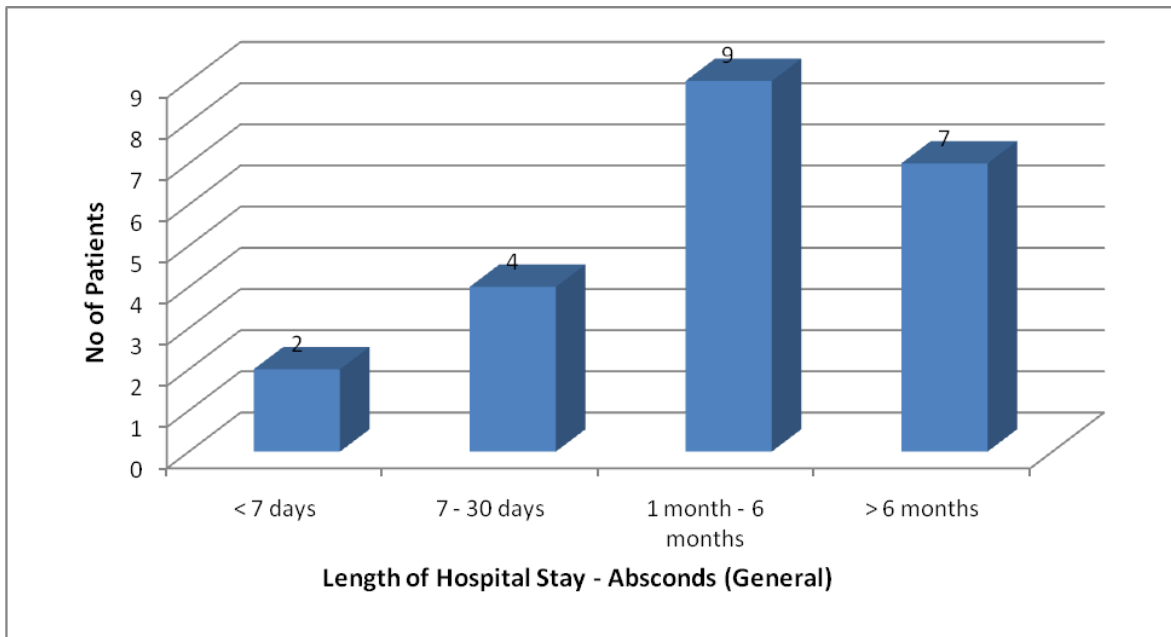


Fig 4.10 Distribution of Length of Hospital Stay for Absconds (General)

If forensic patients were excluded and only absconds from the general side reviewed, the mean length of stay was significantly less (1531 days versus 100 days). However, this figure still includes psychiatric patients from the general side who did not return from LOA.

4.8 Psychiatric Diagnosis

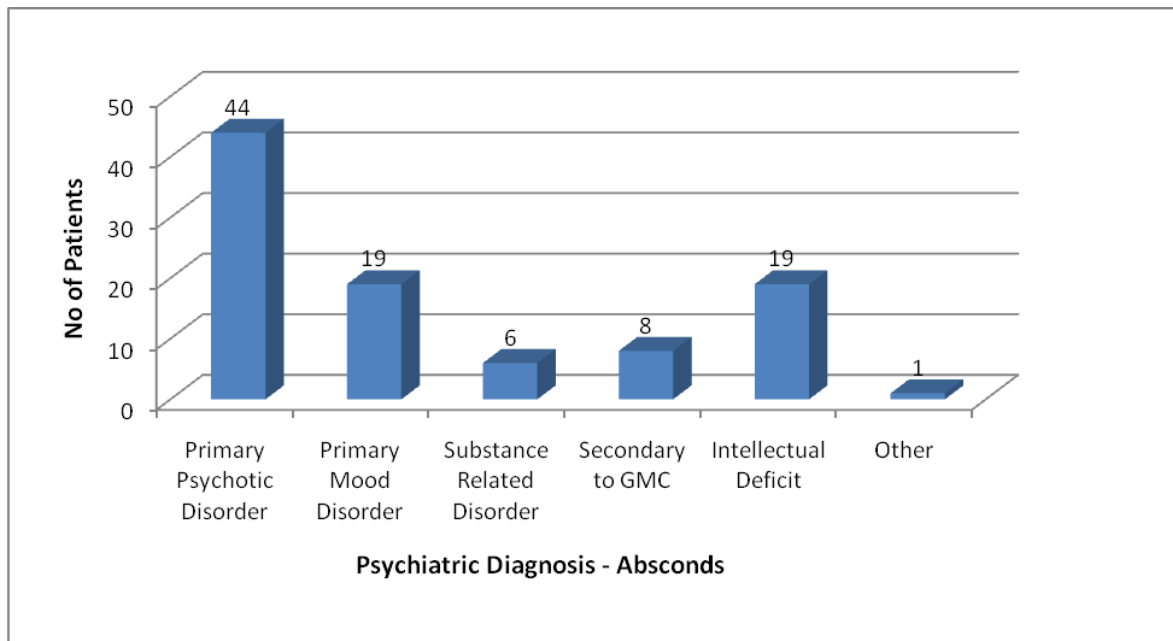


Fig 4.11 Distribution of Psychiatric Diagnoses across Sample Population

Of the 97 patients who absconded, 44 (45.36%) were diagnosed with a primary Psychotic Disorder. Second in prevalence were 2 diagnoses with 19 (19.59%) each: primary Mood Disorder and Intellectual Deficit. Mental Disorder secondary to a General Medical Condition (Organic Mental Illness) was the primary diagnosis in 8 (8.25%) of absconded patients. 6 (6.19%) of absconded patients were primarily diagnosed with a Substance-related Disorder. Only 1 (1.03%) patient had another mental illness as the primary diagnosis.

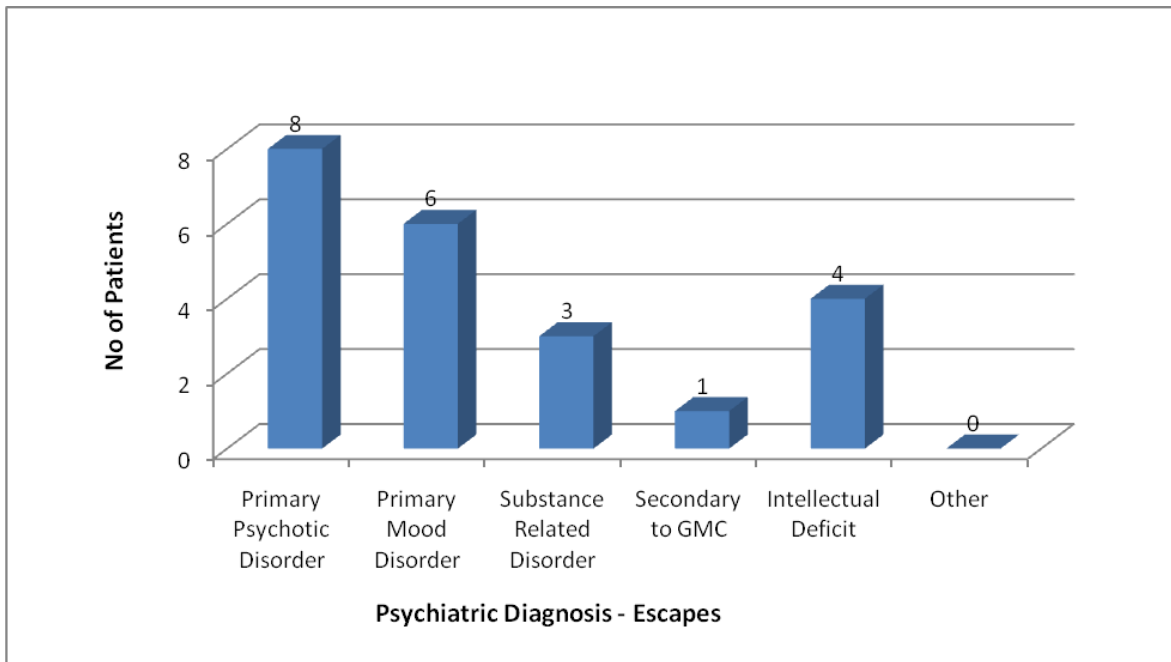


Fig 4.12 Distribution of Psychiatric Diagnoses across Escaped patients

In reviewing escaped patients only, a larger proportion of patients was diagnosed with a Substance-related Disorder: $n = 3$ (13.64%) and the proportion of patients with Intellectual Deficit was the same: $n = 4$ (18.18%). However, Fisher's exact test did not elicit a statistically significant link between any particular psychiatric diagnosis and method of abscond.

4.9 Substance Use

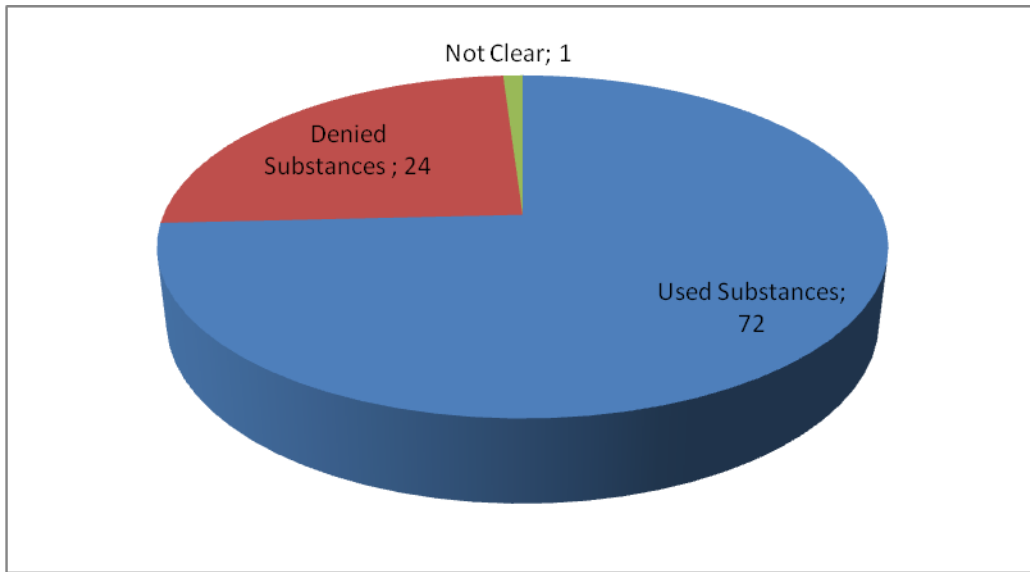


Fig 4.13 Distribution of Substance Use in Sample Population

Of the sample ($n = 97$), 74.23% ($n = 72$) used substances of some kind (most commonly cannabis and alcohol), 24.74% ($n = 24$) denied using any substances and in 1.03% ($n = 1$) of patients substance use was not clear. At face value, the prevalence of substance use increases to 90.91% in the escape population (20 out of 22) but on further testing the association was borderline ($P = 0.05$).

4.10 Factors that may have contributed to the abscond

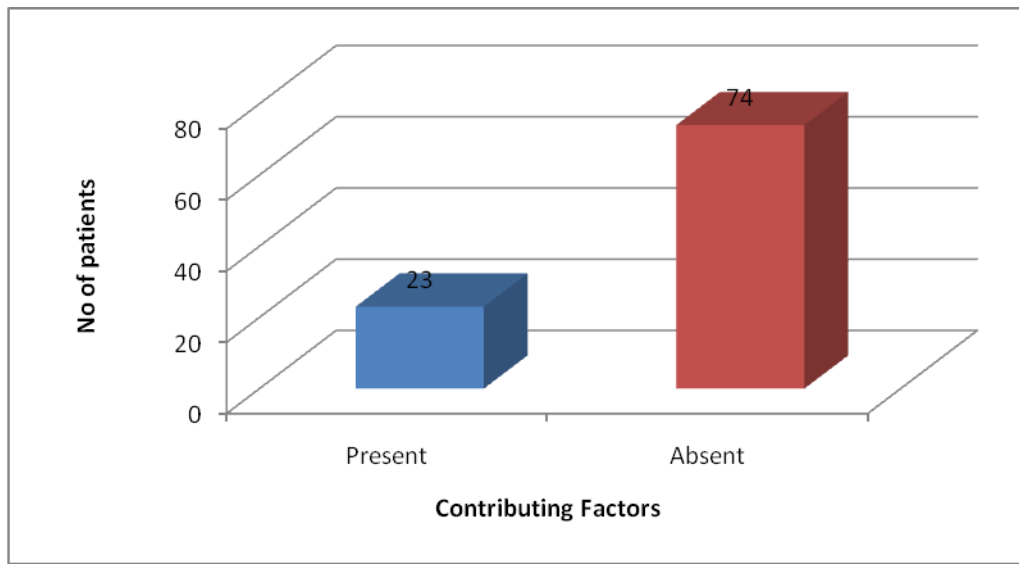


Fig 4.14 Distribution of Contributing Factors across Sample Population

23.71% (n = 23) of patients had contributing factors documented in their files prior to absconding, while for 76.29% (n = 74) there were none. In the escape population, the frequency of documented contributing factors increased to 40.91% (9 out of 22). This link was statistically significant (P = 0.03).

For the escaped patients, some of the contributing factors documented were: not having visitors, being denied LOA, poor family support, fighting with fellow patients, failed attempts at escape, xenophobic attacks in the ward, pending placement or deportation, financial stressors at home, wanting to obtain cannabis, psychotic relapse and episodes of aggression or self-harm. One patient faked physical symptoms so that he would be taken to a district hospital for a medical opinion and thus created an opportunity to escape.

For those patients not returning from official LOA, the following reasons were cited: defaulting treatment, refusing to return, poor family insight, abusing substances, family conflict, traditional

or cleansing rituals, no finances to return patient, marital or financial stressors, attempted suicide or aggression, relapsing, preference to follow-up with community-based care, admission to district/provincial hospitals or no longer perceiving the need for psychiatric care.

4.11 Past psychiatric history

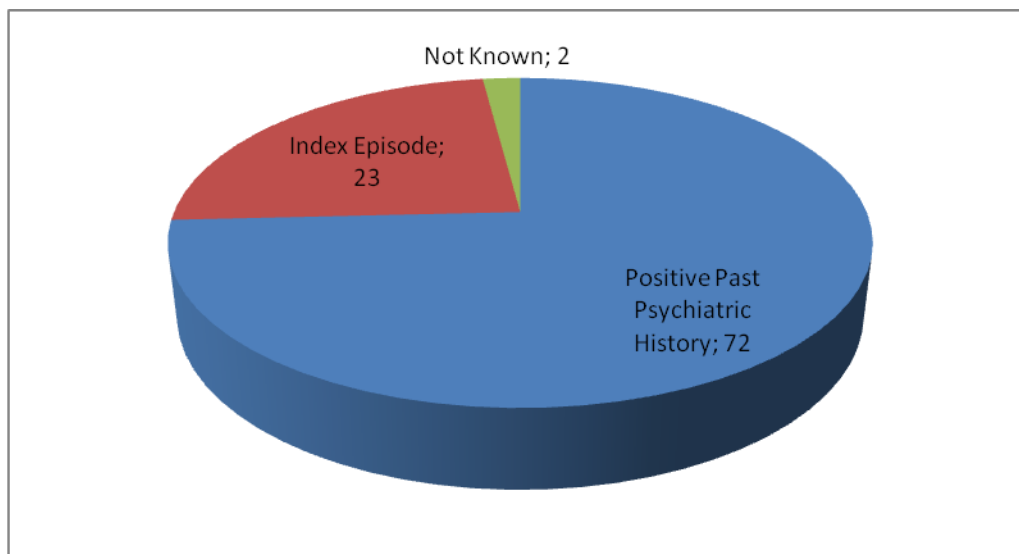


Fig 4.15 Distribution of Psychiatric History across Sample Population

For 23.71% (n = 23), this was their index presentation. For 2.06% (n = 2), the presence of past psychiatric history could not be determined. 74.23% (n = 72) of the sample had a positive past psychiatric history. The number of documented previous admissions for these patients ranged from 0 – 18. There was no link between the presence of past psychiatric history and method of abscond (P = 0.31).

4.12 Previous absconds

This reflects patients who had absconded prior to the study period (2008). For 52.58% (n = 51) of the sample, this was their first abscond. 47.42% (n = 46) had absconded previously. 1 patient absconded 13 times prior to 2008.

4.13 Repeat absconds

Table 4.2 Repeat absconds

Number of Absconding Events	Absconding Patients	% of Absconders (n=97)	% of Repeat Absconders (n = 7)
1	90	92.78	-
2	4	4.12	57.14
3	2	2.06	28.57
4	1	1.03	14.29

These are patients who absconded more than once during the sample period (2008). Of the 108 abscond events, 18 (16.67%) were by users who had absconded repeatedly in 2008. 1 patient escaped 4 times during the study period!

4.14 Returned/Re-admitted or not

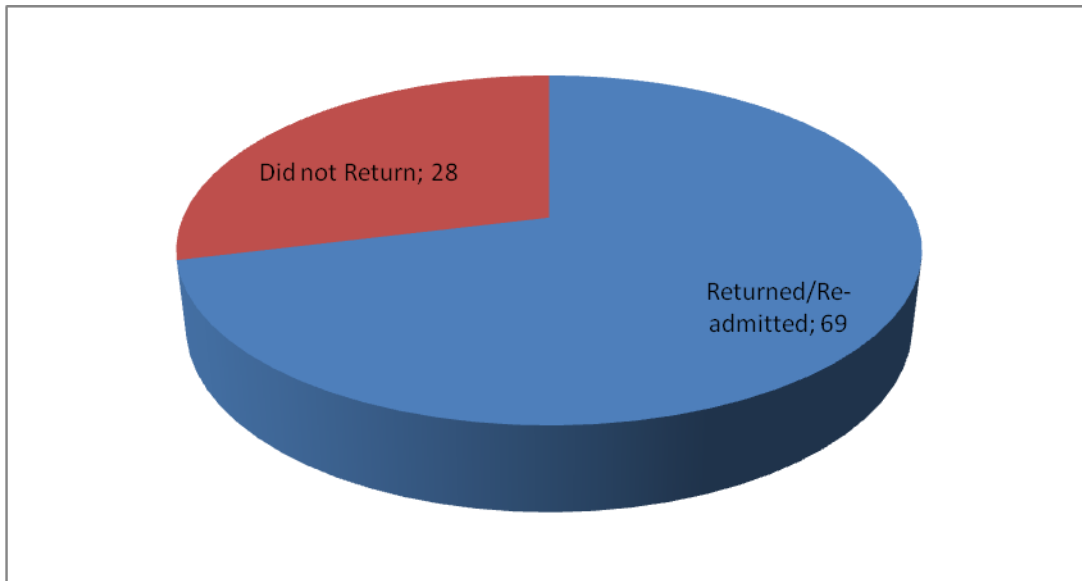


Fig 4.16 Proportion of Sample Population who were Returned or Re-admitted

71.13% (n = 69) of all absconded patients had either been re-admitted or returned to the hospital prior to data collection, while 28.87% (n = 28) had not returned. There were no associational relationships between any of the other variables and those who re-established contact with the hospital.

CHAPTER FIVE: DISCUSSION

A total of 97 patients absconded during the study period of 1st January to 31st December 2008. Of these, 7 patients absconded more than once, resulting in a total of 108 absconding events. During Siwinska's study in 1993, a total of 99 patients absconded over a 6 month period. The author does not mention how many absconding events there were, so it is possible that some patients may have absconded more than once during the study period.

Comparing the current study with Siwinska's study, this is a greater than 50% reduction in the patient-based abscond rate (i.e. 97 patients over 12 months versus 99 patients over 6 months). If the event-based abscond rate is being compared, this results in a 45% reduction (i.e. 108 absconding events over 12 months versus 99 absconding events over 6 months), taking into account that Siwinska did not mention repeat absconds.

This significant reduction could be due to several reasons:

- 1.) A retrospective record review may have resulted in unreliability due to under-reporting of abscond events. This could also result in more files missing and incomplete data recorded. This is in contrast to Siwinska's study (1993) which was prospective.
- 2.) There is a genuine reduction in the number of patients absconding. This lends itself to the theory that deinstitutionalization has improved mental health care, with an emphasis on least restrictive care and thus less MHCUs wanting to escape. One of the main reasons for the overhaul of the previous legislation was in order to reduce stigma, improve care and promote human rights. On the other hand, the drive to deinstitutionalize (Kaliski, 2013) may have resulted in inappropriate and/or premature discharges due to bed shortages, thus reducing the need to abscond.

3.) Minimal data is available on those MHCUs attempting to abscond/escape and failing.

This may suggest improved infrastructure, security and clinical monitoring as compared to previous years.

5.1 Abscond rate

The event-based absconding rate in this study is 7.83%, while the patient-based absconding rate is 7.03%. Siwinska (1993) did not calculate an abscond rate as such (Molnar and Pinchoff developed their formula around that time period). However, using the data provided in that study, it is possible to calculate the abscond rate which works out to 16.70%. This is **more than double** that of the abscond rate calculated for 2008.

Inconsistencies in the formulae and definitions used lead to incomparability of results between studies (Bowers, 2000; Mosel, 2010; Muir-Cochrane, 2011). According to a literature review done by Bowers, et al. (1998), the mean rate of absconding for general psychiatric services is 12.6 with a range of 2 – 44. Muir-Cochrane, et al., 2011 studied absconds from an Australian hospital over a 12 month period and calculated an event-based abscond rate of 20.82 per 100 detained patients. While they acknowledge that their findings are higher than in previous Australian studies, the authors do not give reasons why this may be so.

Perhaps it would be more prudent to compare our rate to those in other developing countries, taking into account similarities in the organisation of psychiatric services, legislation, resources and cultural influences. An Indian study (Khisty, et al., 2008) calculated an abscond rate of 14.28%. This was significantly higher than in previous Indian studies. The authors largely attributed this to changes brought about by the implementation of the Mental Health Act 1987 in 1993 (in particular, patients became financially responsible for their psychiatric care and had to be

accompanied by a family member for the duration of their admission). A study conducted in Iran (Yasini, et al., 2009) obtained an abscond rate of 3.0%. However their sample included 2 paediatric psychiatric wards and this would detract from most other studies that exclude forensic and adolescent psychiatric services. Our study included forensic psychiatric services (excluded by all of the studies cited above) and the abscond rates are on the lower end of the range. This suggests that absconding may not be as rife in South Africa as we originally anticipated. If patients not returning from official LOA were excluded from the definition used, the abscond rate would be even lower.

While comparison of absconding rates between studies remains difficult, the findings of the present study are particularly important because to date, no other identified study reports an absconding rate based on South African data. Hence, comparisons and subsequent interpretations of absconding have not been established in a South African setting. The current study has been able to establish an abscond rate based on reliable and meaningful data that will be useful for any comparison studies in the future.

5.2 Sociodemographic profile

The current study suffers from a lack of a control/comparison group. If we extrapolate on the sociodemographic profile formulated in a recent South African study on involuntary psychiatric admissions to two Northern Gauteng hospitals (Mabena, 2010), a measure for potential comparison becomes possible.

5.2.1 Age

The mean age of the abscond group was 33.8 years. However, if escaped patients were considered in isolation, the mean age was 26.2. This compares consistently with Siwinska's findings of 35.5 and 29 years in the 2 groups (Did not Return and Escape respectively). Khisty, et al., 2008 found that the mean age of their abscond group was 33.2 and that this was not statistically different from the control group. This finding is also broadly consistent with other international findings (Meehan, 1999; Yasini, 2009; Mosel, 2010). This is hardly surprising as most psychiatric illnesses begin in early adulthood and this age is consistent with the profile of the typical psychiatric admission (54% of involuntary admissions were between the ages of 26 and 50 in Mabena's study, 2010).

It is also not surprising to find that the escape groups may be slightly younger. There was a significant link between young adulthood (26 – 45) and escape as the method of abscond. The possible reasons underlying this could include lack of physical impairment (Pages, et al., 1998), efforts to obtain substances, feeling more restricted and poorer insight.

5.2.2 Gender

Approximately 85% of the absconding sample was male. The escape group consisted of 100% males (n = 22). There was a statistically significant link between male gender and escape as the method of abscond. Siwinska (1993) found a male prevalence ranging between 70 – 100% among the different groups. According to Muir-Cochrane, et al. (2011), men are NOT necessarily more likely to abscond than women. Due to a greater number of male admissions (65.5% in Mabena's study, 2010), they are responsible for more events and a larger number of them abscond. The greater representation of men in absconding figures may be due to their high proportion in acute

care settings (Bowers, 2003 and Muir-Cochrane, 2011). However, Pages, et al. (1998) and Yasini, et al. (2009) identified male gender as a significant predictor of future absconding. Of interest, Khisty, et al. (2008) cites a previous study in India by John, et al. (1980) who found the absconding female: male ratio of 1:15. The authors postulated that the low absconding rate found in their study was due to the “culturally inculcated restrictions in Indian women”. This may be a factor in our setting as well. Future studies examining the influence of culture on psychiatric care, particularly gender effect and absconding, may prove valuable.

5.2.3 Employment status

Almost 83% of the sample was unemployed. A further 10% received a disability grant and just over 7% were gainfully employed. There was no link between employment status and method of absconding. This is in keeping with the fact that the majority of the patients come from disadvantaged backgrounds (Bowers, 1998; Pages, 1998; Meehan, 1999). However, both Bowers, et al. (2000) and Khisty, et al. (2008) had control groups in their studies and did not find any association between unemployment and absconding. In Siwinska’s study (1993), the range of unemployment was 83 – 97%. The question arises as to whether unemployment is as a result of mental illness or the unemployment may be a contributing factor to the mental illness.

Regardless, the rate of unemployment in South Africa is exceptionally high. Many people work in the informal sector and this may not translate as gainful employment when statistics are considered.

In addition, some patients are regarded as being unfit to work and they receive a disability grant from the Department of Social Services. In this study it is unclear whether those receiving this grant are doing so on the grounds of psychiatric illness or due to other medical conditions. In many households this meagre disability grant is the sole income and is used for the entire

household's expenses. It may contribute to families insisting that patients be given LOA (in most cases, the patient needs to physically receive the grant) and may aggravate failure to return from LOA on time. Furthermore, it may contribute to patients wanting to abscond if family members at home are financially reliant on them.

For those patients who are unemployed, the admission may represent a reliable source of food and shelter. One would assume that these patients are less likely to want to leave the hospital. However, this is presumptuous as the unemployment figures in the absconding population are high and there isn't a reliable control population for comparison.

Frequently, the hospital is faced with difficulties discharging patients who have nowhere else to go. This social burden becomes a drain on valuable hospital resources which may be better used in the treatment of psychiatrically unwell patients.

Further investigation of the impact of unemployment and disability grants on absconding and psychiatric care in general may prove quite useful.

5.2.4 Marital status

85.57% of our sample was single. 10.30% were married and 2.06% each were divorced or widowed. This is in keeping with global trends (Bowers, 1998 and Meehan, 1999). Bowers, et al. (2000) and Khisty, et al. (2008) found no link to absconding in their studies which included a control group. These findings also coincide with Siwinska's (1993) range of 76 – 89%.

However, in the South African setting, we must take into account cultural/traditional unions that are not recognised as marriage by law and may be under-reported by patients or not recognised by interviewers. This could falsely inflate this finding. In the current study, the relationship status

was captured as documented by the interviewing doctor. In most cases, this was not specific enough to determine whether cultural or traditional unions were included or not.

Generally, more psychiatric patients tend to be single (76% in Mabena's study, 2010). This could either be due to the impact of their psychiatric illness on their social skills or conversely: not being in a supportive relationship could predispose to their psychiatric illness.

5.2.5 Sociodemographics in summary

Although race, ethnicity and culture were not considered in this study, these factors could have provided a clearer picture as to the changing profile of demographics in South Africa. Since the end of apartheid and the implementation of the new Mental Health Care Act of 2002, psychiatric resources have become more equally distributed and race is no longer a deciding variable.

Patients are more inclined to be admitted closer to where they live, rather than being forced to use racially-designated amenities.

In their literature reviews, both Bowers, et al., 1998 and Muir-Cochrane, et al. 2008 found that the likely sociodemographic profile of the absconder is: young, single male, from a disadvantaged background, legally detained and diagnosed with schizophrenia. However, Meehan et al. (1999) have argued that young male schizophrenic patients are more likely to be admitted to in-patient facilities, which leads to an over-representation of these patients when constructing a statistical profile. These findings are corroborated locally by Janse van Rensburg (2007), Mabena (2010) and Jonsson, Moosa & Jeenah, et al. (2013). Bowers et al., 2000 conducted a study with a control sample for comparison. They concluded that absconders ARE more likely to be young, single, males, diagnosed with schizophrenia and have a history of previous absconds and refusal of treatment.

The current study concludes that the sociodemographic profile of the absconder is: single, unemployed male in their early 30's. This is broadly consistent with Siwinska's (1993) and previous studies. However, this is likely to be an over-representation of these characteristics in the general psychiatric population. Patients who utilise escape as their method of abscond are more likely to be younger and of male gender. In any event, this profile is rather broad and vague and provides little guidance in addressing risk assessment and the prevention of absconding.

5.3 Method of Abscond

The overwhelming majority (77.32%) of patients in our sample did not return from an official LOA. This is significantly increased compared to the findings of 33% in Siwinska's study (1993). LOA is frequently used as a preparation of re-integration into society. This implies that these patients were sufficiently clinically improved and being considered for possible discharge and/or reclassification. Their inclusion in our sample falsely inflates figures. This highlights the need for a more accurate definition for the phenomenon of absconding. In contradiction, Kaliski (2013) postulates that a greater proportion of MHCUs are being given premature/inappropriate LOA due to bed shortages. This could account for the larger number of patients at risk for this method of absconding.

Only 28 patients escaped while under direct hospital supervision. Methods of escape included: running away while on OT/IT parole, escaping from Yusuf Dadoo or Leratong Hospitals while receiving medical care (Sterkfontein Hospital does not have advanced medical facilities and patients are frequently referred to other hospitals for medical opinions or treatment), escaping from a sporting event, breaking doors, escaping through the roof, jumping the fence/wall, walking through unlocked ward doors, breaking windows and jumping out of transport vehicles. Muir-

Cochrane, et al. (2008) found that most absconding events were impulsive and opportunistic. They also found that staffing levels had no significant relationship to absconding. This study did not measure absconding in relation to staffing levels and this may be an important basis for a future study.

The patients who escaped were more likely to be male, younger, involuntarily detained (under Section 34 of the MHCA) and admitted to a closed general ward. They tended to escape within 6 months of admission and were more likely to report contributing factors prior to escaping.

5.4 Section under which admitted

The highest proportion of absconding events occurred with forensic state patients (Section 42 of the MHCA) i.e. 68.04% (n = 66), 59 of whom did not return from an official LOA. This is an important finding, as it further stresses the need for a more specific definition for absconding. This skews the figures and falsely gives the impression that dangerous forensic patients are escaping custodial care. More accurately, most of these patients simply fail to return from an official LOA. The fact that they are given LOA suggests that they are clinically improved to the extent that they are being considered for reclassification.

The above finding differs significantly from that of Siwinska (1993) who found that only 22 – 40% of her abscond sample were forensic state patients. The majority of her abscond sample were involuntarily detained patients (i.e. Sections 9 and 12 of the recalled Mental Health Act, No. 18 of 1973). With the implementation of the MHCA No. 17 of 2002, there has been a paradoxical increase in involuntary admissions (Ramlall, Chipps & Mars, 2010 and Kaliski, 2013). Kaliski (2013) attributes this in part to the reduction of psychiatric beds, premature discharges, inadequate community-based resources with subsequent relapse and re-admission of MHCUs involuntarily.

This high turnover results in earlier discharges and LOA, reducing the opportunity to abscond. When an involuntarily admitted MHCU absconds, he is more likely to physically escape the hospital premises than a state patient (who is more likely not to return from LOA).

Conversely, the forensic mental health system has seen a burgeoning in the number of state patients since the advent of deinstitutionalization (Kaliski, 2013). The new MHCA has very stringent criteria for conditional discharge that few state patients fulfil. In addition, more state patients are being admitted annually than ever before. Kaliski (2013) has aptly named this phenomenon “Reinstitutionalization by stealth”. This has led to increased numbers of state patients either as in-patients or out on LOA and thus they form a bigger proportion of our absconding population.

Due to differences in legislation and detention of MHCUs, it is difficult to compare South African studies with international studies. At Sterkfontein Hospital, ALL admissions are legally detained under different sections of the MHCA or the CPA. Most studies conclude that patients who abscond are more likely to be legally detained or court referred (Falkowski, 1990; Bowers, 1999; Meehan, 1999; Bowers, 2000) as compared to voluntary patients. Pages, et al. (1998) and Meehan, et al. (1999) point out that legally detained patients (they do not specify status) who abscond are more likely to be reported, as the perception of their risk of dangerousness is greater.

It is of interest that no *observandi* (awaiting trial detainees) absconded or escaped during the study period (i.e. referred in terms of Section 77 and 78 of the CPA). This is probably due to the mandatory extra police supervision and differences in infrastructure of the observation ward (i.e. higher perimeter walls, better ward design and nursing monitoring). Khisty, et al. (2008) also commented on this phenomenon in their study. The court-referred patients in India are accompanied by a personal police escort for the duration of their admission.

5.5 Type of ward

Sterkfontein Hospital has no open forensic wards. However, there are several open general wards (viz. Dual Diagnosis Unit, Integrated Living Unit, chronic male wards and 1 female ward). The total abscond figures bear no relevance to whether a ward is locked or not because no differentiation is made between patients escaping from these wards and failing to return from official LOA.

Siwinska (1993) did not differentiate absconds between the different types of wards.

If we examine the escape group only ($n = 22$), our findings suggest that fewer MHCUs escape from open wards i.e. 4 out of 22 (18.18%). This is in keeping with the theory by Khisty, et al. (2008), who hypothesised that the duration of stay in open wards is usually short and the environment less restrictive, therefore the motivation for patients to escape from these wards is probably different. It is also likely that the nature of patients admitted to these open wards is generally more stable and they pose less risk if they do leave the hospital without the appropriate permission.

Muir-Cochrane, et al. (2011) suggest that locking ward doors will not necessarily serve as a deterrent for the patient who wishes to leave, but rather result in over-restriction of patients.

Khisty, et al. (2008) also hypothesize that a longer psychiatric admission can be a predictor of absconding, especially in a closed door and long-term facility. There is an incentive to escape from a restrictive environment. This may hold true for our long-term forensic state patients for whom LOA has not been possible.

5.6 Month of abscond

Bowers, et al. (1998) and Muir-Cochrane, et al. (2008) have found that more patients abscond during warmer months. However, this is strongly disputed by several other studies who maintain that there is no link between seasonality and absconding (Bowers, et al., 2000 cites Dickens & Campbell, 2001).

In this study, the escapes and absconds appear quite randomly distributed throughout the year. Siwinska (1993) did not review seasonal variation and absconding. In South Africa the high rate of unemployment leads to a higher proportion of informal housing and homelessness. It is probably to one's advantage to be admitted to hospital where basic shelter and warmth is provided. While one would be tempted to suggest that more patients would abscond during religious holidays or the festive season, this did not bear out.

5.7 Length of Hospital stay

This greater-than-expected finding far surpasses international findings. Many studies report the first 7 days post-admission to be a high risk period for absconding (Meehan, 1999; Khisty, 2008; Muir-Cochrane, 2008). However, most studies do not include forensic psychiatric patients. Tomison (1989), as cited by Khisty, et al. (2008), found that a longer admission could be a predictor of absconding, especially in a closed-door, long-term facility. The forensic wards at Sterkfontein Hospital would certainly fit these criteria. The forensic patients are generally admitted for years at a time, even if part of that time may be spent at home on official LOA. Delays in reclassifying or discharging these state patients results in prolonged admission.

In Siwinska's study (1993), the length of hospital stay for forensic patients ranged from 12 days to over 8 years. The average length of hospital stay of absconded general psychiatric patients was 100 days (range 0 – 437) and if the method of abscond was escape, it was more likely to occur within 6 months of admission. Siwinska (1993) found that the length of hospital stay of the general psychiatric population ranged from 13 to 263 days.

This, even though far less, still exceeds international expectations. Reasons for this include: some of the patients included in this number are those that do not return from LOA timeously, social issues hampering discharge, patients taking a longer time to recover and patients being heavily sedated or restrained during the initial period of admission. It might be important to note that many patients are referred to Sterkfontein Hospital because efforts to contain them elsewhere have proven difficult and that they pose a continued risk to themselves or others.

5.8 Psychiatric diagnosis

Most of the studies from developed countries find that schizophrenia is the most common diagnosis in patients who abscond (Falkowski, 1990; Meehan, 1999; Muir-Cochrane, 2009). This is corroborated by both the current study (45.36% of all absconds) and Siwinska's (1993) findings (up to 59% of sample). Again, this could simply reflect an over-representation of this diagnosis in all patients admitted (corroborated by Janse van Rensburg, 2007; Mabena, 2010 and Mosel, et al., 2010). However, Muir-Cochrane, et al., 2011 found that there was a higher proportion of schizophrenic patients in their abscond sample when compared to a control group.

The second most common diagnoses are Primary Mood Disorder and Intellectual Deficit (19.59% each). The number of patients with intellectual deficit who are reported as having absconded is perhaps unexpected. These patients are usually signed out by responsible family members and

the implication is that these family members did not think it necessary to return these patients on time. This may imply that these patients are clinically stable. Again, this may falsely inflate perceptions that dangerous mentally ill offenders have escaped custodial care.

The number of patients with intellectual deficit in the sample is probably indicative of the overall numbers of patients with this diagnosis at Sterkfontein Hospital. This is reflective of the inadequate resources available for this population group within the community and the misuse of valuable tertiary resources that should be put to more appropriate use.

Two studies from developing countries (Khisty, et al., 2008 and Yasini, et al., 2009) found that Bipolar disorder was the most common diagnosis in their absconding population and relate this to differences in the training and diagnostic style of their doctors.

Substance-induced disorders have not played as big a role as they did in Siwinska's study (1993). This is not due to this condition being less frequent. In fact, substance use and abuse is on the increase. It is likely that an underlying psychotic process is thought to exist in these patients and they are preferentially being diagnosed with a primary psychotic disorder. A limitation of this study was not considering those patients with a dual diagnosis (i.e. Substance abuse in the presence of another major psychiatric disorder).

5.9 Substance Use

Almost 75% of the absconding sample used substances of some kind. This is higher than Siwinska's findings of 38%. A potential limitation is that in most files no differentiation was made between substance use and abuse. Had this been particularly studied, perhaps a more accurate picture of the role of substances in the South African psychiatric setting would have been painted.

Janse van Rensburg (2007), Mabena (2010) and Jonsson, et al. (2013) indicate between 40 – 53% of patients admitted fulfil criteria for substance abuse. These rates are probably higher than most international findings, as drug use and abuse in South Africa is particularly high, even among the general population. What is perhaps indicative of this, is the increased proportion of patients with substance-related diagnoses in both mine and Siwinska's (1993) escape populations as compared to the abscond groups on the whole. One might speculate that obtaining substances might have motivated these escapes. This finding replicates those in several international studies that have found that substance-related disorders are higher among absconding populations versus control populations (Pages, 1998; Yasini, 2009).

5.10 Factors that may have contributed to the Abscond

For 23 patients, contributing factors were documented in their files. For the patients not returning from official LOA on time, reported contributing factors included: being non-compliant, abusing substances, relapsing, re-offending with subsequent arrest, family conflict, no money for transport, poor family support, family unwilling to bring patient back, suicide attempts, self-mutilation, medical problems and attending cultural cleansing or initiation ceremonies.

For those escaping from hospital custody, reported contributing factors included: being returned early from official LOA, quarrelling with family members, LOA or discharge being denied, smoking cannabis, fighting with fellow patients, being placed under Constant Special Observations, not being picked up for scheduled LOA by family, having no visitors, failed abscond attempts, pending placement, poor family support and breaking windows. In fact, a number of patients had voiced their intent to abscond prior to the actual event. The reasons cited above are similar to those found by Siwinska, 1993; Bowers, et al., 1998 and Bowers, et al., 2000. Bowers, et al. (2000) found

that absconding was linked to other forms of difficult and non-compliant behaviour in the 7 days preceding the absconding event. This study found an association between documented contributing factors and escaping as a method of abscond.

Two foreign nationals reported that they were going to try to return to their own countries prior to escaping. One also reported a xenophobic attack by fellow patients. This highlights the increased incidence of foreigners being admitted for mental illness in our setting.

Due to the retrospective nature of this study, it was not possible to interview patients who had returned. This would have been quite informative to ascertain their reasons for absconding. Most of the information above was obtained from files of patients who have since been in contact with psychiatric services. In addition, nursing and doctor's notes were scrutinised for potential contributing factors in the weeks preceding that may have precipitated the abscond.

5.11 Past psychiatric history

For 74.23% of the sample, this was not their first contact with psychiatric services. Many patients who absconded had a long-standing psychiatric history. This may reflect an attitude of apathy and boredom in the patient who has "been there, done that" and who may not see the value in yet another admission. However, Bowers, et al. (2000) found no association between past psychiatric history and absconding when comparing their sample with a control population. The high prevalence in the current study may merely reflect the chronicity of most psychiatric illnesses.

5.12 Previous absconds

Almost half of the sample patients had absconded previously (prior to 2008). This is in keeping with several international studies. Mosel, et al. (2010) found that nearly 40% of absconding events were by users who had previously absconded. Muir-Cochrane, et al. (2011) suggest that once a patient absconds, the risk of that patient absconding again is increased and may serve as a predictor of absconding. Bowers, et al. (2000) predicted that a patient who has previously absconded is 9 times more likely to abscond again!

What is particularly alarming is the number of patients given LOA whilst having a poor record of not returning timeously from previous official LOA. This may be reflective of the pressure for beds resulting in the premature LOA or discharge of patients who may not be sufficiently rehabilitated. Furthermore, the history of previous absconding events should form part of a risk assessment tool, which could be used to determine the level/intensity of psychoeducation and security needed for that patient.

5.13 Repeat absconds

7 patients absconded repeatedly during the study period and were responsible for 18 absconding events. One patient, in particular, escaped from the ward 4 times during the study period.

Falkowski, et al. (1990) found that 39% of absconds during his study period were repeat absconds by the same individuals who absconded between 2 – 12 times.

This makes one speculate as to what, if any, changes were made to patients' management once they returned. In addition, if a patient is so determined to escape, perhaps alternative facilities

and security should be considered (e.g. referral to the National Maximum Security Unit at Fort England Hospital).

5.14 Returned/Re-admitted or not

The overwhelming majority (71.13%) of patients had re-established contact with the hospital at the time of data collection. Siwinska (1993) documented a return rate of 37.37% DURING the study period. Some returned on their own volition. Most were brought back by family, particularly after they became aggressive or had relapsed. This raises the concern that the hospital may be viewed as a “dumping ground” for patients when it is no longer convenient for families to have them at home. This brings into question the level of insight of family members (i.e. need for compliance, laws governing forensic patients, etc.) and the efforts made by staff to psychoeducate them.

Of concern is the reported minimal involvement of the SAPS in apprehending and returning absconded patients, as set out in the MHCA of 2002. This may reflect the limited resources available and may also be indicative of the poor communication and rapport between the police and psychiatric services. They may simply view absconding as low priority and potentially draining of their resources (Muir-Cochrane, et al. 2008).

5.15 Limitations

Due to the retrospective nature of the methodology, the following limitations pertain: missing files and incomplete data. Patients whose abscond could not be confirmed or the file was missing were excluded from the study. This was a methodological limitation as the entry point into the

sample was official documentation of the absconding event. If the abscond did not arouse sufficient concern and was thus not reported accurately, it was not included in this study. To offset this, records of faxes sent to the MHRB and ward movement books were scrutinised. These were not always specific or complete. Several ward movement books for 2008 were also missing. Every effort was made to collate information.

Due to time and resource constraints, a control population was not studied. This would have given a more accurate picture of the links or associations between absconding and the variables considered. This would be the perfect basis for a follow-up study. The small sample size was also a limitation.

Race, culture and ethnicity were not studied. These may have more accurately detailed any changes in the demographic profile of absconding patients since the end of apartheid and with the implementation of the new MHCA of 2002. Post-democracy there has been a major re-distribution of resources in South Africa.

Another limitation was psychiatric diagnoses. These were not standardised and sometimes changed during the course of the admission. Patients with pathological personality traits were not always investigated for the presence of an underlying personality disorder. In some instances, the diagnosis was vague and unclear and not clarified during the course of the admission. For the purposes of this study, the psychiatric diagnoses were defined into 6 broad categories. Patients were categorised according to their documented major pathology. Substance abuse was not mentioned as a separate diagnosis. This does not provide accuracy with respect to the prevalence of dual diagnosis in the sample population. In addition, the type of substances used was not specified. Multiple diagnoses were simplified into the most likely prevalent diagnosis for ease of statistical analysis.

The documentation of previous psychiatric admissions was sometimes vague and incomplete. Frequently it was simply noted that the patient had a past psychiatric history. Details were scanty and/or poorly interpreted. This may have been improved had a prospective study been conducted. Exact time of escape was not captured. This would have shed light on any potential correlation between escape and particular time of day/night and staffing levels during these shifts.

Several patients had subsequently re-absconded i.e. had absconded again after returning from their abscond in 2008. These patients were not always recorded correctly. Due to the retrospective nature of the study, there may have been bias due to under-reporting of absconding events and unreliability due to frequent staff rotations. For those patients who absconded repeatedly, it would have been interesting to document whether any changes were made in their management plan on return (e.g. high security ward, increased sedation or Constant Special Observations, referral to National Maximum Security Unit at Fort England Hospital, etc).

Clear documentation was not always evident once MHCUs had absconded or failed to return from LOA on time. This may have shed light as to their reasons for absconding and the circumstances surrounding their return. Most patients only re-established contact with psychiatric services once they had relapsed and been re-admitted. Few, if any of these cases had documented interviews upon return.

These limitations should not detract from the final results and conclusions of this study.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

The calculated abscond rates in our setting were lower than the international mean and at the lower end of the acceptable range. This was calculated using a definition that included patients not returning from official LOA. If these patients were excluded, then the abscond rate would be even lower. A differentiation needs to be made between patients not returning from an official LOA and those physically escaping from hospital custody, as the risk assessment and management are very different. Furthermore, for ease of comparison, future studies should separate forensic and general populations.

A sociodemographic profile of the potential absconder as described (i.e. single, unemployed male in their early 30's) is of limited value. It reflects the over-representation of these characteristics in admitted psychiatric patients. A study using a control population for comparison could ameliorate this limitation. A more specific profile of the potential absconder could be developed, using more sophisticated statistical techniques that address not just single variables, but also the interactive effects of situational and environmental factors. Seasonality does not appear to have an association with absconding. The profile of the patient who escapes is slightly more circumspect: more likely to be male, younger, involuntarily detained in a closed ward and abscond within 6 months of admission.

The excessive length of hospital stay found in this study is concerning. Even when lengthy forensic admissions were excluded, the average length of hospital stay exceeds international means. This has remained largely unchanged since the previous study by Siwinska (1993). Further studies examining this phenomenon and the factors contributing to it are warranted. There is a significant proportion of patients who abscond repetitively and the majority of absconds have future contact with psychiatric services (due to relapse and re-admission). Increased involvement of the SAPS in apprehending dangerous patients may prevent adverse outcomes of absconding.

Advances in understanding the motivation of patients who abscond may help us devise strategies to reduce the associated risks. This may be more important in the prediction of the potential absconder and needs to be taken into consideration for future studies.

The proportion of patients diagnosed with intellectual deficit who abscond is higher than in international studies. This may reflect the proportion of tertiary resources being allocated to this population. Likewise, the problem of substance use is more prominent in our setting. This warrants further investigation and recommendations on how to better manage this problem in the community.

Important trends were elicited in this study. While the impact of race and ethnicity were not studied, the sociodemographic profile of the potential absconder may merely reflect over-representation of the admitted population and remains largely unchanged. The prevalence of substance use/abuse appears to have escalated since the previous study in the same setting (Siwinska, 1993). The incidence of absconding seems to be significantly reduced, and the predominant method of abscond has also changed. Less involuntarily detained patients are absconding, but larger numbers of state patients are not returning from LOA timeously. This infers that the process of deinstitutionalization has significantly impacted on psychiatric clinical practice, but perhaps not in the way intended by policy-makers. Due consideration needs to be given to the problems experienced thus far and the integration plan needs to be adjusted.

Even a study with modest aims such as this can help in formulating measures at hospital level to potentially reduce absconding. As far as possible, those at high risk should be identified as early as possible. Additional supervision (especially for those granted ground parole), security (including constant special observations and less penetrable fences), seclusion and chemical restraint may be needed for those who verbalise their intent to abscond. Patients deemed as high risk may warrant referral and transfer to more appropriate Maximum Security facilities. Patients and their

relatives should be educated up-front about the consequences of absconding. Intended or current substance use should be an integral component of risk assessment.

The formulation and use of a risk assessment tool as a matter of routine on all admitted patients may be of great value. The factors that should be considered in the risk assessment tool are: current/past violence, use of substances, intent to leave, history of successful LOA, presence of active psychotic symptoms, presence of suicidality or homicidality, forensic history, insight, rapport with treating multi-disciplinary team, and supportive and psychoeducated family members . An environment as unique as Sterkfontein Hospital would benefit from the development of a highly specific risk assessment tool. Perhaps modification or adaptation of previously used and effective risk assessment tools (e.g. HCR -20 or **Short-Term Assessment of Risk and Treatability**) should be considered.

Other recommendations to reduce absconding include: effective nursing practices , close therapeutic relationships, educating and engaging with relatives, telephoning patients at home, controlled home visits (resources permitting), careful breaking of bad news, regular checking of urine for cannabis use, multidisciplinary reviews, treatment strategies to cope with anger and conflict, more intensive social interventions, adequate preparation and psychoeducation prior to LOA. The timeous and appropriate reclassification and possible discharge of state patients may reduce the large contribution this population has on absconding figures. The problem of substance abuse requires focused and appropriate acute and rehabilitative services. Community resources need to be enhanced and aligned with tertiary services, so that a complementary and cohesive relationship is maintained.

Risk assessment and management need to be put into human resource and epidemiological perspectives. Further research that builds on these South African findings would be useful to examine risk assessment and management practices in relation to absconding, directorate and

hospital absconding policy and practices, and perceptions of mental health care users, staff and family members in relation to this stressful event.

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APPENDIX A

NUMBER OF PATIENTS AT RISK OF ABSCONDING DURING THE PERIOD 1ST

JANUARY TO 31ST DECEMBER 2008

Total number of in-patients (as at 01/01/2008)	306
Plus Admissions	
❖ January	77
❖ February	42
❖ March	81
❖ April	84
❖ May	109
❖ June	94
❖ July	101
❖ August	109
❖ September	98
❖ October	109
❖ November	93
❖ December	77
TOTAL	1074

APPENDIX B

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

R14/49 Dr Feroza Arbee

CLEARANCE CERTIFICATE

M090540

PROJECT

A Retrospective Record Review of Mental Health Care Users who Abscond from a Psychiatric Hospital

INVESTIGATORS

Dr Feroza Arbee.

DEPARTMENT

Department of Psychiatry

DATE CONSIDERED

09.05.29

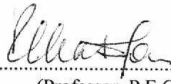
DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.05.29

CHAIRPERSON


(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Dr U Subramaney

DECLARATION OF INVESTIGATOR(S)

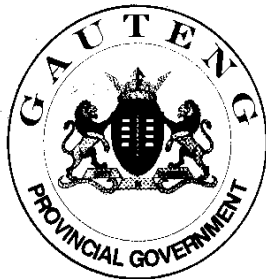
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

.....

APPENDIX C



Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnnyango wezempilo
OFFICE OF THE CEO
STERKFORTEIN HOSPITAL

ENQUIRES: Dr K.A. Mustafa

Dr Feroza Arbee
Psychiatry Registrar

PERMISSION TO COLLECT DATA FROM STERKFORTEIN HOSPITAL FOR RESEARCH PURPOSES

Please be informed that management has given you permission to collect data from Sterkfontein Hospital for research purposes.

Regards.

A handwritten signature in black ink, appearing to read "K.A. Mustafa".

DR K.A. MUSTAFA
CHIEF EXECUTIVE OFFICER

02/03/2009

cc. Dr U. Subramanoy
Mr Ledwaba



PRIVATE BAG X2010, KRUGERSDORP 1740
TEL (011) 951-8257 FAX (011) 956-6907 EMAIL : Sithole.Toleka@gauteng.gov.za

APPENDIX D

Data Collection Sheet:

Number:

Age:

Sex:

Employment status:

Section of MHCA under which admitted (33, 34 or 42):

Marital status:

Ward: open / closed

Forensic / general

Date of admission:

Date of abscond:

Length of hospitalisation:

Diagnosis:

Substance use: Y / N

Contributing Factors:

Past Psychiatric History:

Previous admissions:

Methods of escape:

Previous absconds:

APPENDIX E

MAGISTERIAL DISTRICTS SERVED BY STERKFORTEIN HOSPITAL

- ❖ Alberton
- ❖ Alexandra
- ❖ Benoni
- ❖ Boksburg
- ❖ Brakpan
- ❖ Daveyton
- ❖ Dunnottar
- ❖ Edenvale
- ❖ Fochville
- ❖ Germiston
- ❖ Hardach
- ❖ Heidelberg
- ❖ Itsotseng
- ❖ Johannesburg
- ❖ Kempton Park
- ❖ Klerksdorp
- ❖ Krugersdorp
- ❖ Nigel
- ❖ Oberholzer
- ❖ Potchefstroom
- ❖ Protea
- ❖ Randburg
- ❖ Randfontein
- ❖ Roodepoort
- ❖ Schweizer Reneke

- ❖ Sebokeng
- ❖ Springs
- ❖ Tembisa
- ❖ Vanderbijlpark
- ❖ Ventersdorp
- ❖ Vosloorus
- ❖ Vryburg
- ❖ Westonaria
- ❖ Wolmaranstad

