ABSCONDING FROM A PSYCHIATRIC SETTING IN INDONESIA: A CASE STUDY

Thesis submitted by

INTANSARI NURJANNAH, BSN

October 2007

for the degree of Master of Nursing Science

School of Nursing, Midwifery and Nutrition

James Cook University

STATEMENT OF ACCESS

I, the undersigned, author of this work, understand that James Cook University will make this thesis available for use within the University Library and, via the Australian Digital Theses network, for use elsewhere.

I understand that, as an unpublished work, a thesis has significant protection under the Copyright Act and;

I do not wish to place any further restriction on access to this work.

_____ _____

Signature Date

STATEMENT OF SOURCES

DECLARATION

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

Intansari Nurjannah Date

STATEMENT ON THE CONTRIBUTION OF OTHERS

This thesis has been made possible through the support of many people as follows:

Supervisors:
Professor Mary FitzGerald
School of Nursing, Midwifery and Nutrition, James Cook University
Profesor Colin Holmes
School of Nursing, Midwifery and Nutrition, James Cook University
Dr Kim Foster
School of Nursing, Midwifery and Nutrition, James Cook University

Financial assistance:
AusAID Scholarship (2005-2007)

Editorial Assistance:
Rose Hogan
Administrative Officer
Faculty of Medicine, Health & Molecular Sciences
James Cook University

Director of Psychiatric Hospital in Indonesia

Research permission and data collection assistance
Sri Warsini
Lecturer, School of Nursing, Gadjah Mada University
Puji Sutarjo
Nurse in psychiatric Hospital, Indonesia
Akrim Wasniati
Nurse in psychiatric Hospital, Indonesia

ACKNOWLEDGEMENTS

There are a number of people, colleagues and friends who have contributed in some way in the development and completion of this thesis through their gift of time, advice, encouragement and support.

I am indebted to Professor Mary FitzGerald and Dr Kim Foster for their patience, careful supervision and encouragement throughout the years of my candidature. As an international student, studying for a master's degree in James Cook University was much more than producing a good quality result in the thesis; it was also learning how to understand a different culture. Both Professor Mary FitzGerald and Dr Kim Foster have shown an 'excellent' and 'supportive' role model as supervisor through the close relationship between student and supervisor. Their support always gave me more energy to do my best, and they were always willing to understand the difference between my culture as an international student and the generally Western culture of the University. My appreciation is also extended to Professor Colin Holmes who always gave me support, encouragement and shared his expertise in psychiatric nursing, which then inspired me as an international student to try to understand the different contexts of psychiatric nursing in Australia and Indonesia.

My sincere appreciation is also extended to the psychiatric hospital where this study was conducted. This was only made possible by the willingness of the hospital's Director who gave permission for this research. I also thank to all support from nurses and administrative staff who were very cooperative and supportive.

I would like to express my deep and sincere appreciation to all the key participants who assisted with the study for sharing their time, thoughts, feelings and ideas about the absconding experience; this all has given me an incredible experience as a psychiatric nurse.

Finally, I would like to thank my family, friends, and work colleagues for their unending tolerance, encouragement and support over the years of my candidature. In particular, I thank to all the Indonesian students at James Cook University for their concern and attention to me and my family; Alexander Salvador and Cinzia Spinelli who were always ready to help me whenever I and my family faced a problem when living in Australia; Vera Fitzgerald who has been such a good friend, for her willingness to share her ideas and experience about the mental health services in Australia; Rose Hogan for her wonderful job who was willing to spend her time editing my thesis; Professor Kim Usher who very kindly supported me through all the processes of my candidature, particularly in the publication of my thesis. Finally, but not least, my husband, Yulistianto for his patience, understanding and support in my 'busy time', and my two sons, who gave me a rich life experience as a student with two wonderful young boys. Thank you

ABSTRACT

Patients absconding from psychiatric settings are a phenomenon that has increasingly caught the attention of nursing researchers in Western countries. This phenomenon also occurs in psychiatric hospitals in Indonesia. However, this is not a topic that has received a great deal of attention in terms of research in Indonesia.

The aim of the study is to provide a profile of absconding events over a one-year period in one psychiatric setting. The objectives of the study are to:

- identify demographic patterns associated with all patients who abscond from one psychiatric hospital during a one-year period;
- describe the experience of patients and nurses related to incidents of absconding;
- identify the contextual factors that promote and obstruct absconding behaviour; and
- discuss the ways in which absconding events in this case differ or are similar to reports of absconding in the West.

A case study using mixed methods and concurrent triangulation has been undertaken in order to provide a profile of absconding events over a period of one year in a psychiatric hospital in Indonesia. Data included a one-year audit of absconding events, a period of observation, and interviews with patients and nurses.

Over a one-year period of data collection 133 absconding events were recorded that involved 106 patients. The predominant pattern of people who abscond is that they are young male patients with a history of previous admission. 70% of patients return to the hospital on the day of absconding. On the face of it, this information is consistent with findings in the West, however qualitative data reveals significant differences.

Sixteen patients who absconded during a seven-month period of data collection were interviewed. Three themes were identified: ‘The call to home’, ‘Hopes and realities’ and ‘Us and them’. All these themes link to the process of recovery. ‘The call to home’ and hopes for happier life are considered as the first step in the process of recovery. ‘The call to home’ reflected the patients’ eagerness to have connection with their family and to feel safe. Patients hope to experience a happier life, however most of their hopes are dashed as they fail to reach home or their family sent them back to hospital. The last theme is ‘Us and them’ in which the patients describe the differences between them and others, and the consequence of the differences which create negative feelings and forms a barrier to developing and growing towards recovery.

Observations and interviews with 24 nurses reveal a style of nursing that is custodial rather than therapeutic. The days are filled with routine duties, and opportunities to prepare patients for discharge as an important part of the recovery process, are missed. The nursing staff is disappointed with the attitude of the family and community towards people with mental health problems and believes that families are responsible for patients once they are ready for discharge.

The majority of patients who absconded from the hospital in this study were ready for discharge and awaiting collection by their family. They were considered to be in the process of recovery, but it appears that there is little adequate support for patients who are ready to be discharged from hospital. It is not unusual for patients who have absconded to be brought back to hospital again by their family if they are not well received in the community.

Short term recommendations centre on the rehabilitation focus and activities in the hospital. Nurses should become more involved with interventions that are appropriate in rehabilitation processes and see it as an integral part of discharge planning included in management plans. In the longer term, nurses require resources to support their education and the implementation and evaluation of person-centered models of care. Strategic plans should be implemented to change public and professional attitudes towards people with a mental health problem. Further research on this topic is required to understand family and community attitudes, recovery from a range of perspectives and test alternative models of nursing care.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

KEY

MM2 = Male Maintenance ward 2

MM3 = Male maintenance ward 3

FM2 = Female maintenance ward 2

FM3 = Female maintenance ward 3

MIW = Male intensive ward

FIW = Female intensive ward

OMM3 = Observation in the Morning at Male maintenance ward 3

HDP = Hospital policy document

Pt = patient

PCA = Prospective chart audit

Rec = data come from interview with nurse

Rec (number)p = data come from interview with patient

X = evidence contradict to proposition

√ = support proposition

- = no evidence

CHAPTER ONE: BACKGROUND OF STUDY

1.1 Introduction

Patients absconding from psychiatric services is a phenomenon that has increasingly caught the attention of nursing researchers in Western countries. Although absconding occurs in Indonesia and anecdotally causes disruption to patients' therapy, distress to family members and consternation amongst the nursing staff who feel responsible, it is not a topic that has received a great deal of attention in terms of research. It is therefore reasonable to begin research in this area in Indonesia with a descriptive/exploratory study that explores absconding in Indonesia, and enables the researcher to identify those issues that are distinctive to the Indonesian health context and culture, as well as more general issues that resonate with the findings in the West.

My role is to teach nursing students about the care of people with psychiatric problems. In this role I spend time in a large hospital for the care and rehabilitation of people with psychiatric problems. It was in this institution that I became aware of the problem of patients absconding. One day I planned to work with a student and began to ask her about one particular patient. The nurse told me I could not meet this patient because he had absconded earlier in the day. I looked up 'elopement precaution' as the term that refers to absconding prevention in the textbook and found a list of behaviours that are deemed to be indicators that a patient is planning to abscond. I asked the student to describe the patient's behaviour the day before. She described a number of signs that could have alerted both her and the other nurses if only they had known what to look for. I was also aware that the textbook did not relate specifically to Indonesia, and I wondered whether the information was really appropriate for our particular culture and context.

1.2 Research Questions

Research question: In what kind of circumstances does absconding occur in one psychiatric setting in Indonesia?

Sub-questions:

- What are the patterns associated with absconding?
- How is absconding viewed by key stakeholders?

1.3 Aim

The aim of the study is to provide a profile of absconding events over a one-year period in one psychiatric setting. The objectives of the study are to:

- identify demographic patterns associated with all patients who abscond from one psychiatric hospital during a one-year period;
- describe the experience of patients and nurses related to incidents of absconding;
- identify the contextual factors that promote and obstruct absconding behaviour; and
- discuss the ways in which absconding events in this case differ or are similar to reports of absconding in the West.

1.4 Significance

The results of this study will constitute the first empirical evidence regarding this issue in Indonesia. It will also provide preliminary information that will raise awareness of this problem in the community, amongst health professionals and, in particular, nurses working in psychiatric facilities. It is anticipated that this increased awareness will lead to collective action to address the problem/s that lead to absconding and the development of appropriate responses after the event. The findings of the study will be used to generate hypotheses for further research in Indonesia and for collaborative research with other countries.

In the rest of this chapter I will provide a description of the context of psychiatric services in Indonesia and present Stuart's theory of psychiatric nursing (Stuart, 2005). In the last part of the chapter I will map out the structure and sequence of the thesis.

1.5 The Context of the Study: Psychiatric Services in Indonesia

Demands on psychiatric services consistently rise each year placing enormous demand on resources. By way of an example in Yogyakarta, where the research was undertaken, the number of patients who attended outpatient services in 2003 increased as much as 50% by 2004, and patients who stayed in inpatient care rose 94% from 2003 to 2004 (Amin, 2005b). The average length of stay in one psychiatric hospital in this city was 26 days (in 2006).

Siswono, writing from Indonesia cites Azwar (Siswono, 2001) who identifies factors that adversely affect the provision of psychiatric services, for example, inadequate government funding, poor facilities and human resources. Poor human resources in this context refer to the lack of psychiatrically trained nurses and doctors.

There is evidence of a lack of support for the health sector as only 3.5 percent of national budget is allocated for health services. The standard promoted by the World Health Organisation is that 5% of the national budget should be allocated to health. In contrast, the budget for health and education in developed countries reaches 30-40% of the national budget (Wilujani, 2001).

Indonesia only has 51 psychiatric hospitals with a total bed capacity in 2006 of 8.630 (*Daftar Rumah Sakit Indonesia,* 2007). Currently, only five psychiatric institutions are managed by the Government Health Department, the rest are managed by local government in each province. This policy of decentralization started in 2001 (Wilujani, 2001). While the rationale for decentralization is sound in terms of local autonomy, it has created the

potential for variation in practice and standards in psychiatric services across the country.

Health professionals are in short supply in Indonesia. By way of an example, Wilujani (2001) says that 430 psychiatrists are provided for 202 million people in Indonesia (approximately 10:4.697.674). In developed countries such as North America, Australia and some parts of Europe and South America, the number of psychiatrists is about 10 per 100.000 people. Also of concern is that the number of nurses has only reached 36% of the required number based on a standard that five beds should be managed by three nurses (Wilujani, 2001). Reliable statistics are hard to come by, particularly as untrained nurses are included in the numbers. Lack of staff and the overwhelming need of people are very obvious in the overcrowded waiting rooms of the outpatient clinics in hospitals, but lack of staff in the health service in Indonesia does not mean that there is a problem with supply of nurses. Eli (2005) reveals that the number of nurses in Indonesia who are unemployed reached 100,000 nurses in 2005.

Azwar (2001, cited in Wilujani, 2001) suggests that other factors such as the high risk of the work and the low salary offered may influence the number of nurses choosing to work in the psychiatric setting. The average salary for nurses is only about 300.000-500.000 rupiahs ($50-$70 per month) (Wilujani, 2001).

As a general rule, each psychiatric institution has its own standard protocols for admission, treatment and discharge of people with psychiatric problems. It is the psychiatrist who assesses patients, makes a diagnosis and prescribes the treatments. Unlike Australia, Indonesia does not have a *Mental Health Act* to provide regulations that are enforceable. There is an awareness that psychiatric services are severely under-resourced and outdated compared with the West. Indeed, psychiatric hospitals are still considered as a prison for

people with mental illness as mentioned by Riyanto (2007, cited in Tok, 2007).

People with mental illness and their families face many problems living in the community. Wilujani refers to Idris (2001) when she suggests that problems are exacerbated by the general public's lack of knowledge about psychiatric problems. People who experience psychiatric problems and their immediate families commonly experience rejection, discrimination, stigmatization and isolation in the community. This community reaction sometimes results in family rejection of people with psychiatric problems. This attitude and behaviour places psychiatric patients at a high risk of human rights violation (Hidayat, 2005). These facts should be understood however, with regard to the socio-economic situation of Indonesia. There is evidence that as many as 80% of patients with mental illness come from the lower socio-economic classes (Hidayat, 2005). When families are poor and eking out an existence it is so burdensome for most that it is hard, if not impossible, to accommodate and support people who do not contribute or who are disruptive, as can be the case.

Many people with mental illness who have been admitted to hospital, completed treatment and discharged home return to hospital again as the result of stigmatization. They experience rejection from their families who feel ashamed of the family member who is 'crazy' (Iskandar, 2005, cited in Fitriawan, 2005). This phenomenon is not isolated to Indonesia, indeed Granerud and Severinsson (2006) comment from their research in the West that some people who have been treated in a psychiatric institution feel they are ignored and looked down upon in the community.

When patients are ready for discharge often the family simply does not pick them up. Eventually some patients give up waiting for their family and leave the hospital without official permission. Tok (2005) and Amin (2005a) agree that this happens in most psychiatric hospitals in Indonesia. The absconding

behavior also creates a burden for the hospital. The hospital in this study calculates that it has lost as much Rp 157 million in the years from 1999 to 2005 as a direct result of people absconding and therefore defaulting on payment (Andung, 2005, cited in Amin, 2005a).

1.6 The Stuart Stress Adaptation Model of Psychiatric Nursing Care

One theoretical model to guide nursing practice in a psychiatric setting is 'The Stuart Stress Adaptation of Psychiatric Nursing Care' (Stuart, 2005, p. 72). Although this model has been developed in a North American culture and context, the underlying assumptions are congruent with the ideals of Indonesian people in humanistic terms. Even though our country does not have the social resources of comparatively affluent nations in the West, the concepts and theories contained in the model provide a guide to the care of people with mental illness, and in this case a starting point for discussion. In the context of this research the model has been used in the interpretation phases of the study and for the recommendations made in Chapter Seven.

The Indonesian Government has a mandate to work towards universal human rights and in this respect have a number of social priorities. Currently, mental health is not one of those priorities. It is my contention however, that taking a theoretical and idealistic model to guide the interpretation of the study data is practical because there are many attitudes and everyday practices that can be confirmed or changed without the injection of economic resources. Health professionals, mentally ill people and the community in Indonesia face many difficulties in day to day life, and this model must be interpreted carefully. It is not a practical template for how nursing should be changed in Indonesia; it is used to try to understand what is happening in terms of what the nurses and patients talked to me about, and what I have seen as a result of this study. The model is viewed as aspirational guide to future development.

Among other models that may be used by mental health professionals, for example the psychoanalytical, interpersonal or social models, the Stuart model

has been chosen as the theory is derived from many theories, and is able to deal with a variety of circumstances in which people with psychiatric problems may find themselves. This model, which is based on the standard of psychiatric nursing care, uses a biopsychosocial approach and favours a continuum of adaptation – maladaptation rather than health – illness. The primary, secondary, and tertiary levels of prevention that form one theory within this model may be used in both developing and developed countries with effect.

The patient treatment stages which are "crisis", "acute", "maintenance" and "health promotion" (Stuart, 2005, p. 72) are used in the latter part of the thesis to explain the results, and in particular, the modes of care provided in the case study hospital. The model may also give an alternative and possible answer, for some problems that may emerge in this study. However, as this model is based on a different culture from Indonesia's, it would need to be subjected to critique and adaptation before it was deemed appropriate for and useful in the clinical context of Indonesia.

Pearson, Vaughan and FitzGerald (2005, p. 37) advise readers to identify three basic components of practice models:

1. The beliefs and values on which the model is based, related to:
    (a) the person;
    (b) health; and
    (c) the environment.
2. The goals of practice or what the practitioner aims to achieve.
3. The knowledge and skills the practitioner needs to develop in order to gain these goals.

In the Stuart model, human beings are viewed as individuals who are "… part of family, group, community, society and the larger biosphere" (Stuart, 2005, p. 60). Individuals are seen as a complicated dynamic system. In addition, human behavior is viewed "… from a holistic perspective that integrates

biological, psychological, and sociocultural aspects of care" (Stuart, 2005, p. 64).

Health in Stuart's model is viewed from a nursing world view as an "… adaptation/maladaptation continuum" (Stuart, 2005, p. 61), and as being adaptive responses to stressors encountered in everyday life. Adaptive responses are those that support integrated functioning which lead to " … growth, learning, and goal achievement" (Stuart, 2005, p. 68). Conversely, there are maladaptive responses to stressors that block integrated functioning and may " … prevent growth, decrease autonomy, and interfere with mastery of the environment" (Stuart, 2005, p. 68). Stuart (2005, p. 62) lists " … indicators of mental health as:

1. positive attitude toward self
2. growth, development, and self-actualization
3. integration
4. autonomy
5. reality perception
6. environmental mastery".

"Environment" to Stuart is the world surrounding human beings. "Each day, environmental forces shape, support, challenge, block and defeat how well the mental health needs of individuals, families, and communities are met" (Stuart, 2005, p. 134). In particular, she refers to structural aspects of the environment such as modern health service resources, policies and organizations, but argues that modern technologies " … will be of little benefit to patients if they cannot gain access to them, cannot afford them, or find them unacceptable" (Stuart, 2005, p. 134). Understanding these structural aspects of psychiatric services may help psychiatric nurses to improve client access to these resources, as The Goal of Nursing in Stuart's model " … is to maximize the patient's positive interactions with the environment, promote a level of wellness, and enhance self actualization" (Stuart, 2005, p. 183).

The knowledge and skills for practice in Stuart's model prioritise "the use of oneself" as the key therapeutic tool of the psychiatric nurse (Stuart 2005, p. 16). The nurse's ability to be therapeutic is important because "The nurse-patient relationship is the vehicle for applying the nursing process" (Stuart, 2005, p. 183). In addition, knowledge and skills for practice in psychiatric care have to be based on standards of care and professional performance.
The summary of the model can be seen in Table 1.1 (Stuart, 2005, p. 72)

Stevens Barnum (1998, p. 171) provides a practical and relatively plain guide to the critique of models of nursing. She distinguishes between internal validity and external validity of nursing theories.

As an international student I have found this model relatively easy to understand, which demonstrates that the model is written clearly and terms are used in a consistent way. The work adequately covers the complex concepts related to psychiatric nursing delivery in either hospital or in community. Furthermore the work has a logical flow from assumptions through to interpretation and guidance for practice.

The external validity of the model is harder to establish, mainly because of the social and cultural differences between my country and the West. This divergence means that it is hard to relate the ideal with the situation facing both people with psychiatric problems and nurses who strive to provide a service in Indonesia. The model has utility for the purpose of this research, rather than as a guide to practice. One of the attractions of this model was its significance in terms of relating to the needs and classification of people with a psychiatric problem. Lastly, although the model distinguishes nursing therapy, the importance of this in a world where client self-care and multi-disciplinary models of care dominate is open to debate.

Table 1.1 The summary of The Stuart Stress Adaptation Model of Psychiatric Nursing Care (Adapted from Stuart, 2005)

Treatment stage	Health promotion	Maintenance	Acute	Crisis
Treatment goal	Optimal level of wellness	Recovery	Remission	Stabilization
Nursing assessment	Quality of life and well-being	Functional status	Symptom and coping resources	Risk factors
Nursing Intervention	Inspire and validation	Reinforcement advocacy	Mutual treatment, planning, modeling and teaching	Manage environment
Expected outcome	Attain optimal quality of life	Improved functioning	Symptom relief	No harm to self or others

1.7 Case Study Setting

Records of all absconding patients over a one-year period have been used to collect prospective demographic data. A purposive sample has been used for the interviews and observations. Stakeholders involved in this study are patients (who absconded and returned to hospital within the seven-month period of research), and nurses on duty when the patient absconded. Patients have been termed 'patient who absconds' if they were absent from the hospital building without notifying a member of the nursing staff on duty.

The study was conducted at a psychiatric institution in Yogyakarta, Indonesia (7 wards, 168 beds) located in the north of Yogyakarta. The drug ward for drug abusers was excluded, so research was conducted only in 6 wards (153 beds). This is a psychiatric institution that was established in 1940. As the hospital has a Rehabilitation Unit patients are able to stay there for all their treatment, making length of stay longer than institutions with only acute services.

1.8 Operational Definitions

In Indonesia, people who come for admission to hospital are referred to as '*pasien*/patient'. This term is different in the West where it is more respectful or politically correct to refer to people with a mental illness as a 'client' or 'consumer'. The term 'patient' will be used in this study as this term relates to the real contextual situation in Indonesia. The term 'patient' also portrays the current role and status of the patient in psychiatric institutions in Indonesia.

The term 'absconding' will be used in this study except in Chapter Six. Many terms have been employed in the literature to describe absconding behavior such as "abscond", "escape", "elope", "absent without leave" or "AWOL/AWOP", or "runaway" (Bowers et al., 1998, p. 344). Each term has a specific sense or meaning. In the Indonesian context, there is only one word for absconding which has a definite meaning relating to running away without permission. The patients in their interviews did not use the word 'absconding' and therefore in Chapter Six the English word 'escape' is used.

Patients who abscond are referred to as such. Terms such as 'abscondee' or 'absconder' are avoided because they are considered disrespectful. Absconding is: any patient absent from the hospital building without notifying a member of the nursing staff on duty.

1.9 Structure and Outline of the Thesis

The study is presented in seven chapters. Chapter Two will be the literature review, and the research methodology and research method will be presented in the third chapter. All results of this study will be presented in Chapters Four, Five and Six. The Stuart Stress Adaptation Model in Psychiatric Care will be used as a theoretical framework in each discussion chapter. The last chapter will be Chapter Seven.

The first chapter provides a background to the study and presents a description of the psychiatric services in Indonesia, followed by an account of the significance of the problem of absconding, The Stuart Stress Adaptation model and the aim of the study.

The second chapter presents the literature review as the source of information about absconding and will detail propositions derived from the literature. The propositions are used to guide the collection of observational, and audit data and interview prompts.

The third chapter consists of the research methodology and research methods. This chapter explains the design of the study, the methodology used, methods of data collection, analysis, theory and reporting. Case study as the methodology in this study is also explained. This chapter also gives a rationale for the use of case study and mixed methods in this research.

The fourth chapter discusses the results of the study. This chapter shows the result of contextual factors and also the pattern of absconding which comes from the observation and chart audit data. Pattern matching will be described to compare the result of the present study and research findings from the West.

The fifth chapter is a discussion of the nurses' views of absconding. This chapter is also divided into five parts, namely; an introduction, a thematic

account of the nurses' views, result, pattern matching and discussion. To aid pattern matching, the nurses's accounts are structured in a similar way to Clark's (1999) research report on absconding.

The sixth chapter is presented in five parts which are; introduction, the patient's stories, patient's themes and pattern matching and lastly discussion. A rationale is given for the selection of four stories from the sixteen told by patients in interview. Three major themes emerged from the patients' stories, and these will be examined with examples from the transcripts.

The seventh chapter will include the research question revisited, the summary of research process and findings, the strengths and limitations of the study, recommendations for practice, policy and and further research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Literature Review

In this section the Western literature is reviewed in preparation for this exploratory study of absconding from mental health services in Indonesia. From this review it is possible to draw information about the characteristics of patients who abscond, including the following variables related to absconding: the predictors, circumstances, consequences, and interventions needed to reduce the incidence of absconding.

Cochrane, Medline and CINAHL databases were used for the search. The key terms used were *absconding, AWOL and mental illness patients, elope* and mental illness patients, escape and mental illness patients, runaway and mental illness patients, psychiatric units, patient dropouts, absconding or psychiatric unit, elope and psychiatric patient.* The search was limited to papers published after 1990, written in English. Papers were only retrieved if they referred to absconding from health service institutions, and literature that referred to forensic mental health was excluded. There was no electronic database available to find Indonesian literature specific to the topic, so the editors of two Indonesian medical journals were approached and it was established that there were no publications on the issue (Ela, personal communication, November 10, 2005). In all, forty papers were retrieved from the search, and fifteen papers have been selected for literature review. These are summarized and recorded in Table 2.1.

Generally, the nursing research on absconding patients is limited to small-scale studies of one psychiatric institution. The design of these studies means that it is difficult to generalize the findings to a population. However, the contextual richness of the data collected locally gives nurses an indication of the nature of the problem, the characteristics of typical patients that abscond, and in a few

studies, interventions that can enable nurses to recognise patients at risk of absconding and take measures to prevent an absconding.

The problem in Indonesia is different from the West in a range of ways that are linked to cultural differences and the resources available for the care and treatment of mentally ill people. Nonetheless, Western literature does provide a useful starting point for a preliminary inquiry in Indonesia. In particular, the questions developed in the surveys, the design of the studies, as well as the findings proved to be useful starting points for this research. The study by Ogulensi and Adamson (1992), which was conducted in a developing country, provided a useful marker for cultural comparison with the West.

2.2 Patterns of Absconding

Most studies report the incidence of absconding in terms of the number of reports during the data collection period. The majority of papers however, are restricted to one institution over a relatively short period. Consequently, absconding events are too few to be used for any purpose beyond description of the local situation.

Absconding is not a behavior likely to be repeated, as shown in some papers. For instance, the majority of patients who abscond do so only once (Falkowski, Watts, Falkowsi, Dean, 1990; Dickens & Campbell, 2001; (Meehan, Morrison & McDougall, 1999; Ogulensi & Adamson, 1992; Walsh, Rooney, Sloan, McCauley, Mulvaney, & O'Callaghan, 1998; Molnar & Pinchoff, 1993).

As many as 175 patients were involved in 498 absconding events over a five-month period from twelve acute admission wards in five hospitals at different sites, as reported in Bowers's study (Bowers, Jarrett, Clark, Kiyimba, McFarlane, 1999b).

Molnar & Pinchoff (1993) report that during a one-year period 172 patients absconded for 342 absconding events. The study was conducted in a hospital

with a rehabilitative mission – a similar feature of the hospital where this study was undertaken. For the sake of a rough comparison with Indonesia, in one mental health hospital with seven wards, approximately 1-2 patients are estimated to abscond every month from each ward; unfortunately, this did not include information about recidivists (Sutarjo, personal communication, November 25, 2005). It is not possible to draw conclusive comparisons from these anecdotal figures, but they do show that it is likely that absconding occurs at a problematic rate and it is worthy of more local attention.

The patient who absconds reported in the literature appear to have a longer average length of stay in hospital than non-absconding in-patients (Meehan et al., 1999), and on most occasions the event of absconding happens in the first two weeks after admission (Bowers et al., 1999b). Interestingly, Molnar and Pinchoff (1993) found that eighty-three percent of 172 patients absconded after they were hospitalized for 30 days or more. In contrast, Dickens and Campbell's (2001) study of 88 absconding patients shows that the length of admission before absconding was not significant.

The majority of patients who absconded returned to hospital (Bower, Jarrett, Clark, Kiyimba, McFarlane, 1999a; Falkowski et al., 1990; Meehan et al., 1999; Molnar & Pinchoff, 1993; Ogulensi & Adamson, 1992). This is confirmed by other research that shows a significant percentage (80%) (n= 95) of patients returned to hospital in 24 hours (Bowers et al., 1999b; Walsh et al., 1998). Molnar and Pinchoff (1993) have given a higher figure, ninety-two percent (158 patients who absconded) returned to the psychiatric centre. Patients who absconded spend their time outside the hospital for about 23.1 hours (Falkowski et al., 1990) and 4.963 days (Ogulensi & Adamson, 1992). The longer time reported by Ogulensi in Nigeria may possibly be similar to the situation in Indonesia because absconding patients are only looked for in the immediate surrounds of the hospital over a three day period. It is not usual to conduct extensive searches for patients who abscond.

Only one study, (Falkowski et al., 1990), explored the reaction of patients to being back in hospital. These included feelings such as being angry or unhappy. They returned to the ward for several reasons, including feeling cold, hungry, unwell, being in need of medication and treatment for side effects of medication (Bowers et al., 1999a). Patients returned to hospital in the following ways: on their own, by police, friends or relatives and in some cases, by hospital staff (Bowers et al., 1999a; Dickens & Campbell, 2001; Falkowski et al., 1990; Meehan et al., 1999; Walsh et al., 1998)

There are some changes in the care of the patient after returning to hospital, for example, being observed more closely (Falkowski et al., 1990).

2.3 Characteristics of the patient who Absconds

Most studies have reported a characteristic profile of patients who absconded. Their most distinctive features appear to be that they were young, single and male (Bowers, Jarrett, Clark, Kiyimba, McFarlane, 2000; Dickens & Campbell, 2001; Falkowski et al., 1990; Meehan et al., 1999; Molnar & Pinchoff, 1993; Ogulensi & Adamson, 1992).

Molnar & Pinchoff (1993) report that males were twice as likely to abscond (21 percent) than females (10 percent). They also found that most patients who absconded were under the age of 35 (23 percent). This is, however, with one exception, as seen in Walsh's (1998) retrospective review over a 12-month period. In this Irish psychiatric hospital the number of female patients who absconded was reported as slightly higher than the number of male patients who absconded. Moreover, Dickens & Campbell (2001) conclude in another retrospective review that neither gender nor ethnicity was conclusively found to be a predictor of the likelihood of absconding. Overall, this evidence leaves readers with, at best, a trend towards young single males, but little other conclusive results on which to base interventions.

Almost all the literature illustrates that schizophrenia is the most frequent diagnosis amongst patients who abscond (Falkowski et al., 1990; Meehan et al., 1999; Ogulensi & Adamson, 1992; Richmond, Dandridge, & Jones., 1991).

The majority of patients who absconded tended to be recorded as people who had a history of admission to psychiatric hospital, and who had a history of absconding (Richmond et al., 1991). In the UK Falkowski et al. (1990) reported that 70% (n=100) of patients who absconded were subjected to the Mental Health Act 1983 (Falkowski et al., 1990), and were compulsorily admitted under a section of the British Mental Health Act (Dickens & Campbell, 2001) as involuntary patients. They had been committed by the court for hospitalization (Richmond et al., 1991). In Indonesia, there are no clear rules for taking psychiatric patients to hospital for psychiatric care. Usually the patient's family takes a relative to the hospital because the person's behavior is disturbing them or their neighbours. There is no law that requires they be detained against their will in a mental health institution.

Bowers et al. (1999a, p. 214) compare patients who absconded with patients who did not abscond, and reports that patients who absconded were considerably more likely to display high-risk behaviours than the control group. Examples of self-harm behaviours were also noted amongst patients who absconded, and included the use of illicit drugs and self neglect.

The other groups of patients who absconded were people with a history of offending, those considered to pose a risk to others, and people with a history of contacts with courts, prison or forensic psychiatry. At least 5% (n=175) of patients who absconded in Bower's (1999a) study had been involved in 'officially reported ward incidents.' Molnar and Pinchoff (1993) also found that thirty-two percent of patients who absconded were either a danger to themselves or to others based on their physician's assessment.

2.4 Predictors of Absconding

Clues to impending absconding behavior have been explored in some of the studies. Bowers et al. (1999b, p. 208) reports that more than half of absconding patients told staff of their intention to leave the ward. Richmond et al. (1991) in a quality assurance study try to recognize factors influencing absconding and to implement specific intervention to reduce absconding. Richmond et al. (1991, p. 76) recounts a number of verbal and non-verbal clues in patients' accounts of their pre absconding attitudes. Examples such as "felt I was ready to go home", "I wanted the alcohol and drug rehab unit, not the crazy ward" were recorded. Moreover, a number of people said they did not understand the cause for their hospitalization and were disappointed with their management or treatment strategies.

Non-verbal clues displayed before an absconding incident are reported in only one study (Richmond et al., 1991). Examples included restlessness and irritability (agitation), and refusal to take medicine or provide laboratory samples. An abrupt alteration in mental status was also reported, such as confusion and disorientation, delusions, threatening behavior, hostility and suspicion. Changing clothing without cause is also one of the clues with respect to patients who might be about to abscond. Another non-verbal clue is sitting or standing near the door to the unit and writing on the patient sign out book: 'going home' (Richmond et al., 1991).

As previously stated, none of the research findings have strong external validity because they tend to report on small numbers of absconding incidents in local conditions and contexts. However, the trends reported in these small research studies resonate with the Nursing Intervention Classification to prevent absconding. This intervention is entitled "Elopement Precaution". For instance, the intervention instructs nurses to observe patients for the following signs: "verbal indications that they want to leave, patients loitering near exits, wearing multiple layers of clothing, disorientation, separation anxiety, homesickness" (Closkey & Bulechek, 1996, p. 243).

It was obvious from the literature that the majority of patients had more than one reason for absconding. According to Bowers, Jarrett, Clark, Kiyimba, McFarlane (1999c), Falkowski et al. (1990), and Meehan et al. (1999) the reasons for absconding included being disturbed either by the ward or other patients, and concern about issues at home. In addition, patients were bored, lacked interesting activities and also desired to do activities outside the hospital. Other reasons for absconding can be explained in terms of the perceptions expressed in interviews with patients, such as fear that they may be harmed in some way in hospital (Falkowski et al., 1990), anger because of delayed discharge, feeling cut off from relatives and friends, feeling trapped and confined (Bowers et al. 1999a), as well as the reason for hospitalization (Meehan et al., 1999). The stigma of being in a psychiatric hospital, disliking the staff/food/ward, lack of privacy and abnormal beliefs or response to abnormal experience is reported in Falkowski's study (1990). Meehan et al. (1999) concludes that patients may get rewards from absconding, such as more attention and better access to nursing staff after they have absconded.

The fact that homesickness or separation anxiety is barely mentioned in the research studies in this literature review is of note. Commonsense would lead to the conclusion that some people will abscond because they miss family, friends or familiar places. Most likely, absconding occurs because the patients' views are seldom canvassed or reported. Indeed the research that does mention a feeling of being "cut off from family and friends" (Bowers et al., 1999c, p. 202) was a study that interviewed 92 patients who absconded after they returned to hospital.

2.5 Circumstances of Absconding

Clues as to the reasons why, where, how and when patients leave the ward, and their condition, may be found in the circumstances surrounding the event. These circumstances provide predictors of absconding behavior, which help health staff to be aware and apply strategies that might be effective in the

prevention of absconding. Unfortunately, only limited research in this review of absconding explores the circumstances surrounding the absconding incident.

The reports here are varied, demonstrating the complexity of the issue and how dependent it is upon individuals and particular contexts. It has been reported that most people showed changes in mental status (psychotic symptoms) prior to absconding events (Richmond et al., 1991). On the other hand, figures show that the majority of patients were fully or partially recovered in their mental state before they absconded. Looking for a contextual rather than medical reason for this behaviour, (Bowers et al., 1999b) reports that the most common situation in which patients absconded was when the ward was open, increasing the opportunities for absconding. Richmond et al. (1991), however, reports that three patients passed locked doors that were attended by staff. Molnar and Pinchoff (1993) reported that ninety-three percent of patients who absconded had off-ward privileges when they absconded. All one can conclude from these apparent contradictions are that it is a multi-factorial issue. The series of small unrelated studies that have been found demonstrate the need for a more co-ordinated approach to research in this area. While the data gained in small studies can have local use it is difficult to synthesize the data in a meaningful way because of the variety of research designs and varying standards of reporting.

Bowers et al. (1999a), Falkowski et al. (1990), Ogulensi and Adamson (1992) and Walsh et al. (1998) report that more than half of patients who absconded went home after absconding. This may be important in terms of alerting the people who live with patients who abscond, because it is the first place to search for missing patients.

Apparently, the majority of patients leave the ward in the evening from 13.00 to 21.00, the most obvious reason being that there is less staff on duty on the late shift (Bowers et al., 1999b, Richmond et al., 1991; Walsh et al., 1998). In one Veteran Administration Hospital the nurses implemented a protocol aimed

at reducing absconding. The protocol included better observation of patients, and it is interesting to note that the absconding events which subsequently took place were between 09.00 and 14.30 (Richmond et al., 1991). In Nigeria, Ogulensi and Adamson (1992) reports that most absconding events happened in the morning shift (07.30 - 15.30). Ogulensi and Adamson (1992) does not provide any reason for this but it might be that, as in Indonesia, staff and patient activities occur in the morning, hence afternoon and night is the time when there is less happening in the ward.

2.6 Consequences of Absconding

Absconding from in-patient care is a significant problem that interrupts therapy and can put patients at risk. Furthermore staff, family and communities are affected. There are reports in the literature of self harm, harm by others, and harm to relatives and stress to staff. The research does not really address the issue of the financial cost of absconding. In Indonesia, fear of patients absconding may make staff overprotective, thus restricting patients more than is necessary. It also causes tension within the nursing team, as blame for the incident is apportioned either from hospital management or the patients' relatives. As patients who abscond are rarely pursued beyond the limits of the hospital, absconding does not pose an obvious financial problem to the hospital.

Only one study by Clark, Kiyimba, Bowers, Jarrett, McFarlane (1999) examines the effect of patient absconding on nurses. This study shows that the majority of nurses felt worried and concerned when patients absconded. Guilt, responsibility and disappointment were frequent responses. Seventeen of the 25 nurses spoke of a " … feeling of relief … " when patients who absconded returned safely to the ward. Nurses also described the experience of blaming each other. In addition, they felt insecure because of penalising measures for nurses who are on duty at the time a patient absconds.

Despite the fact that only a few absconding incidents resulted in any harm, either to the patient or others, the examples described in the studies bring home the clear message that these people are vulnerable. Several reports illustrated the close link between absconding and risk to patients, such as suicide or attempted suicide (Bowers et al., 1999a, Falkowski et al., 1990, Meehan et al., 1999). In addition, injury and sunburn was reported in Meehan's sample (1999). Dickens and Campbell (2001) reported self-harm by patients who absconded.

Some patients who abscond harm others, as Meehan et al. (1999) shows, where one patient violated his mother. Dickens and Campbell (2001) in a sample of 88 absconding patients report that:

> … on six occasions criminal offences were recorded. Two of these incidents involved arrest by British Transport Police for undertaking train travel without a ticket. The other four incidents involved actual or potential violence and/or aggression, including criminal damage and possession of a weapon. On other occasions, AWOL patients were apprehended by police for acting suspiciously. On five occasions, AWOL patients were aggressive on their return; on three of these occasions safe patient restraint was implemented. (Dickens & Campbell, 2001, p. 548).

On the other hand, patients who abscond may become victims involved in other offences when absconding. Dickens and Campbell (2001) write that, on three occasions patients reported being the victim of sexual exploitation or sexual assault during an absconding event. However, the frequency of absconding patients being harmed is very small, and it is difficult to identify the specific features of the outcome of absconding behavior.

2.7 Interventions to Reduce Absconding Events

Clark et al. (1999) explore nurses' opinions on how absconding may be reduced. The findings show that nurses believe that the following measures may reduce the incidence of absconding: increased staffing levels, less reliance on agency staff, closer observation of patients, improved communication and locking the ward. It should be noted that seven nurses only mention the last point. However, all nurses (n=25) in the study stress that risk assessment should be on-going from the time a patient is admitted to hospital, and many nurses express a sense of inevitability about absconding. Results also show that not every nurse uses a specific tool to calculate risk of absconding. Indeed the majority of nurses mention that they disagree with doctors over risk assessment, which is not surprising, if they are not using the same assessment criteria.

Three studies undertaken between 1990 and 2005 refer to intervention procedures to reduce absconding. A package of measures to reduce absconding is introduced by Richmond et al. (1991) in a two-stage study. The dominant part of the intervention is regular inspection of patients who are most likely to abscond by using a checklist of nursing duties for confirmation of patients' presence and status. This checklist is derived from the first stage of the research by Richmond et al. (1991), which explores the clues that may be drawn from patient behavior following absconding events. The most important aspect of the intervention is increasing patients' participation in care planning, and also increasing the role of nurses in preventing absconding through regular observation.

The quality assurance project reported by Conroy and Jorgensen (1995) in the Journal, *Nursing Quality Connection*, offers suggestions for reducing absconding. A multi-disciplinary team assessed the relatively high rate of absconding in the mood disorder unit identified as having the highest frequency of absconding in the hospital. The team developed a range of interventions to improve in-patient care generally: " … group psychotherapy (3

times/week), education groups (nursing), daily morning physician rounds, multidisciplinary treatment, team planning (4 times/week) critical care plan for depressive illness, family therapy group, intensive patient orientation" (Conroy & Jorgensen, 1995, p. 30). With such intensive therapy it is hardly surprising that over a three-year period they reported an increase in the number of patients treated, and reductions in the percentage of patients who absconded from 34.7% to 9%. Unfortunately, the project, by its nature, does not really produce any findings from which general conclusions can be drawn, but it does support a broad range of therapies to cover the range of variables involved in this complex issue.

Bowers, Alexander, Gaskell (2003), who are considered the experts in this area, developed 'the anti absconding intervention' and trialed it in a 'before and after study' on five acute psychiatric wards. Bowers' intervention method consists of the following:

- assessments of patients at highest risk of absconding,
- nursing time spent talking with the patient and attempts to meet the patient's needs,
- using an 'in and out' book for patients,
- clarifying rules and review of consequences for patients who abscond,
- careful delivery of bad news to patients,
- enabling social contact for patients who are at risk of absconding,
- assessment of patients who are involved in ward incidents, and
- a multidisciplinary review following two absconding events.

With this range of interventions Bowers reports that absconding rates dropped by 25% during a five-month period in five wards. While his statistics were favorable for the intervention, two of the five wards, in fact, had higher absconding rates after the intervention. Bowers explains that these wards had problems adhering to the new protocol. However, once again, the intervention was based on improving standards of care generally. While the increase in care of the patients described by Bowers is laudable, the change that would be

needed in Indonesia to enable staff to provide this type of service would be great. This type of change with obvious resource implications would have to be backed by high quality evidence that related to the Indonesian context.

2.8 Conclusion

Despite the weakness of the evidence, it is possible to draw a number of propositions from the findings of the studies reported in this review as shown in table 2.1.

Table 2.1 Table of propositions

No	Proposition	Citation
1	That the largest groups of patients who abscond are young male, single persons.	Bowers et al., 1998; Bowers et al., 2000; Dickens & Campbell, 2001; Falkowski et al., 1990; Meehan et al., 1999; Molnar & Pinchoff, 1993; Ogulensi & Adamson, 1992.
2	That in some instances patients may give overt signals that they intend leaving (e.g., say they are going, put on outdoor clothing).	Bowers et al., 1999b; Richmond et al., 1991.
3	There is no one typical profile of patients who abscond, they may be relatively fit or on the other hand in a state of psychosis.	Ogulensi & Adamson, 1992; Richmond et al., 1991.
4	Schizophrenia is the most frequent diagnosis found amongst patients who abscond.	Falkowski et al., 1990; Richmond et al., 1991; Meehan et al., 1999; Ogulensi & Adamson, 1992.
5	23 hours to 5 days is the typical range of time that patients who abscond are away from the hospital before returning.	Falkowski et al., 1990; Bowers et al., 1999a; Walsh et al., 1998.
6	Absconding is not a behavior likely to be repeated.	Dickens & Campbell, 2001; Falkowksi et al., 1990; Meehan et al., 1999; Ogulensi & Adamson, 1992; Walsh et al., 1998.
7	Patients who abscond are more likely to display high risk behaviors than patients who do not abscond.	Bowers et al., 1999a; Bowers et al., 2000.

8	Nurses are most directly responsible for identifying patients likely to abscond and for implementing preventative strategies.	Richmond et al., 1991; Conroy & Jorgensen, 1995; Bowers et al., 2003.
9	That more observation of people who are identified as 'high risk' of absconding can reduce absconding.	Richmond et al., 1991; Clark et al., 1999; Conroy & Jorgensen, 1995; Bowers et al., 2003.
10	The majority of patients who abscond return to hospital.	Falkowski et al., 1990; Bowers et al., 1999a; Meehan et al., 1999; Ogulensi & Adamson, 1992; Molnar & Pinchoff, 1993.
11	Nurses report that they feel worried and concerned when patients abscond, and they feel relief when people who have absconded return safely to the ward.	Clark et al., 1999.
12	People who absconded return to the ward for a variety of reasons: • feeling cold • hungry • unwell • in need of medication and treatment for medication side effects.	Bowers et al, 1999a.
13	The majority of patients leave the institution on the evening shift from 13.00 to 21.00 (Western literature). The most common months were: May, June and August. Weekend is the lowest rate. The majority of patients who abscond do so in the first two weeks.	Richmond et al., 1991. Bowers et al., 1999b; Walsh et al., 1998; Bowers et al., 1999b.
14	The majority of patients who abscond go home after absconding.	Falkowski et al., 1990; Bowers et al., 1999a; Walsh et al., 1998; Ogulensi & Adamson, 1992.
15	Patients who abscond are at risk of being hurt or of hurting others.	Bowers et al., 1999a; Molnar & Pinchoff, 1993.
16	The absconding mostly causes no harm to self or others.	Bowers et al., 1999a; Dickens & Campbell, 2001; Falkowski et al., 1990; Meehan et al., 1999.

17	The distribution of patients who abscond between wards varied significantly.	Bowers et al., 2000; Dickens & Campbell, 2001.
18	The majority of patients who abscond had previous admission in psychiatric hospital.	Falkowski et al., 1990; Meehan et al., 1999.
19	Patients who abscond return to the ward mostly on their own or with police or hospital staff.	Bowers et al., 1999a; Dickens & Campbell, 2001; Falkowski et al., 1990; Meehan et al., 1999; Walsh et al., 1998.
20	The most common situation for the patient to abscond is when the ward is open.	Bowers et al., 1999b.
21	The most common patient reaction to being back to the ward is anger or unhappiness.	Falkowski et al., 1990.
22	The majority of patients return to hospital in 24 hours.	Bowers et al., 1999a; Walsh et al., 1998.
23	There is no single reason for absconding; however, the reasons can be divided into: • 'Unpleasant hospital life': anger with staff, food, ward, being disturbed by other patients, feeling trapped, stigma, reason to be hospitalized, delay to discharge. • Concern for home: feeling cut off from relatives and friends, home, household responsibility. • Abnormal belief or experience. • Due to others: the desire to carry out some activity outside the hospital, reward for absconding.	Falkowski et al., 1990; Bowers et al., 1999c; Meehan et al., 1999.
24	Nurses believe that staffing levels should be increased to reduce absconding events.	Clark et al., 1999.

In effect, the propositions provide a useful summary of the findings from the literature review. Clearly these propositions need further refinement before

they can be promoted as theory with predictive qualities, but they do however, represent current best available evidence.

In this case study the propositions will be used to guide the development of data collection protocols, and will be used to analyze the data collected in the study. This study will improve knowledge about the complex nature of absconding from a range of vantage points.

CHAPTER THREE: STUDY DESIGN

3.1 Design

The design of the study is the overall plan and includes: the methodology; methods of data collection for chart audit, interview and observation including validity of the study, ethical comportment; confidentiality, handling and storage of data, means of analysis and theorizing. The design of the study is informed by an exploratory study of absconding in one mental health institution in Queensland, conducted by Meehan et al. (1999).

3.2 Methodology

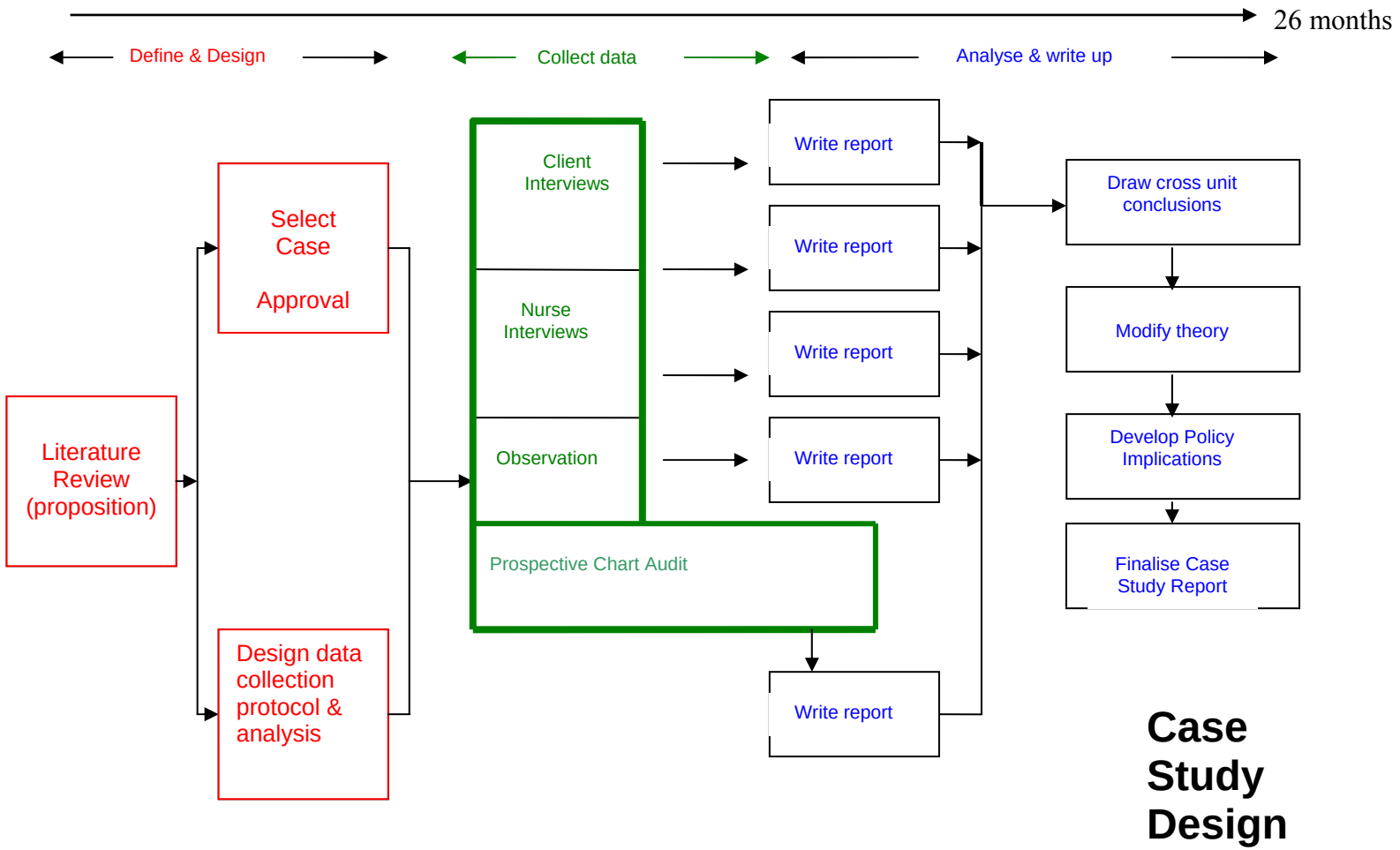
A case study approach as described by Yin (2003) has been chosen. Hoskins and Mariano (2003, p. 31) define a case study as "A holistic, detailed, and in-depth exploration of an individual, group as entity, an organization, or an event in context, conducted in natural, real-life situation". In this study, 'the case' is one psychiatric institution from which patients absconded. Yin (2003, p.13) proposes that case study methodology is particularly suited to the investigation of a "… contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". The literature shows that absconding involves many variables, and researchers consistently comment on the complexity of the issues surrounding absconding. Furthermore, case studies are conducive to the collection of a range of data that can be used to build a multi-perspective picture of the circumstances surrounding absconding events in one institution. The theoretical framework for this study has been developed in the form of propositions arising from the findings of research into absconding from mental health institutions.

The goal of a case study according to Yin (2003) is to expand and generalize theories. Importantly, he refers to an analytic generalization rather than a statistical generalization. This analytic generalization is achieved through a

process of ‘pattern matching logic’ or comparisons between the ideas emerging from the case study and findings from previous studies or theories in the form of propositions. By comparing data with the propositions it is possible to test the propositions. More importantly, in this study is also possible to use a case study to explore issues in their natural setting and develop theory inductively, albeit to a primary level. In this study the researcher intends to test the propositions while at the same time being open to the development of new understandings of the factors that relate to absconding events in an institution in Indonesia. This means that while the propositions will help guide data collection, the researcher will also be searching for phenomena as yet unidentified, but embedded in the case study context and revealed by study participants.

This study has been conducted over a 26 month period. Figure 3.1 shows a diagram of the phases of preparation, data collection, analysis and interpretation.

Figure 3.1 Design of Study



3.3 Methods of Data Collection

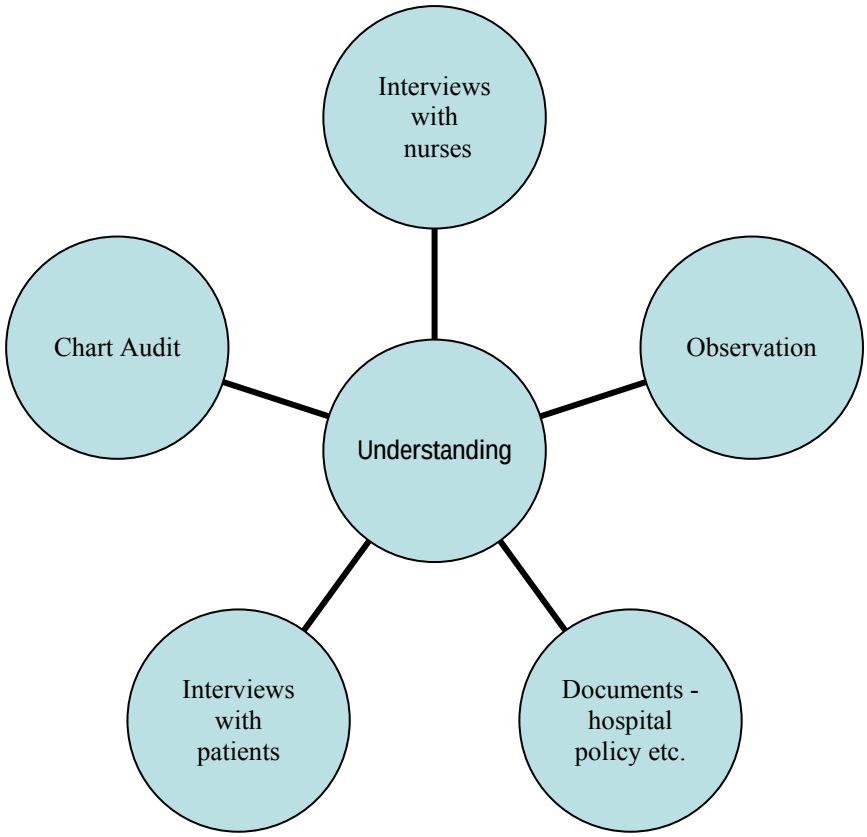
Data were collected from a number of sources or 'sub-units'. These sub-units were: hospital documents; patient records; interviews with patients and nurses; and observations. These discrete sub-units are the hallmarks of what Yin terms "an embedded case study" (Yin, 2003).

Creswell (2003) describes the use of mixed methods within a case study. This case study will involve the collection of quantitative data from a chart audit to demonstrate the pattern of absconding over a one year period, and qualitative data from hospital policy documents, interviews with patients and nurses, and observations in the care context, to explore the circumstances of absconding events in the study institution[1]. It is usual in a mixed methods study for either the quantitative or the qualitative data to dominate and this is shown by writing the dominant data in capital letters (quantitative/QUALITATIVE). As this is an exploratory descriptive study of one psychiatric hospital in Indonesia where no research has been conducted before this study is predominantly inductive and therefore the qualitative side of the study is dominant.

Yin (2003) proposes that it is possible with the case study approach to compile a broader scope of historical, attitudinal, and behavioral concerns by using multiple sources of evidence. Data triangulation from multiple sources of evidence will assist the researcher to provide more convincing findings. Fig 3.2 demonstrates the convergence of data to build information in what Creswell, Plano, Gutmann and Hanson (2006) term concurrent triangulation. This diagram is adapted from a similar one by Yin (2003, p. 100), however, he places 'facts' at the central point. Given the lack of preliminary evidence and the relatively modest aim of this study the centre has been re-named 'understanding'.

[1] The third person is used throughout this chapter however as this is a quantitative/QUALITATIVE study the first person is used in following chapters.

Figure 3.2 Convergence of data in a single case study (adapted from Yin, 2003, p 100).



3.3.1 Chart audit data collection

Data collection from patient records was guided by a protocol (see Appendix 2) compiled in light of the extant evidence from the West. All absconding events in the hospital were reported to the Deputy Executive Medical Officer from 0800hrs to 1400hrs each day. The researcher was notified daily of any absconding events. However, to avoid data loss, the researcher also checked by visiting or contacting the Head Nurse on each ward in the hospital at least once a week. Once notified, the researcher then visited the ward and collected the data from the notes of the identified patient/s. The principal researcher collected the quantitative data for seven months. During this time she trained

an assistant to collect the data for a further six months. Data collection started on 15th of April 2006 and finished on 15th April 2007

After 27th May 2007, the researcher could not collect any data directly from the hospital because of disruption caused by an earthquake and volcanic eruptions during this period. The case study hospital is right in the middle of the disrupted region so the researcher, hospital staff, patients and their relatives had a difficult period. Processes of data collection were back to normal by the middle of July 2007. When the researcher returned to the hospital the names of patients who had absconded had been recorded in the report book and the data was collected. At the end of the data collection period, 106 patients in 133 events of absconding from the hospital were reported and entered into the audit.

3.3.2 Interviews

3.3.2.1 Sample

The sample selected for interviews of nurses and patients was purposeful (Polit & Beck, 2006) in as much as the participants in the study were the people most readily available with the required experience. Nurses were eligible for interview if they were on duty when a patient absconded during the data collection period. Any employee who worked with the title nurse was eligible to be included[2]. Patients were eligible for inclusion if they absconded and returned to the hospital during the data collection period.

There was no intention to generalize from the data collected and therefore the sample size was not a major concern. During the seven months of data collection all the patients and all the nurses who volunteered were interviewed. The texts of the transcribed interviews provided enough material to extract a rich description of the experiences of both parties. Twenty three interviews with nurses and sixteen interviews with patients provided enough data to reveal

[2] Educational preparation of nurses identified in Chapter Five

examples of commonality and uniqueness experienced by participants (Denzin & Lincoln 2000, p. 370).

3.3.2.2 Recruitment

Initially, eligible participants were provided with information about the study (see Appendix 3). When they indicated to a third party that they were willing to talk to the researcher then the researcher approached them, answered questions and asked them to sign a consent form (see Appendix 4).

Although there was a plan to conduct all the interviews within two months, this was not practically possible. A number of things happened to disrupt the recruitment of participants: the first and most obvious was the earthquake. This prevented the researcher from visiting the hospital for a number of weeks, and then the month of fasting leading up to Ramadan occurred. However, participants did volunteer, and over the seven months 16 patients who had absconded and 18 nurses who had been on duty when the event took place volunteered to take part in the study.

3.3.2.3 Form of Interviews

The interviews were largely unstructured, but there was a set of prompting questions written around the propositions which were developed from a review of the literature and discussion and thinking surrounding the topic. The questions were used only as an *aide memoir* for the researcher regarding the kinds of issues that might be covered (see Appendix 2). On the whole, participants were invited to tell the researcher what they believed to be relevant about a particular absconding incident. This semi-structured approach suits interviews and ensures that the cultural and contextual aspects of absconding that are particular to an Indonesian mental health institution were canvassed (Schneider et al, 2007).

As anticipated, it was not possible to access relatives able and willing to participate in interviews. The perspective of the relatives is still considered to

be an important component of this issue and there are plans to extend the study to research with relatives, and indeed the broader community.

3.3.2.4 Data collection and storage

After each interview the researcher engaged in a process of critical reflection in order to refine her interview skills (Taylor, 2000). The interviews were all tape-recorded and transcribed *verbatim* in the native language of the participants (Indonesian and Javanese). As is common in everyday speech in Indonesia most of the interviews contain a mixture of the two languages. All identifying markers were removed from the transcripts. Two interviews were translated into English, so that the initial coding of the interviews could be done with the supervisor on return to Australia from Indonesia. All the other interviews were analyzed in the original language in Australia. Details of the validity and reliability of translation, analysis and interpretation of the data will be explained later in this chapter.

During the fieldwork the researcher made field notes and reflective notes, and these were kept in chronological order in notebooks. These notes included ideas regarding interview technique, methodology and any contextual observations that related to absconding. The researcher recorded the data in the notebooks and kept them at home in a locked place.

3.3.2.5 Interviews with patients

Sixteen patients were interviewed during seven months of data collection. There were fifteen male and one female patient who volunteered and consented to take part in the study. During the period of data collection, one patient was interviewed twice because he absconded twice, and one patient interview was unusable because he was difficult to understand. Altogether there were 17 transcripts from interviews with patients.

The researcher asked an independent person to give an information sheet to patients returning after an absconding event (Appendix 3). The researcher approached only the patients who indicated that they were prepared to talk to

the researcher. On a first meeting they were given the consent form and asked to sign. The researcher made sure that the person understood the consent form and gave him or her an opportunity to ask questions.

It was not always easy to find a private place for the interview. In some cases patients asked to be interviewed outside the ward as they felt more comfortable there. The range of time taken for interviews with patients was from 6.58 minutes to 41.32 minutes.

Some participants were not well enough to be interviewed immediately after their return to the hospital, and those interviews were postponed until they were ready and able to speak with the researcher. Nursing staff were asked to give an expert opinion when they thought the patients were well enough to participate in and consent to be interviewed. Although one participant cried when he talked about his life it was not necessary to discontinue the interview. The researcher spent time with this participant after the interview to ensure that he was recovered. Some of the participants appeared eager to express their feelings and talk at interview.

The interviews were open-ended with some questions held in reserve for prompting if required. Generally the participants were asked to tell the researcher what they remembered about the time leading up to, during, and after the absconding event.

3.3.2.6 Interviews with nurses

Interviews with 18 nurses were recorded. They were scheduled to be undertaken within seventy two hours from the time of each absconding event. However, out of 24 interviews, six were conducted more than one week after the event, for a number of reasons. These reasons all related to the availability of the researcher and the nurses. The natural disasters disrupted working routines of both the researcher and the nurses for a period of time. After that nurses arranged to talk to the researcher at a time that complemented their shift duties, social life and studies.

All interviews were conducted in the hospital in a place where the nurses felt comfortable. The range of time taken in interviews was between 5 minutes and 43 minutes. The average time of interview was 36 minutes and 8 seconds.

The propositions developed from the findings in research studies reviewed in Chapter Two form the basis for a pattern matching exercise (Yin, 2003). At the end of Chapters 4, 5, and 6 the propositions will be revisited and the findings from this study will be compared with the propositions. The propositions are presented in table form and evidence from this study summarised by each propositon. This analysis will help to ascertain the degree to which findings from the West resonate with Indonesia and whether or not interventions to prevent absconding used there may be adapted and adopted for use in Indonesia.

A process of pattern matching with the extant literature as described by Yin (2003) has also been undertaken. These two types of analysis will enable the researcher to test the findings in Western literature, and to look for and find a specifically Indonesian phenomenon.

3.3.3 Observation

The purpose of the observation phase of the study was to undertake what is called a *grand tour* or a general description of the place (Streubert & Carpenter, 1999). The researcher wanted to be able to build an image of the atmosphere in the hospital, the layout of the accommodation and the types of things that both staff and patients do during the day and night. These observations were made bearing in mind the relationship between what was seen and heard and absconding. The researcher looked for clues to how absconding was possible and why patients might choose to abscond.

In the preparation of observation data collection, the researcher met with each Head Nurse (six head nurses) to ask about the routines in each ward. These meetings helped the researcher to orientate herself before the observation

began. Typically there are four types of observation technique; complete observer, observer as participant, participant as observer, and complete participant (Bull, 2002). These classifications refer to the degree to which the researcher is involved in the context, either by intervening or responding to people observed. During the observation the researcher tried to take the position of a 'fly on the wall'. However, when approached by anyone during the fieldwork the researcher did respond to them. Burgess (1982) and Whyte (1984) make the point that observers may move between types of observation. In the case of this study the researcher was usually a 'complete observer' but when necessary was an 'observer as participant'. As with the interviews the researcher engaged in a process of critical reflection following each observation (Taylor, 2000).

3.3.3.1 Sample

The type of sample in this phase of the study is called *event sampling*, which in this case is divided into morning, evening and night shifts. Event sampling is defined as ' … a sampling plan that involves the selection of integral behavior or events' (Polit & Beck, 2006, p. 499). Observations were guided by a protocol for observation data collection (see Appendix 2, C). In this study, the researcher observed six wards for a total of 16 hours, and also conducted 1.5 hours observation in each rehabilitation unit (Female and Male Rehabilitation Units), 40 minutes observation for the early, middle and late night periods. The final observation was conducted to check the effect of medicines that were given at different times on each ward. It was made very clear that the observer was observing nursing practice and seeking information about everyday occurrences rather than observing the patients; for this reason the patients were not required to consent to be part of the observation. The researcher recorded short field notes during the observation period, and these were typed in full onto a laptop computer immediately following the observation period.

Table 3.1 Observation schedule

No	Date	Time	Ward	Hour/minute
1	22nd August 2006	7.30-8.30 am	MMW2	1 hour
2	22nd August 2006	13.30–14.30 pm	MMW3	1 hour
3	2nd September 2006	9.30-10.30 am	FMW3	1 hour
4	2nd September 2006	11.30-12.30 am	MIW	1 hour
5	9th September 2006	15.30–16.30 pm	FMW2	1 hour
6	9th September 2006	17.30–18.30 pm	FIW	1 hour
7	10th September 2006	10.30-11.30 am	FMW2	1 hour
8	10th September 2006	12.30–13.30 pm	FIW	1 hour
9	17th September 2006	14.30–15. 30 pm	MMW2	1 hour
10	8th October 2006	16.30–17.30 pm	FMW3	1 hour
11	10th October 2006	5.25–6.25 am	FIW	1 hour
12	10th October 2006	6.30–7.30 am	FMW2	1 hour
13	12th October 2006	6.30–7.30 am	FMW3	1 hour
14	12th October 2006	5.15–6.15 am	MMW2	1 hour
15	14th October 2006	18.30–19.30 pm	MIW	1 hour
16	14th October 2006	19.30–20.30 pm	MIW	1 hour
17	14th October 2006	21.15–21.20 pm	MMW2	5 minutes
18	14th October 2006	23.15-23.30 am	MMW2, MMW3, FMW2, FMW3.	15 minutes
19	15th October 2006	2.30–2.40 am	MMW2, MMW3	10 minutes
	15th October 2006	4.00– 4.10 am	FMW2, FMW3.	10 minutes
20	17th October 2006	8.30-9.30 11.00-11.30	Male Rehabilitation	1.5 hours
21	11th October 2006	8.30-9.30 11.00-11.30	Female Rehabilitation	1.5 hours
Total hours observation				19hrs 40 mins

3.3.3.2 Recruitment

Information about the observation was distributed to 91 nurses working in the wards. As many as 89 respondents were willing to participate. Two nurses did not want to be participants and therefore the shifts that they were working were not included in the observation.

Observation on the wards was conducted over sixteen hours. In the early part of the night shift most of the patients were sleeping, so the researcher decided to conduct the observation in the middle and late parts of the night shift.

Although neither the nightshift nor the Rehabilitation Unit were originally included on the observation schedule, it became clear many patients abscond during the night shift, and as many patients abscond from Rehabilitation Unit. The following periods of observation were undertaken during the night shift (21.15–21.20 hrs 23.15-23.30hrs, 02.30–02.40hrs, 04.00–04.10hrs). These observations were also based on the information that there were differences between wards regarding the time of the last medicine round and therefore the effects of sedating drugs on sleeping patterns might be of use. The Male and Female Rehabilitation Units were each observed for 1.5 hours. As a consequence, 13 more informed consents were offered to officers in the Rehabilitation Units. All officers agreed to participate in the observation study, and as a result, the total observation period was 19 hours, 40 minutes.

3.4 Quality of Findings

Polit and Beck refer to the credibility of qualitative data and explain that by credibility they mean " … confidence in the truth". This roughly relates to validity and reliability in quantitative studies (Polit & Beck, 2006, p. 332). In this study various techniques were employed to improve the credibility of the description of circumstances relating to absconding in one institution. These are:

1. Prolonged engagement (seven-month period of data collection) (Lincoln & Guba, 1985);
2. Triangulation of data, which refers to multiple sources of data (nurses, patients, researcher and administrators) which provides a variety of perspectives (Polit & Beck, 2006);
3. Triangulation of method which promotes the collection of subjective and objective data (audits, interviews and observation);
4. Dual analysis of the data;

5. Methodological and transparent translation techniques and retention of original language in the quotations (Hsieh, Cholowski & FitzGerald, 2005; Vijver, 1997);
6. Critical reflection was employed to review the researchers' credibility (Polit & Beck, 2006).

3.5 Ethics Approval

An application for ethical approval from JCU Human Ethics Review Committee was processed in February 2006 and approved (H2269). Ethics approval was also obtained from the Medical Faculty, Gadjah Mada University (KE/FK/08/EC Jan 2006). Written permission to conduct the study was obtained in February 2006 (070/0105/11/06) from the Director of the psychiatric hospital, Yogyakarta, Indonesia,

3.5.1 Possible harm

There were no physically invasive or painful procedures related to this research. The process of interview and observation was not anticipated to cause any physical discomfort or emotional distress to the participants. The researcher always asked respondents how they were feeling before finishing the interview.

The researcher has sound experience in communicating with people with mental health problems, and has been trained in therapeutic communication in 1998. The researcher has also taught therapeutic communication to undergraduate nurses from 1999 to 2004 in the School of Nursing, Faculty of Medicine, Gadjah Mada University, Indonesia (see Appendix 5). It was therefore deemed reasonable that she be allowed to talk with this group of people and enable them to voice their opinions.

3.5.2 Withdrawal of participants

All interviewees were assured they had right to withdrawal at any time, and that withdrawal would not affect either their treatment or care in the case of

patients, or their work in the case of nurses. However, it should be noted that the research involved vulnerable people who were used to obeying rules. Both the nurses and the patients were unused to research and the techniques used to recruit participants in research. It was imperative that nurses and patients understood that there was no need for them to participate, and that there would be no penalty if they refused or chose to withdraw at any stage. The researcher did not wear a uniform and made it clear that she was independent of the hospital administration. The fact that the recruitment of participants took so long to complete shows that participation in the study was not forced.

3.6 Confidentiality

For the duration of the study, and in subsequent publication in a refereed journal, the confidentiality of all participants is maintained by the use of pseudonyms in all written and transcribed data. Indonesian names are used when referring to patients, and Western names are used for the nurses' names. Where necessary descriptions of nurses have been deliberately modified to avoid identification.

3.6.1 Anonymity

All data extracted from medical records was assigned a code number, which has been used as the only identifier in the data. There was one list with participant medical record numbers (no names) recorded next to the assigned codes. This list was accessible only to the researcher.

3.7 Handling and Storage of Data

Interview transcripts were kept in a locked office in School of Nursing, Faculty of Medicine, Gadjah Mada University during the fieldwork. On return to Cairns the materials have been stored in a locked cupboard in the postgraduate students' office. Password protected electronic copies of the transcripts have been kept on the researcher's laptop and backed up on a hard drive.

Field notes from the observation have been recorded in books, and stored as above. During the observation period the researcher kept them on her person at all times. No names have been recorded in the notes.

All data will be retained for at least 5 years after publication and stored in the School of Nursing Sciences, James Cook University.

3.8 Analysis and Theorizing

3.8.1 Process of analysis

Each set of data has been analyzed separately and a report written as follows:

Policy documents were read and summarized to reveal how the rules and regulations regarding absconding govern behavior in the organization.

Chart Audit Patient Notes: The researcher manually entered the patient records data into a database that matches the protocol. Measures of central tendency have been determined and used in a pattern matching analysis described by Yin (2003). It has been possible to demonstrate patterns in terms of demographics; the length of time people who return after absconding are away, the most usual time for absconding to occur, [3]the signals typical of patients who abscond, the diagnosis, typical range time of absence from the hospital, frequency of absconding, intervention related to absconding, the reasons for returning to the hospital, the places where patients go after absconding, and the consequences of absconding.

Yin (2003, p. 116) claims that " … pattern matching is still relevant, as long as the predicted pattern of specific variables is defined prior to data collection" (see Appendix 5). The pattern matching results are featured in tables at the end of each of the data chapters.

[3] were investigated through observations and interviews

Interview data from nurses have been transcribed verbatim in the original language, the text has been coded to label concepts, then the concepts have been examined and relationships explored. When relationships or links are found, the concepts have been clustered in sub themes and themes. The themes have been reported using direct quotations. When reporting the themes, the theory of Stuart (2005) has been used to give the interpretation a contemporary holistic and humanistic frame. Secondly, the qualitative data has been analyzed by using *pattern-matching techniques* described by Yin (2003) where possible and appropriate, to test the study propositions developed from previous literature (including data from observation). The development of themes from the text is an example of inductive theory building, and the pattern matching is deductive because the starting point was from a position of knowledge (Polit & Beck, 2006). The interview data from the patient interviews followed a similar process except that each patient's story was written in English as an adjunct to the preliminary coding.

3.8.2 Translation

The majority of the theory of translation of research data from one language to another involves translation of data collection instruments (Hsieh, Cholowski & FitzGerald, 2005; Vijver, 1997) and a technique of 'back translation', where the English in translated to another language and then back again to English to highlight differences. This level of accuracy was not required or indeed needed, in a qualitative study where understanding could be masked by literal translation. Instead, the following process was undertaken to ensure integrity of meaning. There were two issues that needed to be addressed: One was the issue of supervision and working with texts that were not in English; the other issue was the accuracy of the translation.

In terms of supervision, the first interview of the nurses and the first interview of patients were translated from Indonesian/Javanese into English by the researcher. The researcher and the supervisor coded the document independently. Subsequent transcripts were read and re-read by the researcher in the original language and coded in English. The supervisor and researcher

worked together with the codes, when identified these were all written in English. The researcher wrote summaries of each patient's story in English, and four of those stories are presented in Chapter Six.

In order to calculate the standard of English translation, an accredited translator has checked the translations into English. Any quotations from the original text that were chosen as examples in the write-up of the themes were translated to English and the original language written alongside.

3.9 Conclusion

Methodology is an important part of the study as it provides guidance for undertaking the research. Careful design of the study with transparent processes will help to confirm the validity and reliability or trustworthiness of the findings reported in Chapter Seven. When unforeseen circumstances affected the data collection process it was possible to identify how this would affect the study and to discuss minor alterations with the principal supervisor. The next three chapters report the findings in the study.

CHAPTER FOUR: CONTEXTUAL FACTORS AND PATTERNS OF ABSCONDING

4.1 Introduction

This chapter will describe the contextual factors and the patterns of absconding. The contextual factors are derived from the observation data and also data from the hospital policy documents. The next part of the chapter will be the results of quantitative data collected over a period of one year that will describe the occurrences of absconding.

4.2 Contextual Factors

Contextual factors are the things which were bound to the absconding phenomena. While the data collected during the observation phase of the study dominates this description of the hospital, some other information from documents and policies will also be put in this chapter if they relate to aspects of everyday occurrences as they are described. In order to give a description of the place where the research was undertaken, a short history of the mental health institution will be given, followed by descriptions of things and events related to the absconding events including the physical environment, staffing patterns, nursing routine activity, patient routine activity and rehabilitation activity.

4.2.1 The history of the psychiatric institution

This research was conducted in a psychiatric hospital[4] in Indonesia which was established in 1938. The owner is the King of Yogyakarta Palace. The psychiatric hospital is on about 104.250 m^2 of land. This hospital has a

[4] *Rumah sakit jiwa* is the phrase used in Indonesian for a psychiatric hospital. The literal translation is House (*rumah*), sick (*sakit*), mental (*jiwa*). We have used the politically correct Western use of psychiatric because there is a movement in Indonesia to reduce the stigma of mental illness and to concentrate on health. Now the name of hospital has been changed and has a meaning as 'graha tumbuh kembang laras jiwa' or house (*graha*), development (*tumbuh kembang*), harmony (*laras*), mental (*jiwa*).

Rehabilitation Unit and a declared goal to prepare patients to be socially skilled before they return to the community.

The hospital is situated in a remote area away from the centre of town. This location is typical of psychiatric hospitals in Indonesia and similar to the placement of large psychiatric institutions in Australia and Europe that are now closed. In the early days none of the health workers employed at the hospital were educationally trained as nurses. The type of service delivery was *custodial,* with therapy limited to traditional herbs which were to be found around the hospital. Patients who came to the hospital were both local Indonesian people and some Chinese. This psychiatric hospital was supervised by staff from another bigger psychiatric hospital which was located in another province.

When Japan occupied Indonesia in War World II, many patients died as food and medicine was no longer provided. After Independence Day in August 1945, the hospital started to be improved. The Government provided a budget for the operational running of the institution. Dutch people returned to occupy Indonesia and to oppose independence between 1945 and 1948, and this continuing dispute caused delays in the development of treatment for patients who had psychiatric problems.

From 1960 the hospital became independent and was no longer supervised by the hospital in another province referred to above. An association with the Medical Faculty of Gadjah Mada University began and they trained doctors to work in the hospital. The bed capacities of the hospital and the number of health professionals employed have steadily increased from this time. Since 1975 the hospital has been appointed as the leader for psychiatric service programs in this area.

Gradually this psychiatric hospital has improved. It now has the capacity to provide clinical experience for nursing students at diploma and undergraduate

level and is one of a handful of psychiatric institutions to provide rehabilitation services to patients. The service is still focused on health, and aims to increase the level of mental health of individuals. Health is considered to include the well-being of the family, the society and the environment.

In 2002 this psychiatric hospital developed a master plan which addressed problems faced by the institution. The plan identified clients as people who, for example, require care and treatment of mental disorders which include drug abuse, disorders brought on by psychosocial stress, child mental health problems such as disturbance and growth development, mental disturbance in adults and the elderly, severe mental illness (psychosis), neurosis and neuro-cerebral dysfunction.

4.2.2 Absconding and the physical environment

The Hospital is located at the foot of a mountain, about 25 km from the city. Here, the air is much colder and fresher than in the city. The hospital lies just beside the main road. There is a big name plate just before the main entrance that shows the name of hospital, making it easy to find. The hospital has many open entrances; only the main access has a gate, and usually this is only closed at night. The fence that surrounds the hospital is only about 1.7 metres high, and is not difficult to jump over. Most of the buildings are old fashioned. There are, however, some new buildings that have been built in recent years which are of a better standard.

The first time I came in I saw that this was an open hospital area. The fact that this hospital is a rehabilitation hospital is obvious at the first glance as I saw many patients, identifiable by their uniform, walking around the hospital freely. However, as I entered each ward, I felt a sense of control and custody as I saw large locked doors behind which other patients congregate in the middle of the day. Some sit alone with head bowed doing nothing, some lie on their beds and others sit together, some lean on the wall outside the ward and smoke cigarettes. I heard no laughter, no chatting from the patients, and I got the

impression that they are all waiting for something to happen. A female patient asks me when she can go home.

The hospital and the ward layout where the research was undertaken are shown below in Figure 4.1

Figure 4.1 Layout of the hospital

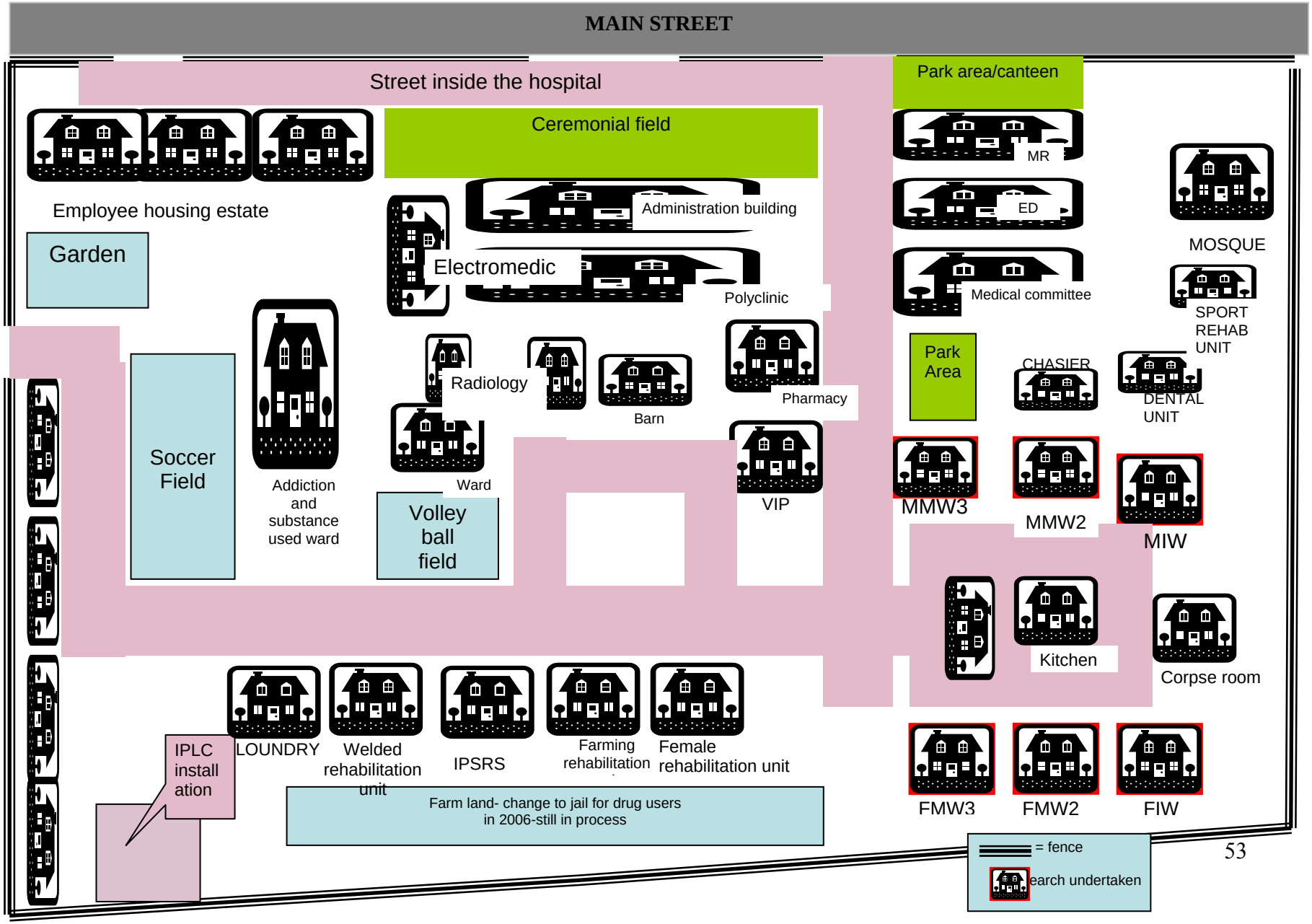
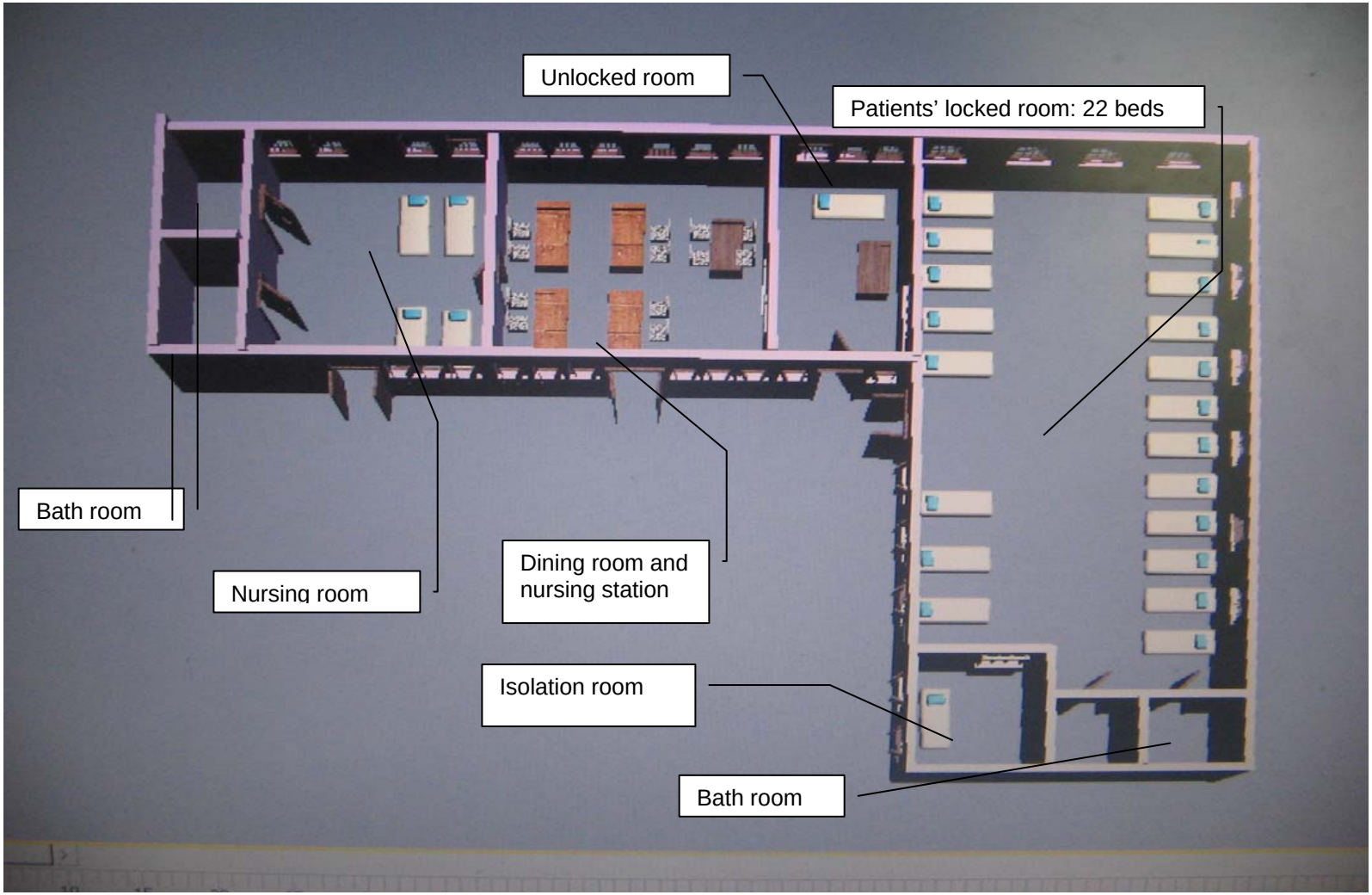
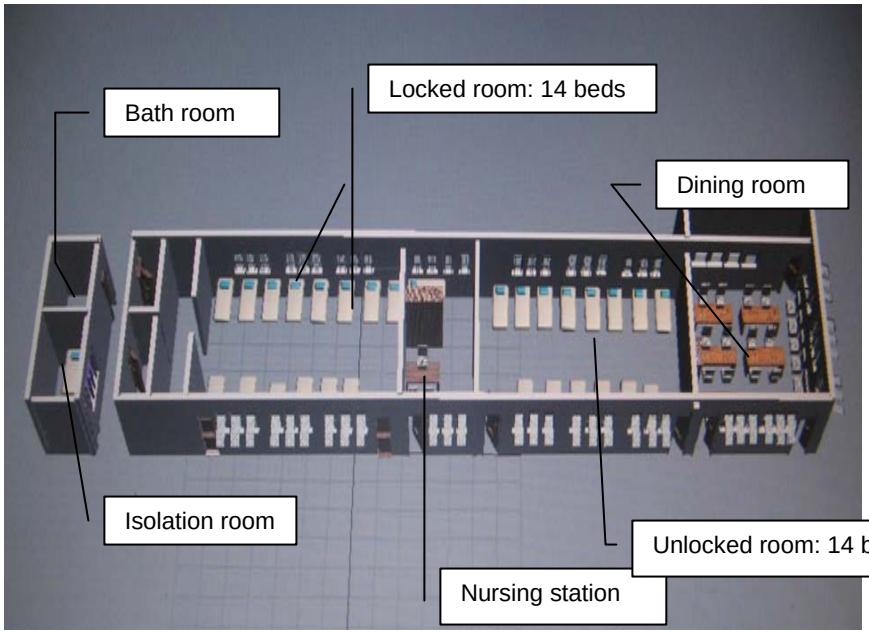


Figure 4.2 Ward layout

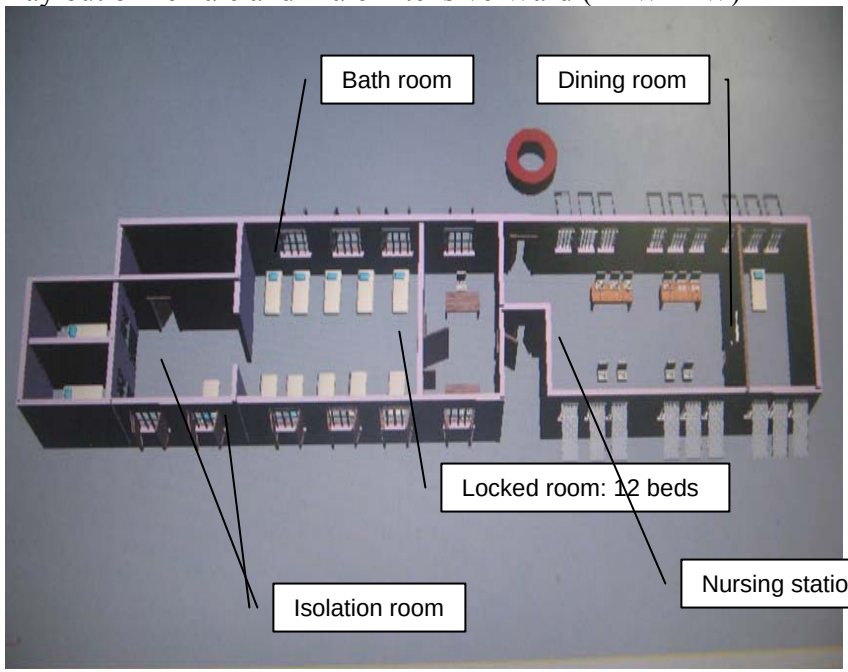
Lay out of Female Maintenance Ward 2 (FMW2)



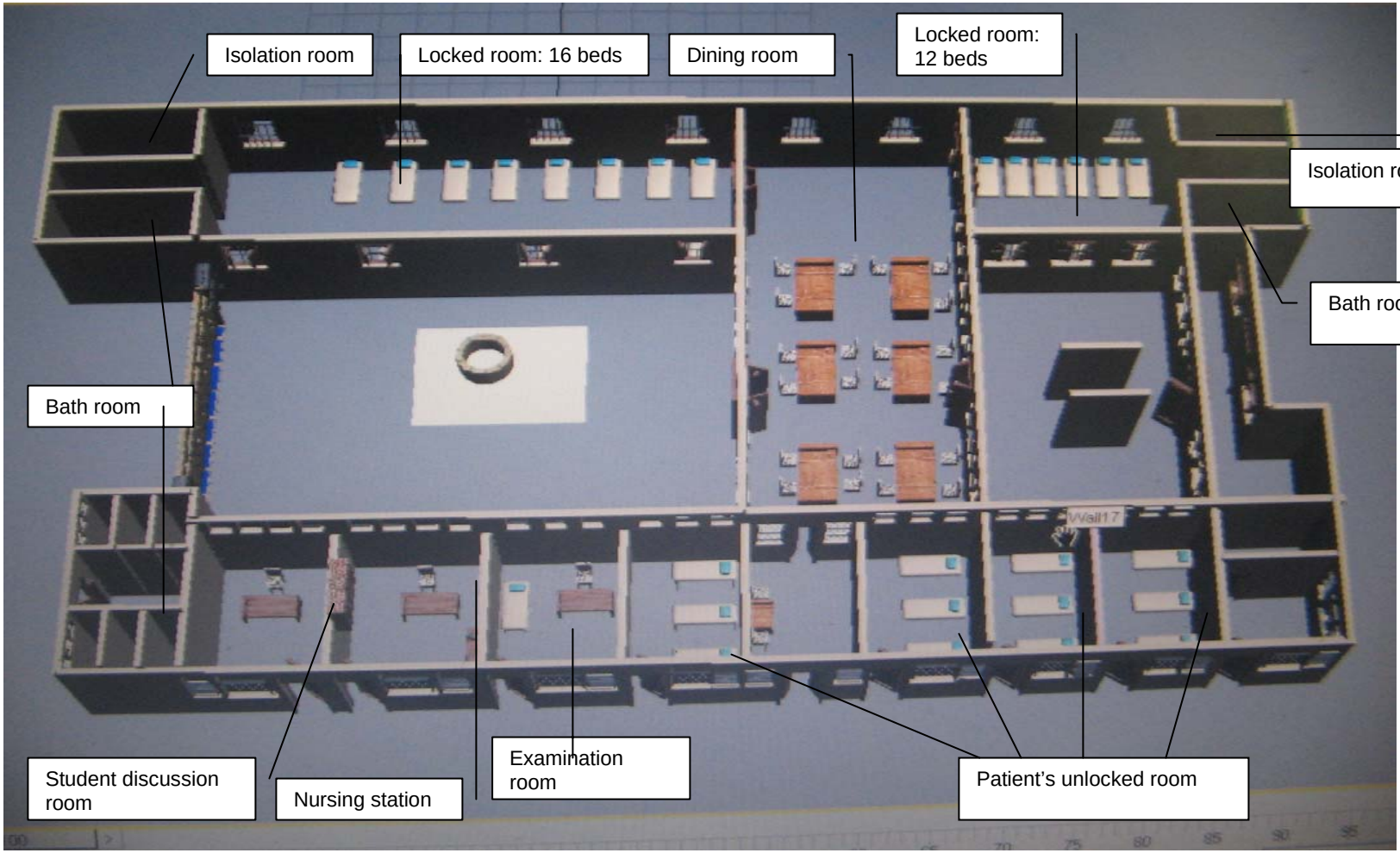
Lay out Male Maintenance Ward 2 (MMW2)



Lay out of Female and Male Intensive Ward (MIW-FIW)



Lay out Male Maintenance Ward 3 (MMW3) almost similar to Female Maintenance Ward 3 (FMW3)



Each ward except the Intensive Ward is divided, with a room that is locked and one that is unlocked. Patients who are considered to be in a better mental status reside in the unlocked room and these are the people who are allowed to walk outside the ward during the day time.

Typically windows in all wards have iron bars across them. The nursing stations in the Male and Female Intensive Wards have a window that looks into the ward so patients may be constantly observed. However, in other wards nurses need to leave their nursing station in order to directly observe all the patients.

Ward capacity

Each ward has a different bed capacity, depending on the size of the ward as shown in Table 4.1 below.

Table 4.1 Ward capacity

No	Name of Ward	Bed Capacity
1.	Male Intensive Ward 1 (MIW)	12
2.	Male Maintenance Ward 2 (MMW2)	28
3.	Male Maintenance Ward 3 (MMW3)	40
4.	Female Intensive Ward (FIM)	12
5.	Female Maintenance Ward 2 (FMW2)	22
6.	Female Maintenance Ward 3 (FMW3)	39

4.2.3 Absconding and staffing patterns

In all my observations, there were always nurses in the female ward. This was in direct contrast to the male wards, where I found the number of nurses on duty was less than there should be or even, on one occasion, no staff in the ward. For example, when I did a period of observation in the morning on one Male Maintenance Ward, there was only one nurse on duty. I also saw in this ward in a period of evening observation that there was no nurse on duty at all. On that occasion after a period of ten minutes one nurse came and told me that s/he was on duty in this ward but had to do something in another ward and left the ward unattended. S/he said that the other nurse who worked in this ward

had gone out to pick up his child from school. In the process of observation, the single nurse just walked back and forth from his ward to another ward. This did not appear to affect the patients as they did not ask for help and nothing was happening.

The Rehabilitation Unit has a different staffing pattern from the general wards. Staff in the Rehabilitation Unit consists of one nurse and the rest (12 officers) are graduates of vocational education. The officers in the rehabilitation ward are people who facilitate and guide patients to do rehabilitation activities, such as farming, gardening, welding in the Male Rehabilitation Unit, or knitting and embroidering in the Female Rehabilitation Unit. The ratio of patients to officers in rehabilitation is 1:5 in the Female Rehabilitation Unit and 1:3 in the Male Rehabilitation Unit.

4.2.4 Absconding and nursing routine activity

I saw nurses engage in a number of activities which included cleaning the ward and helping patients with personal hygiene, meal distribution and supervision, administration of medicines to patients, and handing over to nurses on the next shift.

Cleaning activity and personal hygiene activity

These activities were conducted just before breakfast (06.30hrs) and dinner time (17.30hrs). Patients take a bath and the nurses are there to help them. I noticed that nurses who worked in the male ward only observed patients who were in the locked room, as they supervised patients to undertake cleaning and personal washing in the morning. But these nurses did not observe patient activity in unlocked rooms. These patients could not be seen by nurses because of the layout of the ward. The patients could walk outside their rooms or even from the hospital very easily without being noticed by nurses in the ward.

Mealtime

In all wards, mealtimes are a busy time. Patients who have a better mental status will walk across the hospital to the kitchen to collect their meal. I saw

the nurses from female wards accompanying these patients to the kitchen, but from other wards I saw patients going on their own or in groups without a nurse. Every mealtime is an opportunity for patients to leave the unlocked rooms and ward.

Nurses hand out the food to the other patients. Patients usually have breakfast and lunch in the dining room but on some wards they have dinner in their locked rooms. When I asked why this was they said it was because there were fewer nursing staff in the evening. During the meal I saw nurses encourage patients to eat if they were not eating, but otherwise conversation was limited to questions about the portions they were serving or instructions for patients who were expected to help clear up. There is a stark contrast between the Intensive Care ward and the Maintenance Wards. In the Intensive Care Ward there is no sound of chatter during the meal, in the Maintenance Wards some patients talked to each other. Meals appear to be very much a routine affair with little out of the ordinary happening to break the monotony of the day. After patients finish their meal they wash the dishes together, observed by nurses. Dinner, the last meal of the day, is usually begun in the early evening about 17.30hrs.

As there is no specific schedule to observe patients in the male wards, nurses check and observe patients while they have a meal. I heard nurses ask where a particular patient is at mealtime – this appears to be a time when if someone is missing it would be noticed. However, in the female wards the nurses appear to observe patients as part of the daily routine; for instance, in the Female Maintenance Ward 3 (FMW3) there are a number of routine activities to check the number of patients just before change over, and the Head Nurse counts the number of patients by going around and checking them in each room.

I noted with interest the different times that the medicines were given in each of the wards. Most patients have a prescribed regime of medications for a range of psychiatric problems. The ideal is for the medications to have a

constant effect over the 24hrs of a day so that distressing and disturbing symptoms are controlled. However, the time of the last medicine round in the Intensive Care Wards and the Male Maintenance Wards is about 17.30hrs, coinciding with the time of the last meal of the day. On the female wards the medicines are spaced out more evenly and the medicine round for the evening is at 19.00hrs and 20.00hrs respectively. I did observation at night, and it is interesting to note on one of the male wards that a couple of the patients had already woken up and were chatting in their bed, and I also heard a patient in this ward taking a bath. Although it is not possible to be certain, I considered whether the effect of their medicines had by this time worn off.

Change over

In the Male Intensive Ward I observed no change over between evening shift and night shift, even though I was there when the new staff came on duty. In other wards, nurses do hand over but it seems that change over is not conducted completely because, for example, some nurses arrive late. When they come late they miss a verbal handover and have to rely on a written report. During another observation I saw some nurses who came late just start to do routine work without discussing the condition of patients with the other nurse on duty

In contrast, I saw that in FMW3 nurses between two shifts, including a student nurse, discuss details of the patients together. The nurses who worked on the previous shift reported the general condition of all patients "slept well, is calm" and gave more detailed information about the patient who was in worse[5] mental condition, and they described what the nurses had done with each patient in the previous shift.

In their routine activity, nurses also have another role as administrator, which consists of organizing, documenting, liaising with other professionals, change

[5] 'worse' *'jelek'* and 'better' *'bagus'* are the literal translation of the words used in Indonesia for a person's mental status and therefore they are used throughout the thesis.

over and organizing learning for students. The way and by whom this work was done is different on each ward. It does not appear that administration is a huge burden for the nurses as there were times on the afternoon and evening shift when the nurses were just chatting in the nursing station.

Discussion and meetings to discuss patient care is the method used to organize the treatment of patients. I saw nurses in all females' wards discuss their patients. However, I only saw the nurses discussing patients routinely in one male ward.

The focus of observation was the nurses and therefore I kept a distance when they were with patient however I was able to make the following notes about nurse-patient interaction. Once I heard a nurse gently questioning a patient about the occurrence of any more hallucinations. I heard nurses chatting with patients on a few occasions but it did not appear that the nurses had a goal for that conversation. I also saw a nurse assessing a patient who was not willing to eat; another nurse assessed a new patient who just arrived as part of the admission procedure, and this nurse then followed written instructions from a doctor in the medical record.

I also saw nurses behaving in non-therapeutic ways. Most of non-therapeutic interventions were either a display of negative approaches to care or lack of skill. For example, one nurse told a patient who cried that he would be put in the isolation room. It suggested to me that the nurse did not feel involved with patients. One morning I saw nurses put as many as 15 patients in the Isolation Room, which is a very narrow room (2x2 meters), while the nurses cleaned these patients' rooms.

I heard one male nurse refer to a patient as "lazy" (OMM3/161). I also observed non-therapeutic communication with patients in the female ward; for example, I heard a nurse criticize a patient who did not want to eat. In another male ward, I saw a nurse who did not want to help a patient to have water for

drinking. While these are things that do not directly relate to absconding, they give an impression of the atmosphere in which the patients live and give some insight into their desire to leave.

Other nursing activities

I saw nurses settle the patients in the locked room after either lunch or dinner. I then observed that they spent time at the nursing station, browsing the internet or reading newspapers. The nurses also watched television, read the report book or the medical records of patients. I also saw some nurses having a chat in their own room with other nurses; from this room it is not possible to see or hear the patients.

4.2.5 Absconding and patients' routine activity

Routine activities

Patients in the ward simply follow a routine which involves personal hygiene and cleaning the ward in the morning, breakfast, followed by rehabilitation if they are deemed well enough. Those who are not stable enough to go to rehabilitation return to the locked room after every meal – in the locked room there is no activity. In all of my observation I saw that the only activity most patients had was just sitting down around their ward, mostly watching television or doing nothing.

Something that attracted my attention during the short periods of observation was seeing patients just walking out of the hospital without a nurse noticing. I saw one patient who just went out from the ward on the night shift (about 19.00hrs) and buy some food outside the hospital. There was no nurse in the ward at that time, so the patient returned on his own, and no comment was made.

The Female Maintenance Ward 2 (FMW2) was different from the other wards, in as much as they had activity for patients in the evening. The Head of Nurses said that some group therapy is scheduled in the evening after patients have had a rest. I did not observe these activities, but I did see signs. On a board

were written ideas that patients had developed about going home; for example, the advantages and disadvantages of going home without permission. The Head of Nurses told me that she organizes activity to minimize the time when the patients have nothing to do. She described activities such as gym, watching television, or vital sign measurement conducted in this ward.

Specific activities for patients

I was able to be in the hospital during August, which is the month where almost all patients are involved with some specific activity regarding the Independence Day Celebrations on 15th August. This was the month when fewer patients absconded (3 patients). All three patients who absconded did so the day after the day of the activity (one patient on the 16th, two patients absconded on 19th). The competition activities were 'putting nail on the bottle', a marble relay race and a message chain. These are well known and popular games in Indonesia, and they are accompanied with much laughter. I saw groups of patients and sometimes staff members compete against one another. The prizes included bathing equipment, t-shirts and sandals. The activity and motivation displayed by patients to prepare for this special day showed me what the patients were capable of when they were motivated.

4.2.6 Absconding and rehabilitation activity

Rehabilitation activities start each morning when the nurse selects which patients from the ward are able to attend. A nurse then accompanies them to the Rehabilitation Unit. The hospital policy states that only five patients from each ward may be selected to go to rehabilitation; however, it is usual for more than five patients to go.

Selection process

I saw a senior male nurse one morning select patients after he arrived late and had missed the handover. He did not even read the report book, and although I am not certain, he appeared to make a good selection as he knew the patients from the day before. He did not, however, appear to access information regarding what had happened to the patients overnight.

After some patients had been chosen to go to rehabilitation, I saw one of the junior nurses check the names of patients by calling their names. She did this three times, and then more than 10 patients were sent to the Rehabilitation Unit.

Rehabilitation activity

The Rehabilitation Unit is much bigger than the wards. There are some outside activities for the patients that make it difficult for staff to observe patients. I saw the process of checking patients in rehabilitation. This is done by calling the names of patients and then dividing them into groups for different activities. One officer takes the rehabilitation patients to a specific place for each activity. Once I saw all the officers had gone, and I noticed that there were four patients who remained there without a group. They just sat silently without talking to each other and did nothing. I waited to see what the patients would do without the officer around them. One patient invited another patient to go with him, and they just walked to the north; it was not absolutely clear whether they went back to their ward or just walked around.

The Female Rehabilitation Unit has a different layout. All patients are inside the room during rehabilitation activity, and the door is open all the time. However, the officers did not observe each patient's activity closely. They appeared to be preoccupied with their own activity such as sewing, embroidery etc. They did not check whether patients had difficulty or did not engage in the activity. On one occasion I saw a patient stop her work and ask a question of an officer; she answered her questions, but did not stop what she was doing, or even look at her.

By the end of rehabilitation time, only half of the patients remained in the Female Rehabilitation Room. An officer took the remaining patients back to their ward and handed them over to a nurse. I wondered where the missing patients were. For example, I saw a patient leave the Female Rehabilitation

Room to get a drink, and one female patient just cried and ran away from the room.

Officers who worked in Male Rehabilitation (male officers) were friendly and respectful; they called the patients by their names, and they encouraged talking about what they would like to do and when they might go home. They were very different from the female officer I observed who concentrated on her own work in the Female Rehabilitation Unit.

4.2.7 Discussion

The most important finding in the process of observation is the way in which care delivery was conducted in this hospital, as this reveals the culture of the organization as well as a picture of how patients and nurses spend their time. The hospital has a rehabilitation mission, and in some cases there is evidence of rehabilitation structures and activities, but there is still an atmosphere of control and custody, particularly in the fact that most patients spend so much time in locked rooms and do nothing in their ward. Although the hospital has an open area, the sense of 'prison' can be found in the large locked room that is the centre of each ward.

The medical model that focuses on the medical treatment is the pattern of delivery service in the psychiatric setting. In this study however, the medical model is a barrier to the patients' ability to become more responsible and self determining. The medical perspective tends to view the patient as passive recipients of their treatments rather than partners in care. This runs counter to nursing theorists who promote therapeutic partnerships and independence (Pearson et al., 2005; Stuart, 2005; McAllister & Walsh, 2003).

According to Stuart (2005) in 'The Stuart Stress Adaptation Model of Psychiatric Nursing Care' the condition of each patient should correspond to a specific goal of treatment, nursing assessment, intervention and outcome depending on which treatment stage they are assessed to be in (health promotion, maintenance, acute or crisis). Refer to Table 1.1 (Chapter One).

The patients at this hospital are classified on purely pragmatic lines. Patients who are in an unstable mental condition are admitted to the Intensive Ward; when they are in a less acute stage they are moved to one of the locked parts of the Maintenance Wards; and when they are ready for discharge/in maintenance stage they are located in the unlocked rooms in the Maintenance Wards. The complicating factor is the accommodation available. People from both the locked and unlocked rooms of the Maintenance Ward may be referred for rehabilitation during the day, but as this is a decision made on a daily basis at the discretion of the nurse on duty it is not wholly consistent, and it is quite possible for a patient to be ready for rehabilitation and spend all day in the locked room. This is contrary to the goal of treatment for patients who are in maintenance stage of treatment, as discussed by Stuart (2005). These patients are in the rehabilitation process and " … this is the process of helping the person return to the highest possible level of functioning" (Sundeen, 2005, p. 239). Locating patients in a locked room should be a nursing intervention reserved for patients who are in a crisis stage where nurses are advised to stabilize a patient's mental status by managing the environment (Stuart, 1995).

From my observations I saw that nurses predominantly have superficial interactions with patients. Interactions with patients were only observed as nurses conducted their 'routine jobs'. The magnetism of the nurses' centre or station was very strong in every ward as a place for nurses to congregate together apart from patients. This personal distance creates barriers to the espoused aim of developing therapeutic relationships as described by Stuart (2005). That this matters is seen by contrasting the engagement of staff and patients during activities around the Independence Day with their engagement at other times. The increased social interaction between staff and patients seemed to make the patients feel happier.

Cleary and Edwards (1999) in their study identified that the patient numbers and staffing levels were factors that influenced the nurse-patient relationship,

along with ward needs and nurses' administrative tasks. Despite the fact that in some cases nurses appear not to have anything to do except chat among themselves, this may be a behavior that has become accepted in a chronically understaffed situation; that is, that talking to patients gets missed on busy days, and has been regarded as a low priority for so long it eventually it drops off the list of nursing interventions altogether, so that even when there is time no one thinks to go and talk with patients. Other factors that may influence low levels of interaction between nurse and patient may relate to lack of communication skills in either old or new nurses who work in this hospital. As already mentioned in chapter one, Stuart (2005) emphasizes the need for nurses to learn to engage with clients.

I noted that these superficial communications with patients led to nurses appearing to be unaware of patients' feelings and behavior, including their personal needs. There is evidence that every time nurses finish their routine work (personal hygiene, mealtime, drug time) they just leave patients to their own devices in their room. From the layout of the ward it can be seen that there is not much provision for privacy or peace and quiet. This layout makes it difficult for a nurse to sit and talk confidentially with a patient.

I saw a nurse give no response to a patient who expressed a desire to go home, and merely said "yes if your family comes to pick you up". The nurse did not really address the patient's feeling of eagerness to go home. This attitude showed that the nurse did not have an ability to show 'immediacy'. Stuart (2005, p. 39) stated that "immediacy involves sensitivity to the patient's feelings and a willingness to deal with these feelings rather than ignoring them".

The nurses I observed seemed not to be aware that the way they responded to the patients would affect the patients' feelings; for example, the nurse who voiced her judgment that a patient was lazy, or the time when one criticized a patient who did not want to eat. How the nurses behave to the patient may be

influenced by whether or not they are open to their own feelings. The ability to " … be open to, aware of, and in control of their feelings" contribute to the nurses' ability to be therapeutic (Stuart, 2005, p. 22). Although there may be a desire on the part of the nurses to deliver a good psychiatric service, I am not convinced from my observations that the nursing staff really understand what is involved, and that the structures, routines and norms of the institution are not conducive to a therapeutic environment.

In other cases, however, nurses in a female ward were able to show their capacity for 'immediacy' to the patient at risk of absconding. I saw evidence that they worked with patients who were eager to go home. They provided them with opportunities to express their feelings and work through the consequences of possible actions. However my interpretation is that their motive is to stop the patient from absconding rather than develop independence.

For a hospital with a common aim it is apparent that there is variation in service delivery between the male and female maintenance wards. The staff on female wards pay more attention to providing patients with things to do – however this is somewhat counter-balanced with the attention female patients were seen to receive in the rehabilitation centre. It is hard to speculate what effect these variations may have on patterns of absconding beyond the obvious one that there are many patients who have little to do all day, and wards where staff try to decrease the inactivity appear to have less absconding events, even taking into account gender differences.

Rehabilitation activity in this study is another issue that needs to be discussed. It is difficult to find in the processes related to rehabilitation activities, from the way patients are selected, or their activities and subsequent return to the ward, any preparation for these people to return to living in their communities. It seems that rehabilitation activity in this hospital tends to focus on the resumption of working skills, for example use of job tools. The skills that may

need to be achieved by patients are living skills, learning skills and working skills including their physical, emotional and intellectual skills (Sundeen, 2005). Although Sundeen (2005) provides guidelines for how nurses in hospital can help patients develop skills that may be needed when they return to their community or family, these guidelines are based on Western culture and may not be appropriate to the Indonesian community.

4.3 Patterns of Absconding

As described in the Methods chapter (page 46) the quantitative data in this study were collected in a chart audit over a period of one year. The data were entered onto Excel and are reported as percentages and averages. The results from the chart audit are reported below. In a discussion that follows the results, certain questions arise that cannot be explained by the quantitative data. These questions will be addressed in Chapter Five and Six where the qualitative data is used to explain some of the complex social and cultural factors that impact on patients who abscond and their absconding behaviours. The last part of this report will be the pattern matching of audit data with similar data collected and reported in the West (Yin, 2003).

The data are organized and reported under the following headings which were derived from the list of propositions in the literature review (Chapter Two) for the specific purpose of pattern matching. The numbers below show where the data comes from the Protocol for data collection (Appendix 2, A):

- the number of patients who absconded and the number of absconding events;
- the characteristics of patients who absconded (age (4); gender (5) marital status (6); ethnicity (7); religion (8), diagnosis (9); socioeconomic class (14); history of absconding behavior (1); history of admission (3); length of stay (3);
- the circumstances surrounding each absconding event: ward (2); timing of absconding events (1); ratio of nurse to patient when absconding occurred

(11 and 12); range of time away from the hospital before return (1 and 13), time taken to return to hospital (13)

4.3.1 Results and discussion

One hundred and six patients absconded during a period of one year of data collection. There were 133 absconding events from six wards with a capacity of 153 beds. The bed capacity was increased to 161 beds after the earthquake that occurred on May 27th 2007. The actual occupancy rate can be seen in Table 4.3.

Table 4.2 The averages of bed occupancy based on the absconding events occurring in each ward during a one year period of data collection

Ward	The number of absconding events (total 133 events)	Average of occupancy	Bed capacity
MMW2	49	26	28
MMW 3	45	38	40
FMW 2	10	21	22
FMW 3	20	34	39
MIW	8	9	12
FIW	1	9	12
Total	133	137	153

The bed occupancy was recorded in order to establish if there was a relationship between high or low occupancy and absconding. The bed occupancy remained stable and therefore no relationship can be established. The relatively higher number of events in MMW2 despite lower numbers of beds maybe related to the layout of the ward which is more open than MMW3 (see Fig 4.2). The distribution between the female wards of different sizes shows no such anomaly. Tables 4.3, 4.4 and 4.5 describe the characteristics of patients who absconded:

Table 4.3 Age

Age	The number of patient (n=106)	Percentage (%)
<15	2	1.887
15-19	6	5.660
20-29	36	33.962
30-34	22	20.755
35-39	17	16.038
40-50	15	14.151
>50	8	7.547

Mean = 33, Mode = 26, SD = 10, 38.

Table 4.4 Characteristics of patients who absconded

	The number of patient (n=106)	Percentage (%)
Gender		
Male	79	74.53
Female	27	25.47
Marital Status		
Married	28	26.42
Not married	74	69.81
Separated	1	0.94
Widowed	3	2.83
Ethnicity		
Javanese	105	99.06
Other	1	0.94
Religion		
Muslim	103	97.18
Christian	2	1.88
Catholic	1	0.94
Hindu, Budhist, Other	0	
Diagnosis		
F.20.3 (Undifferentiated schizophrenia)	63	59.44
F.20.5 (Residual schizophrenia)	12	11.32
F.25.0 (Schizoaffective disorder, manic type)	5	4.72
F.25.1(Schizoaffective disorder, depressive type)	3	2.83
F.23.0 (Acute polymorphic psychotic disorder without symptoms of schizophrenia)	2	1.89
F.20.0 (Paranoid schizophrenia)	7	6.60
F.71 (Moderate Mental Retardation)	2	1.89
F.20.1 (Hebephrenic schizophrenia)	4	3.77
F.20.2 (Catatonic schizophrenia)	2	1.89
F.23.2 (Acute schizophrenia-like psychotic disorder)	1	0.94
Multiple diagnosis	4	3.77
Not yet diagnosed	1	0.94
Socioeconomic status		
Use healthy card	79	74.53
Pay hospital cost	27	25.47
History of absconding in one year period of data collection		
No History	89	83.96
Twice	10	9.43
Three times	5	4.72
More than three times	2	1.89
History of admission		
New admission	38	35.84
Once	29	27.36
Twice	14	13.21
Three times	8	7.55
More than three times	17	16.04

The majority of patients are Muslim, which is the dominant religion in Indonesia.
In Indonesia, almost every province has a psychiatric hospital which provides service for their local community. Therefore it is reasonable that most patients are Javanese because almost all patients who are hospitalized are local residents.

The majority of patients who absconded (63 patients) had a F.20.3 diagnoses which is based on the ICD-10 and classified as 'undifferentiated schizophrenia' which is described as "Psychotic conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the subtypes in F20.0-F20.2, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics" (WHO, 2006).

The over representation of this 'umbrella' diagnosis may dicate that patients are not receiving the same type of psychiatric assessment that patients in the West may have. This will render the pattern matching of diagnosis of people who abscond across the world inaccurate. This lack of differentiation probably caused by the medical resources available to establish psychiatric diagnoses which are through history taking and observation rather than laboratory testing or other diagnostic tools (Bardwell & Taylor, 2005).

However, even though this is the assigned diagnosis in the data, the majority of the patients included in the sample were not actively psychotic at the time of absconding.
The majority of patients who absconded (64.16%) are recorded as people who had a history of admission to psychiatric hospital. McGorry explains that "A typical course [of schizophrenia] is a pattern of acute exacerbation, possibly precipitated by stress, illicit drug use, non-compliance with maintenance treatment, or some combination of these, with residual impairment between episodes" (McGorry, 2004, p. 4) There is no mental health act applied in Indonesia, and the reason why patients are admitted to hospital depends

predominantly on the patient's family or community decision, rather than a professional assessment of their mental health. Therefore, multiple admissions to a psychiatric hospital in this case may not reflect the same level of mental illness as it does in the West.

Table 4.5 Length of stay of patients before absconding

Length of stay before absconding	Number of patients (n=106)	Percentage (%)
One week	25	23.58
Two weeks	11	10.38
Three weeks	11	10.38
Four weeks	14	13.21
More than four weeks	45	42.45

Most patients in this study who absconded had been in hospital more than 28 days which shows when compared to average total length of hospital stay in 2006 (26 days) that these patients were likely to be ready for discharge. Hospitals that provide rehabilitation services, such as the one in this study, will record longer length of stay because patients stay a longer time in hospital in order to engage in the process of rehabilitation. By comparison, the average length of stay of patients in the psychiatric wards in two different general hospitals (Sardjito Hospital in Yogyakarta and Banyumas Hospital, Central of Java) is 9 days (Nurjannah, 2004). The result of this study shows that the majority of patients absconded after a stay of more than one month in the hospital which may be associated with the longer length of stay compared to acute care facilities in the UK, for instance.

The chronic nature of schizophrenia is a plausible reason for patients with F.20.3 classification of 'undifferentiated schizophrenia' to have multiple admissions. When these patients are admitted to a psychiatric hospital that offers rehabilitation they will require a longer length of stay. They appear to be bored as a consequence of staying a longer time in hospital, and this is a commonly described feeling by participants in the interviews. This finding again points to patients who are feeling better and ready for discharge

becoming restless when they are not collected by their family. This frustration is described in the qualitative data (Chapters Five and Six).

The majority of patients (74.53%, n =106) used a 'healthy card' for psychiatric services in this study. This means that they are poor people who cannot afford hospital charges so the government helps them by covering all costs during admission. Poverty may influence the type of medical treatments they receive in hospital (the bare minimum) and increases the impost they are on their family and community, who are also likely to be impoverished. Both mental health status and social well-being have a relationship with absconding tendencies. In this case it appears that better mental health or readiness for discharge and poor reception from the family and community occur in the majority of absconding events. There is no data that tells us whether these characteristics are just as apparent in the rest of the hospital in-patient population and therefore they should be interpreted with caution.

The present study found as many as 133 absconding events occurred in the one-year period of data collection. The tables below describe the different number of absconding events by ward, month, day, and, shift, and based on the ratio of nurse to patient.

Tables 4.6, 4.7, 4.8 and 4.9 describe the circumstances surrounding the absconding events.

Table 4.6 The number of absconding events in each ward

Ward	The number absconding event (total 133 events)	Percentage (%)
FIW	1	0.75
FMW 2	10	7.52
FMW 3	20	15.04
MIW	8	6.02
MMW 2	49	36.84
MMW 3	45	33.83

Among the six wards in which data were collected, the Male Maintenance Wards 2 and 3 had the highest number of absconding events. The least

absconding events were from the Male and Female Intensive Wards. This may be explained by the increased security in the form of locked accommodation in these wards and by the staffing levels which have been described earlier in this chapter as being higher than the general wards. The differences between the general wards needed to be explored to understand the different characteristics of each ward that may have influenced the number of absconding events. The most obvious explanation for this is that male patients have a higher risk of absconding than female patients. However, this does not explain the difference in the number of absconding events between the two male wards, considering that one has almost half the number of beds. Factors which possibly influenced the number of patient absconding events are described in the qualitative and observational data.

Table 4.7 The number of patients absconding each month

Month	The number absconding event (total 133 events)	Percentage (%)
April	9	6.77
May	7	5.26
June	20	15.04
July	16	12.03
August	3	2.26
September	8	6.02
October	12	9.02
November	13	9.77
December	11	8.27
January	13	9.77
February	10	7.52
March	11	8.27

The average number of absconding events per month is eleven. However, some extraneous events in the geographical area of the hospital influenced the number of absconding events, such as the earthquake in Yogyakarta and the Merapi volcano eruption in May and June 2006, or specific social events such as religious occasions (Ramadan) in October or national events organized in August to celebrate Independence Day. The highest number of patients (27 patients) absconded in the two months after the earthquake and volcano

eruption. They were involved in 36 absconding events. These disasters not only affected patients but also nurses who worked in the hospital. It is not possible to determine from this data the relationship between the number of nurses affected negatively by the disasters and the increase in the number of patients who escaped.

The fasting month of Ramadan (October 2006) saw a modest rise to above average patient absconding events. As shown in Table 4.8 the number of patients who absconded in October and November is slightly higher than the average of absconding events per month. A description of the significance of Ramadan to one patient who absconded and the influence it had over his decision to abscond is included in Chapter Six. This case illustrates some possible reasons for the higher rate of absconding in this time period.

In August 2006, only three patients absconded. August is the time in which many patients participate in a whole month of competitive activities leading up to Independence Day celebrations in Indonesia. Most patients who were considered to be in a better mental health condition were involved in the competition. This series of competitions also provided prizes for the winners. Most activities involved the patients in group activities. The patients were able to interact during this time with students, and even have a competition with nurses. One other activity involving both patients and nurses was a picnic held in September just before the fasting month. One patient who was thought to be at risk of absconding chose to 'muscle in' on the picnic activity even though he was not chosen to follow this program.

Table 4.8 Timing of patient absconding events

Time of absconding	Absconding events (total 133 events)	Percentage (%)
Day of absconding		
Sunday	26	19.55
Monday	19	14.29
Tuesday	12	9.02
Wednesday	20	15.04
Thursday	21	15.79
Friday	12	9.02
Saturday	23	17.29
Shift of absconding		
Morning shift	65	48.87
Evening shift	25	18.80
Night shift	43	32.33

Most absconding events occurred in the morning and on Sundays. The contextual factors which contribute to the day-time absconding events will be explored in the qualitative data (Chapter Five).

Table 4.9 The number of patient absconding events based on the ratio of nurse to patient

The number of patient absconding events each ward							
Nurse: patient	MM W2	MM W3	FM W2	FM W3	MI W	F I W	Total
1:1	0	0	0	0	2		2
1:2	0	0	0	0	3	1	4
1:3	0	0	2	0	1		3
1:4	2	0	1	1	1		5
1:5	2	1	1	2			6
1:6	0	5	0	3	1		9
1:7	3	5	2	1			11
1:8	4	3	0	2			9
1:9	10	1	0	1			12
1:10	2	2	2	1			7
1:11	4	3	2	1			10
1:12	1	3	0	2			6
1:13	8	4	0	6			18
1:14	10	1	0	0			11
1:15	1	0	0	0			1
1:18	0	3	0	0			3
1:19	0	4	0	0			4
1:20	0	3	0	0			3
1:21	0	3	0	0			3
1:28	2	1	0	0			3
1: 38	0	2	0	0			2
1: 39	0	1	0	0			1
Total	49	45	10	20	8	1	133

Table 4.10 The standard ratio of nurse to patient for each ward based on the bed capacity

Ward	Morning shift	Evening shift	Night shift	Bed capacity
MMW2	1 : 9	1 : 14	1 : 14	28
MMW3	1 : 7	1 : 13	1 : 13	40
FMW2	1 : 6	1 : 7	1 : 11	22
FMW3	1 : 8	1 : 13	1 : 13	39
MIW	1 : 3	1 : 4	1 : 6	12
FIW	1 : 3	1 : 4	1 : 6	12

It is difficult to draw conclusions from data about the ratio of nurse to patient when patients abscond. However, Table 4.9 shows that in the two Male Maintenance Wards the observed ratio of nurse to patient was less than it should have been. This was not observed on the female wards which maintained their staffing levels throughout the data collection period.

In this study the ratio of nurse to patient in the Intensive Ward was found to range between 1:1 and 1:6. The ratio of nurse to patient in open ward/maintenance wards at the time of absconding events was in the range 1:4 to 1:39 for the Male Maintenance Ward and in range 1:4 to 1:14 in the Female Maintenance Ward. The fluctuations may indicate that workload and staffing is dependant on nursing availability, rather than patient need. The standard ratio of nurse to patient is different among the wards. It makes it difficult to compare the number of patients absconding based on the ratio of nurse to patient. It appears in this study that the female wards did not experience the extreme fluctuations of staff that was the case in the male wards. For instance, as many as 57 absconding events in two male maintenance wards happened when the ratios of nurse to patient were less than standard.

Table 4.11 Time taken to return to hospital

Patient returned to hospital	The number of patient return to hospital (80 patients returned to hospital)	Percentage (%)
The same day	56	70.0
One day	12	15.0
2-8 days	10	12.5
After 29 days	2	2.5

Twenty six of patients who abscond did not return to hospital. Once again this may be a result of the relatively better mental condition (ready for discharge) of the Indonesian patients who absconded. It may be explained by the fact that there is no mental health act in Indonesia, which means there is no clear mandate to bring patient back to the hospital. Indeed, after three days the patient is automatically discharged and no longer considered a responsibility of the hospital.

As many as 70% of patients returned to hospital on the same day. However, there is no clear pattern regarding the length of time that they are away.

4.3.2 Pattern matching

As explained in the Chapter Three, studies from the West are considered to be case studies and are used here for a comparison in what Yin (2003) calls a process of pattern matching with the extant literature. The Table of Propositions (Table 2.1) provides information to establish the main similarities and differences in the samples and contexts of the studies in Indonesia. Ogulensi & Adamson (1992) is the only study included in the literature that is undertaken in a developing country, and, where appropriate, similarities in context between Nigeria and Indonesia will be highlighted.

Pattern matching between propositions and the result below will only refer to the audit data in this chapter.

Table 4.12 Table of pattern matching

No *	Literature from the West	Finding in this study	Y/ N	Explanation
1	That the largest group of patients who abscond are young male, single persons.	Male 74,53% (n=106) 20-39 year : 70,755% Single : 69,81.	√	
4	Schizophrenia is the most frequent diagnosis found amongst patients who abscond.	83,96% Schizophrenia (ICD-10) (n=106).	√	Even though this is the assigned diagnosis in the data the majority of the samples in this study were not actively psychotic at the time of absconding. The diagnosis Undifferentiated Schizophrenia is possibly overused in this hospital.
5	23 hours to 5 days is the typical range of time that patients who abscond are away from the hospital before returning.	Patients returning the same day: 70% patients. Total patient return to hospital = 80 patients.	X	The fact that there is no Mental Health Act in Indonesia which means there is no clear mandate to bring a patient back to the hospital. Indeed, after 3 days the patient is automatically discharged and no longer considered a responsibility of the hospital.
6	Absconding is not a behavior likely to be repeated	Only 16.04% patients absconded more than once.	√	The common denominator for difference finding appears

				to be the rehabilitation factor and the readiness of the patient who absconds for discharge.
10	The majority of patients who abscond return to hospital	75.47% patients (n=106) returned to hospital.	√	
13	The majority of patients leave the institution on the evening shift from 13.00 to 21.00 (Western literature).	Total 133 absconding events After earthquake=36 events (in 2 months).	X	
	The most common months were: May, June and August.	August only 3 absconding events.	X	
	Weekend is the lowest rate.			
	The majority of patients who abscond do so in the first two weeks.	Mean = 11 absconding events/month.		No information from proposition.
		Sunday the most absconding events: 26.	X	
		Morning shift 65 absconding events.	X	However, the finding similar to Ogulensi & Adamson's (1992) study
		Length of stay before absconding Pt abscond after 1 week: 25 pt Pt abscond after 2 week 11 Pt abscond after 3 week 11 Pt abscond after 4 week 14 Pt abscond after >	X	This finding again points to patients who are feeling better and ready for discharge becoming restless when they are not collected by their family. This frustration

		4 week 45 pt.		is described in the qualitative data (Chapters Five and Six).
17	The distribution of patients who abscond between wards varied significantly.	76.69% patients (n = 106) absconded from male ward 23.31% patients (n = 106) absconded from female ward.	X	Even though one ward was identified as having therapy and activities for patients. There is no real difference between the rates of absconding events.
18	The majority of patients who abscond had previous admission in psychiatric hospital.	64.16% (n = 106) of patient who abscond had a previous history of admission to psychiatric hospital.	√	
22	The majority of patients return to hospital in 24 hours.	70% (n = 106) patient returned to the hospital on the same day.	√	
24	Nurses believe that staffing levels should be increased to reduce absconding events.	42.85% absconding events (Total 133 events) happened when the ratio of nurse to patient less than standard.	-	

4.3.3 Summary

The pattern matching achieved in this part of the study relates primarily to the quantitative data, and as required by Yin (2003), the categories were predetermined before data collection commenced. This data is only a small part of the entire study and therefore it is not surprising that this exercise has not yielded a great deal of useful information. However, in a case study it is as useful to find dissimilarities as it is to confirm patterns in the West because the purpose of the study is not to replicate services in the West, but to recommend

changes that are specific to the Indonesian context.

We can confirm from this exercise that the major characteristic of patients who abscond are that they are young, male, single and have a diagnosis of schizophrenia. In all studies a history of more than one hospital admission prevails as a common denominator. None of the studies sheds light on the significance of nurse to patient ratio in relation to numbers of absconding events. Like other researchers, in this study, we have a strong sense that nursing models of care play a part in explaining the difference in number of absconding events between seemingly similar wards. However, the statistical data does not confirm this and an exploration of this phenomenon in more detail through the use of the observation and interview data will follow in the next two chapters.

CHAPTER FIVE: NURSES' VIEWS OF ABSCONDING

5.1 Introduction

This chapter is divided into two parts: First, the thematic accounts from the data collected from nurses' interviews; and second pattern matching with research from the West, and a discussion of the themes.

5.2 Thematic Account

The views from the perspective of nurses were drawn from the data collected in 29 interviews with 18 nurses and six head nurses (Table 5.1). All 18 nurses described their experience relating to 19 patients who had recently absconded. Where appropriate, reference is made to the other data collected in the study that is from patient interviews, observation notes or chart audits.

Table 5.1 Education and experience of the 24 nurses surveyed

Name of Nurse	Level of Education	Work Experience
Robert	Diploma	1 year
Yvette	Below Diploma	9 years
Peter	Diploma	1 year
Chaty	Diploma	1 year
Rodney	Diploma	12 years
Alan	Below Diploma	7 year
Federer	Diploma	Less than one year
George	Diploma	1 year
Emeline	Diploma	Less than one year
Evan	Below Diploma	10 years
Carol	Diploma	Less than one year
Rebeca	Diploma	Less than one year
Owen	Below Diploma	14 years
Debbie	Diploma	1,5 years
Shara	Diploma	Less than one year
Angela	Diploma	Less than one year
Vicky	Diploma	Less than one year
Betty	Diploma	Less than one year
Michael	Diploma	15 years
Jackson	Diploma	9 years
Daniel	Diploma	12 years
Melia	Diploma	15 years
Ivone	Diploma	17 years
Natalie	Diploma	15 years

Eight nurses in the interview were talking about five of the patients who were interviewed in this study. It was not possible to match all interviews between nurses and absconding patients because participation was voluntary and not everyone responded to the invitations to be interviewed.

5.3 Results

The findings from this interview data are reported in the following eight themes:

- time or opportunity for absconding
- patient condition when absconding
- nurses' views on the reasons behind patients' decision to abscond
- clues before absconding events
- consequences of absconding
- prevention and intervention regarding absconding
- circumstances that create situations where patients are able to abscond
- nurses' perception of patient, family and community.

5.3.1 Time or opportunity for absconding

Information about time of absconding collected from nurses and patients was quite different for the same absconding event. The overall impression was that nurses and patients were not aware of a time-pattern of absconding. For example, nurses and patients had different opinions about exactly what time or particular occasion patients absconded, even when they talked on the subject of the same absconding event. In addition, the nurses themselves expressed a range of ideas about the time and circumstances of absconding events. Owen and Vicky said that mealtime was when most patients seemed to abscond. Others thought that most patients who absconded did so on a Sunday. This could be because Sunday is the day with less activity and staff on duty, as mentioned by Yvette.

Nurses expressed their opinion that patients were triggered to abscond in the month of Ramadan. Vicky and Betty said that they heard that a patient wanted

to celebrate the end of Ramadan at home. Vicky heard that a patient wanted to have fasting experience at home.

As Vicky said:

> *… started the fasting that actually already already patients already started to show confusion and wanted to have fasting at home …*
> *…mulai puasa itu sebenarnya sudah sudah pasiennya sudah mulai bingung pengen puasa di rumah … (Rec 71/80-81).*

That patients wanted to abscond at the end of Ramadan was supported by reports, written by a nurse on the five days leading up to the end of Ramadan. He wrote:

> Last night I [name of nurse] heard that patients who were in (an) unlocked room have planned to abscond together (they said they felt bored, no family picked them up for a long time). They have planned to abscond after Jum'ah prayer, three days before celebrating the end of fasting month/iedul fitri. Please make extra observation for risky time (especially with the coming of celebration, the end of Ramadan at 23rd-24th October 2006) (PCA/17-24).

Yvette suggested that the time a patient chose to abscond could depend on which nurses were on duty. For example, if a patient had a previous absconding experience with a certain nurse then the patient was more likely to abscond again at the same time when the same nurse is on duty.

5.3.2 Patient condition when absconding

Nurses were asked to describe the mental status of patients when they absconded. From the 19 patients that were discussed by nurses only five patients were described by nurses as being in a worse mental condition at the time they absconded. The first patient described was considered unstable with

labile emotions; he could not follow instructions, and would steal his friend's food. The second patient absconded naked through a drain in the isolation room. He was a patient who was put in isolation because he scattered sheets and splashed water, but he was not violent towards other patients. The third was considered to be mentally unstable as he absconded from an isolation room by breaking the door. The fourth was a female patient who was described as being withdrawn. The last one is described in the same way by two nurses. This male patient was crying and making many requests. For example, he wanted to go to another ward and wanted to go to emergency. This patient then was accompanied by a student nurse (as per the order of the head nurse) but the student nurse did not observe this patient closely and the patient absconded.

The nurses were clearly familiar with the patients who had absconded and knew something of their emotional and mental state and would describe their behaviours. Just one nurse was not sure about the patient's condition because he came late on duty when the patient absconded. Patients deemed to be in a good mental condition were described as 'ready for discharge', 'attending rehabilitation activities' and 'able to follow routine activities in the ward independently'. The following quotations are examples of descriptions of patients who were in a good mental condition:

> *Actually a patient already has got permission to go home but because their family did not pick them up then they felt pressure to go home.*
> *Sebenarnya pasien itu sudah boleh pulang Cuma keluarganya ndak jemput akhire di sini tertekan pengen pulang* (Rec 63/108-110).

> *Clearly, firstly those patients, both of them, [they are] patients [who stay] outside [the locked room]… so patient who in the term of good, term in here [mean they are good], their ADL good, [they] already can help [with] other patients' need*
> *Yang jelas pertama pasien, itu kan yang dua itu kan pasien di luar ya … jadi pasien yang sudah istilahnya sudah bagus, istilahnya sini kan*

sudah bagus, sudah ADL nya bagus, sudah bisa mbantu e kebutuhan teman temannya yang lain (Rec 23/3-6).

The opinions nurses had of patients' mental status at the time they absconded matched up with the patient interviews. Data from interviews with 16 patients in Chapter Six showed that only three patients described psychotic symptoms as a trigger for absconding. Two of these three patients absconded because of command hallucination and one patient felt a sense of power and then broke the door. That the patients who absconded in this study tended to be in a good mental condition is supported by the data that four patients who are described in Chapter Six (Bayo, Bakri, Noto and Riri) already had permission to be discharged before the absconding event occurred. Other patients interviewed (9 patients) did not have permission to go home, but they had already demonstrated better mental status and been granted 'off-ward' privileges. For example they participated in the rehabilitation unit, or even worked in the traditional market near the hospital.

With regard to the general mental status of patients in this hospital, I was informed of a crude measurement that nurses had undertaken to estimate the dependency of patients. In October 2006, nurses in the Male Maintenance Ward 3 measured the general dependency of patients according to their mental status over a period of two weeks. They used the categories, 'acute', 'maintenance' and 'health promotion' derived from the work of Stuart & Sundeen (1995), and a scoring system devised by Nurjannah (2004) to determine which category each patient should be placed in. The results were meant to help nurses to manage and calculate the number of nurses needed for every shift. They did an estimate of dependency randomly ten times and calculated the average of patient dependency. All measurements were conducted in the morning shift. The results were reported as follows: 5 patients in acute condition, 20 patients in maintenance and 14 patients categorized as in health promotion. This showed that most patients were in better mental status and it would be reasonable if they wanted to go home.

In their written reports of 106 patients who absconded over a one year period as mentioned in Chapter Four, nurses wrote that only nine patients absconded by what was considered to be an unusual method. Three of them absconded through the drainage system in the isolation room, one patient broke the window glass in the bathroom, one patient broke the roof, one patient broke the doors of the isolation room, one broke the ventilation to abscond and the last jumped over the fence. Otherwise, people left without incident, damage or personal injury.

5.3.3 Nurses' views on the reasons behind patients' decisions to abscond

One nurse in the interview believed that the trigger for absconding was not the negligence of nurses, but that a variety of factors contributed to absconding. The nurses reported the most common cause was concern about family, followed by long hospitalization. Other factors included family attitude and ward environment.

Nurses said the concern about family, the dominant reason for patients to abscond, was exacerbated when patients felt they did not belong in hospital, and particularly when they began to feel better. They persistently asked when they could go home or told others that they wanted to go home.

The nurses recognized a relationship between reasons for absconding and a patient's mental status. For example Melia believed that patients in a good condition absconded due to their concern for their family, whereas patients in a worse mental condition absconded because they rejected hospitalization. Melia explained:

> *Patients who are in the intensive care ward have a higher tendency to abscond because [they] feel [that they are] not sick, feel that his/her place is not in the hospital. If [a] patient [is] in another ward [maintenance ward] the cause of absconding for example is because of*

missing the family.

Pasien di intensive ward punya kecenderungan lari tinggi karena masih menolak di rawat di rs pasien yang datang pasti merasa tidak sakit, merasa tempatnya bukan di rumah sakit. Kalau pasien di ruangan lain penyebab melarikan diri antara lain adalah karena kangen keluarga (Rec 15/289,291, 296, 31, 316).

Nurses explained that many patients had been in hospital for a long time. This information corresponds with data derived from quantitative data. It was calculated that most patients who absconded had been in hospital more than 30 days (Chapter Four page 86). Some patients (Noto and Bakri) also complained, asking why they stayed in hospital for such a long time.

Nurses believes, family attitudes, in particular neglect by family, affected absconding in a variety of ways. Referring to a patient, Robert said:

Have a permission to go home, … eeeh … about one week ago the family, yes yes … the family promised to patient that they will visit on Sunday. [patient name], but after he waited until midday, maybe patient, family have not come yet then the desire to go home arose.
Ya. Sebetulnya pasien juga dengan kondisi boleh pulang, e … kurang lebih 1 minggu itu keluarganya … .menjanjikan pada pasien bahwa hari minggu itu juga ingin menjenguk itu, sodara (A) itu, tapi setelah ditunggu sampai siang, keluarga belum datang-datang terus keinginan pulang timbul (Rec 1/131-134).

It appears that a number of families were reluctant to bring patients home from hospital. As a result patients felt disappointed when they were not picked up, and were left alone. The nurses appeared to have some sympathy for the patients and demonstrated some frustration with the family members. They knew that these patients' mental status was better and they already have permission to go home, but the family still wanted the patient to stay in

hospital. Nurses sometimes believed that the reason families wanted patients to stay in hospital was not because of concern for the health of the patient, but because of the needs and desires of the family. Even when the family said that the reason was for the patient, the nurses did not believe them. For instance, Robert told me that on one occasion he found that the family had an event at home and did not want their son at home at that time. They insisted that their son should stay longer in hospital even after the nurse told them that he had permission to go home.

Another issue regarding the influence that the family has on decisions to abscond is family visits to the patient while they are in hospital. Robert said that one patient absconded because he was not visited for one month. Other nurse participants agreed with this view as mentioned by Rodney:

> *Firstly, certainly patient X that he has not been visited for a long time by his family, yes he asked when he can go home…*
> *Pertama-tama memang mas X itu e lama tidak dijenguk oleh klg ya pernah suatu ketika anaknya e kira kira bisa pulangnya kapan gitu … (Rec 13/3-5).*

Most nurses said that families almost never visited patients during their admission, and this matches what the patients said and my observations. Emeline said that one patient, who absconded on several occasions, had never been visited at all. One patient, Bayo, said that in almost six weeks no one visited him. In the process of admission, the family has to sign a form stating that the family agrees or is willing to visit the patient at least once a week and is willing to accept the person home as soon as possible if the patient has permission to be discharged (HPDAgreement/41-43). It can be concluded that many families do not obey the admission rule. Evan expressed his anger at family behavior and believes that patients who are abandoned by their family should be legitimately thrown out of the hospital:

… he (family) also have felt guilty because according to the rule he at least visit during two weeks – but sometimes never in a month, if for example patient was thrown away based on rule is legitimate.
… dia juga sudah merasa salah sih karena aturan kan dia sedikitnya dua minggu besuk kadang sebulan ndak pernah, nek misalkan pasien itu saya buang kan sudah halal kan hukumnya (Rec 36/169-172).

George described a different reason for a patient absconding: the patient was afraid of being in the ward. On one occasion there was an electricity blackout and another patient was screaming a lot. When asked by the nurse why he absconded, the patient said:

… because of the dark and there was a patient whose name is [name] screamed …he afraid ….
… dia bilang karena takut gelap dan ada pasien yang namanya [nama] teriak teriak … dia takut … (Rec 27/41-43).

Finally, Owen mentioned one patient who absconded because he went looking for cigarettes, and even produced a cigarette and offered the nurse half as proof:

His condition when he came back, he realized his behavior he said I went out to look for this cigarette Mr I went out to look for this half for me half for you

Kondisinya waktu kembali dia menyadari tentang perbuatannya katanya keluar mau mencari rokok ini pak saya keluar mencari ini ya bapak separoh saya separoh gitu (Rec 43/34-36).

In summary, views expressed by nurses at interview indicate that decisions to abscond made by patients were influenced by a whole range of internal and external factors – how patients were thinking and feeling and how they were

responding to the context in which they were currently living. Nurses seemed have similar views to patients about the things that triggered an absconding event, as their accounts corresponded with accounts given by patients at interview. The nurses were aware that being visited and being picked up were important indications of family support for patients. Indeed, some patients who were increasingly isolated from their family in hospital may decide to abscond.

5.3.4 Clues before absconding events

In this study Yvette, Emeline, Carol and Owen said that it was not easy to predict which patients were likely to abscond because some of the patients showed signs of impending absconding but others not at all. Chaty, however, said that whatever the patient's mental condition, they all needed to be considered as being at risk of absconding. Nevertheless, the nurses had examples of the patients expressing verbal or nonverbal signs that could be identified, albeit with the support of hindsight, as predictors of absconding.

The clues of absconding that the nurses talked about will be described below and presented in two parts, firstly the clues which were noticed by a nurse in the actual case that the nurse is describing, and secondly, the general opinion of nurses regarding things that may considered as clues of pending absconding events.

5.3.4.1 Clues to absconding based on specific absconding events

As the nurses who were interviewed told me about specific absconding events they all provided their view on what they saw of patient behavior before the patient absconded and what they considered with hindsight to be the clues to the absconding event. Yvette, Vicky and Rodney said that patients asked to go home and asked for their family to visit before absconding took place. Evan, Owen, Vicky and Betty said that patients sometimes showed a rise of emotion before absconding; for example crying, being offended by an officer's attitude, or fighting with another patient. Vicky and Betty described a patient who started asking to go home about three days before he absconded:

He … he wanted to go there [to intensive ward] *to the point where he cried and cried…*
dia dia pengen ke sana gitu sampai nangis nangis gitu … (Rec 71/32-33).

One note written by a nurse and noted in the Prospective Chart Audit (PCA) showed that a patient who got angry with one officer was considered as at risk of absconding.

Patient Y… is a risk of absconding angry with [name of officer] because he/she was told he could …(PCA)
Pasien Y resiko lari marah sama [nama petugas] karena dikatakan tidak bisa(PCA).

Robert, Peter, Federer, Emeline and Angela on the other hand said that patients did not show any specific behavior that could be considered as a sign of intending to abscond. It was because their patients were in a calm or better mental status, and as Yvette said, if patients were in better/calm condition it was more difficult to predict their intention to abscond.

However, Debbie said that with hindsight one patient offered to help a nurse to prepare a meal before he absconded. By doing this he was positioning himself to escape. Debbie and Robert recall that Inang volunteered to help prepare the meals – Debbie now knows that Inang wanted to be able to get out of the locked room.

Non-verbal clues displayed before a specific absconding incident were also reported. One nurse said that some patients changed their patient's uniform to daily clothes before absconding. This finding is matched by some patients, for example Tian, who changed his clothes before absconding; or Suno who thought that his absconding effort would be successful if he changed his uniform. This data is also supported by one nurse in the interview. Emeline

said that she had noted that Tian changed his uniform to daily clothes before absconding. She told me:

> *Yes, at that time I found him, coincidentally it was the afternoon shift like this, he had changed clothes put on a hat but he was caught then - was caught then he was afraid* [and] *changed back into to his uniform, ha .. ha.*
>
> *"I will not runaway miss"* [he said] *so I asked that I asked, "are you going to run away" I asked like that, "are you going to runaway Sir?" "No I won't Miss, I won't runaway I just felt" he said… ha … ha… cold, change clothes.*
>
> *Iya waktu itu saya pernah ngonangi pas jaga sore kayak gini dia udah ganti baju pake topi tapi keconganan terus nganu keconganan kan terus dia takut sendiri ganti baju sini lagi ha ha [ketawa] … "aku ra arep mlayu kok mbak" gitu saya Tanya "arep mlayu yo pak" saya kan gitu "arep mlayu yo pak" "ora kok mbak ora arep mlayu kok adem" gitu katanya dia ha ha [ketawa] adem ganti baju … (Rec 35/130-140).*

5.3.4.2 Clues to absconding based on non-specific absconding events

Speaking generally about absconding, Natalie said that patients who were at high risk of absconding were the patients who had a higher desire to go home, did not feel sick, had a history of absconding, missed their family, had been a long time in hospital, had not been visited in a long time, or felt abandoned. In this context, Tian's statement that he felt recovered may have been a clue to his decision to abscond.

Other nurses told me that they heard patients convey their desire to leave the locked room. However, Yvette said that almost all patients talked about wanting to go home and hoping that they would be visited. While this ought to be a good clue that the person is planning to abscond, this is not the case, as

many people voice these feelings and desires and do not later abscond. Therefore, patients who say they want to go home are not automatically rated as high risk of absconding.

The nurses could, with hindsight, tell me the slight changes in the patients' behaviour that might have predicted the subsequent absconding event. For instance, Evan told me that he had noted that patients sometime edged away from him towards the exit as if they were restless. Or as Jackson said, patients showed a restlessness when they wanted to go home. Pretending behavior as a precursor of absconding behavior was admitted by Suno. He said that on the way to absconding he acted as if he was doing something else when he met the nurse or officer, but when no-one could see him then he absconded.

Shara mentioned that those patients who wanted to abscond usually did not obey the instruction to go back to the locked room. Yvette told me about one patient who hid away from the nursing staff before absconding. She also mentioned those patients who intended to abscond were eager to go out when the door opened, or they loitered in the room and often looked outside. Yvette clearly said that:

> *If there is an open door he … very likely really wants to go out*
>
> *Ada pintu dibuka dia anu banget gitu loh…ya … ya … terus kepengen kepengen keluar (Rec 4/105-107).*

Yvette described for me an incident where she picked up the impression or a clue that the patient had decided not to abscond:

> *The clue where patient did not want to abscond anymore is … ehm sometimes he said that ok Mr, I do not mind to be here but tomorrow if my family came please* [tell me].

Dia sudah anu kadang dia ngomong … ya udah lah pak kulo tak teng mriki mawon ndak apa apa tapi besok kalo pas keluarga saya besok tolong saya di ini gitu (Rec 4/119-121).

5.3.5 Consequence of absconding

The consequences of absconding for nurses in this study is divided into types; firstly emotional consequences for nurses, and secondly, professional consequences for nurses.

5.3.5.1 Emotional consequences

Almost all absconding events created negative emotions for nurses. However, nurses' feelings were influenced by the general condition and mental status of the patients when they absconded. The majority of nurses reported that they felt worried when any patient absconded in a poor condition because they feared for their safety. During the earthquake nurses had another cause for concern when patients absconded. This concern was for the physical safety of the patients in a country where many houses had been destroyed and the streets were unsafe. Besides these concerns for the patients' well-being, nurses also worried about how the family would respond to the news of the escape.

For example, Peter said he worried about the family response as the patient had just absconded previously. He did not worry very much about the patient's safety, as he knew that this patient usually reached home. He only worried about family views as he was afraid that the patient's family thought that the observation of patients in the hospital was not good enough.

However, Peter's worry was reasonable, as Yvette said that she had had to face a patient's family who protested and were angry because the patient absconded. However, in the case described by Yvette, the patient was in a worse mental status and would have been at risk of coming to harm had he absconded. Angela simply stated: *"of course if patients runaway …it's problem" jelas kalau pasien lari itu yo…susah lah"* (Rec 65/136).

Two things made Emeline, Rebeca and Evan feel less worried when a patient absconded; firstly, when a patient absconds in a good mental status, or when the patient who has absconded has a history of successful absconding in the past. By 'successful' they mean that the patient previously found his or her way home without mishap. Evan said that he did not worry at all as he knew that the patient was in a good condition and had a history of absconding. He also said that he had many experiences working in mental health institutions so he intuits which patients can reach home or not.

Other emotions were described by a small number of nurses: concern, fear, guilt, disappointment, pity for the patient, discomfort, optimism that the patient will reach home safely, burden, panic, confusion, curiosity, eagerness to find the patient, being confronted by the difficulty of the situation, fear of being blamed and feelings of amazement.

Vicky expressed disappointment as she thought that the nursing team had tried hard to take care of one particular patient who absconded. She also expressed her pity for the patient's family and felt sad in case the patient did not reach home.

Carol mentioned an extreme feeling; she said that she felt she had done wrong, or in her words 'had sinned', and felt that she could not do her job well:

> *Yes, a while ago like before equally I felt as If I had sinned. To me the main thing is if I can't do my job well*
> *Ya tadi seperti dulu sama merasa berdosa kalau saya itu pokoke seperti tidak bisa melakukan tugas dengan baik (Rec 41/44-46).*

Another example given by participant nurses were feelings of pity for the patient while also thinking that the patient was stubborn.

Feelings of amazement were described by Alan who said that he almost did not believe that the patient absconded, as he thought that it was not possible for a person to pass through the drainage system in the isolation room. He never imagined it was possible for a patient to escape through that hole. But then he found that the patient was able to escape because he was naked, so he was able to pass through the small opening.

When a nurse experienced a patient absconding for the first time, it seemed to create a more negative feeling for new nurses, as described by Angela. She felt confused and did not know what she should do. She also said that there is no information about the procedure or anything about absconding events available to new nurses. She said that she got information orally from her senior. She did not refer to the written guidance that is available on every ward when the patient she was describing absconded.

Angela said that she did not want to be blamed by other nurses if patients absconded. She told me that she remembered her instructions, and did not let the patients outside. However, the senior nurse let one particular patient stay outside her locked room. Angela did not really understand how the more senior nurse was able to make this decision. As she said:

> *Confuse, ha ha ha - absolutely confuse. I'm continually confused and also for example I will be blamed - I also don't want*[this] *because at least I have already asked why that patient was let out*
> *Bingung ha ha ha yang jelas bingung saya bingung terus dan lagi misale saya mau disalahkan saya juga nggak mau soale paling nggak saya udah Tanya to udah tanya lho kok itu dikeluarkan (Rec 65/42-46).*

However, Angela and Yvette both said nursing staff seldom blamed each other when a patient absconded. This fact did not stop nurses worrying that they may be held responsible.

The nurses appreciated a formal regulation in the hospital helps nurses feel clearer about their responsibility for patients and absconding events. This rule is shown to patients' families prior to admission. Statement 6 in the admission form explains that if a patient absconds then both officers in hospital and family members (if it is possible) will search for the patient together. The responsibility will be given fully to the family if the patient still cannot be found three days after the absconding event (HPD/Agreement). Evan expressed his feeling regarding the rule. He said that the rule was good for them because the family had to accept responsibly and agree with the policy if they wanted their relative to be treated in hospital.

5.3.5.2 Consequences for nurses' work

The nurses explained to me that absconding events caused them additional work. They needed to search for the patient, contact the patient's family by telephone or visit the family in person in order to report the absconding incident, or to find out whether the patient had reached home or not.

Searching for patients was done as far as the grounds surrounding the hospital, and usually a little further in the direction of the patient's home. Robert who felt responsible and guilty said that he searched for his patient three times after the absconding event. Peter explained that he decided that he could not chase a patient who absconded because he was in sole charge of 35 patients who were at breakfast, and he also felt he would be at personal risk if the patient fought against him.

Alan and Emeline said that they asked other patients who were in better mental status to join with the nurses in finding patients who absconded.

When the family did not have a telephone it was difficult to tell them about the absconding event. In theory, there should be subsidies for nurses who need to search for patients, but as one nurse said it was long time since there was money for this and that the procedure to get the money was very difficult. Furthermore, the amount of money available was not worth the effort it took to

get it. Nurses who wanted to search for patients who had absconded needed to use their own vehicle. If they needed to contact a patient by telephone sometimes they used the hospital telephone (often in the morning) but the telephone was in the main building as there was not a telephone in each ward. However, since November 2006, after the observation period finished, new telephone lines were installed in each ward.

A nurse also mentioned that they had to struggle to bring patients back to hospital. Peter and Angela said that bringing patients back to hospital is a difficult process. Peter described how he had to chase a patient around the traditional market: He attracted lots of attention and disturbed people going about their market business. He said that it was not easy to persuade the patient to go back to hospital. The patient showed the symptoms of his mental illness by making disassociated remarks in response to questions, and making it impossible for Peter to communicate with him in any meaningful way when he at last caught up with him in the market. Peter then told how he eventually persuaded the patient to come with him by paying him a little money when the patient requested funds. Despite the difficulty of the situation, Peter was able to recount the event with a great deal of humour.

In another difficult case, a female patient was crying on the street before the nurse could bring her back to hospital.

> *Only when I was I was told by by Mrs T Mrs T happened to be at he market [the name of the market] that truly A crying well the main thing kneeling she [said] kneeling or sitting, I don't know how she cried the main thing she just kept crying there like that*
> *… Cuma pas saya ini saya Cuma diceritain bu S bu S pas di pasar (nama pasar) itu memang N itu nangis nangis nangis nangis yo wis pokoke ndeprok lah katanya ndeprok duduk, opo mboh nggak tahu nangise piye pokoke terus nangis disitu gitu ya (Rec 65/109-113).*

The absconding report is the last piece of work that nurses tell me they have to do when an absconding event occurs. At the very least, all nurses reported absconding events in the report shift book. It should also be written down in the patient's medical record. A verbal report is given to the head of nursing, doctor, and sometimes to security. However, Alan admitted that he did not report to the doctor (because at that time there was no doctor on the ward) and he managed the situation by himself by giving medicines to patient's family in case he arrived home.

From my observations and talking with staff, it appears that the specific report form which is provided in the hospital for such occurrences is seldom filled in by nurses. This form is called an official report, and consists of the details of absconding events. An official report is only required if the family of a patient who has absconded complains and needs more information. Usually this happens when patients have not been found within three days of an absconding incident.

Daniel told me that most nurses do not write this official report because patients are usually found within three days of absconding. Two nurses had contradictory views about the need to complete this official paperwork. One nurse said that there is no punishment if nurses do not write the official report; although another said that there were longer term consequences, for example, the nurse who wrote reports may be given preferential access to further training ahead of a nurse who was known not to fill in reports.

Treating and caring for patients on return to hospital after absconding created another burden for the nurse, as patients were usually in a worse condition when they returned to hospital, according to one nurse. The nurse said that patients may abscond when they were in good condition, but then their mental status deteriorated when they returned to hospital because of their family's apparently harsh or uncaring attitude towards them. None of the nurses gave other reasons for deterioration such as lack of medication or disorientation.

5.3.6 Prevention and intervention regarding absconding

There are several approaches to preventing patients from absconding; for example, limiting patients' freedom by confining them to locked rooms or isolation rooms, or moving patients to the intensive ward where there is a higher nurse to patient ratio. However, not all health professionals make the same decision to move patients to the intensive ward. I was told of an incident where Yvette, one of the nurses, had a discussion with a psychiatrist who disagreed with her about relocating a patient following his return. Yvette wanted to send the patient to the intensive ward but the doctor held the opposite view. The doctor said that the patient was still suitable for care on the maintenance ward, and the nurse complied with the doctor's order.

One nurse referred to 'shock therapy'. By this she meant all 'therapies' which make a patient afraid to abscond, for example telling the patient that they will be restrained or put in the locked room if they abscond. Another method employed to prevent patients from absconding is observation. As one nurse told me, checking patients or regular observation were methods of reducing the likelihood of patients absconding. Written and oral communications amongst the nurses were ways that nurses planned to prevent absconding, for example deciding that a particular patient needed more observation.

Limited access was described by Yvette who said that the nurses tried to limit patients' access to areas beyond their room. They did this because of staff shortages which reduced their ability to observe patients:

> *… up to now we restricted him/her going out it's because really, at the most, there are only three or for nurses here*
> *Kalau selama ini kita membatasi dia untuk untuk keluar itu kita karena memang ya paling banyak di sini kan perawatnya tiga ya kalo ya empat lah … (Rec 4/110-112).*

Communicating with any patient who has an identified risk of absconding is another strategy which may prevent an absconding event. Rodney gave me an example of a patient who asked him when he could go home. Rodney took time to explain to the patient that if he stayed calm then a nurse would have a discussion with the doctor. The doctor would decide whether the patient could go home or not. If the doctor said 'yes' the patient would need to wait for his family to pick him up. He added that going home without permission and alone would be viewed as absconding, which was prohibited.

An example of a written report regarding a plan to prevent or minimize the risk of a patient absconding was found when I checked the charts. Three days before the end of Ramadan, a nurse who worked on the morning shift wrote: "Monitor patient, risk to abscond together before the end of fasting month" (PCA/27-29). In the evening shift the nurse also wrote the same thing (PCA/33-35). There was no indication in writing what was meant by 'monitor'.

Nurses were aware that more patients wanted to go home during Ramadan. The interview with Vicky showed the team's awareness and then she described how they applied different approaches to prevent patients from absconding during this time. For example, the nurses searched patients and then put them in the locked room earlier than usual (about 1800hrs). Nurses usually locked the door at 19.30hrs. These two methods were used during the fasting month for two reasons: Firstly, nurses were aware that patients were more likely to abscond during the fasting month; and secondly, because nurses needed to break fasting at about 18.00hrs themselves. In the hospital, fasting by patients is not allowed, as they have to take their medicine regularly. The hospital management does not prepare their food schedules or menus for fasting. However, nurses could not force patient to eat if they insisted on being able to fast for Ramadan.

It was very difficult to stop well patients from absconding, as those who were in a better mental status were better able to manage and execute their

absconding plan. One nurse actually approved of some patients being able to leave of their own volition. She explained that those patients who were in better mental status could make a plan to abscond. They could ask for money (from the shop or even people on the street) so they would have money for public transport to reach home. On the other hand, patients who were in a worse mental status did not think ahead and plan their escape, so they usually absconded on foot. Nurses also recognized those patients who were in better mental status would have a relatively 'smooth departure' compared with those patients in a worse condition. 'Smooth departure' means that the patient was able to 'plan' the escape. For example, one nurse said that a patient who was ordered to do massage to (name of nurse) received money. He collected the money and went to the front part of the hospital, where he bought some food and was ready to abscond with money and some food. The nurse also said those patients who were in worse condition would just run from the ward when they absconded, and the nurse would recognize them easily.

The simplest and crudest technique reported by nurses to prevent patients from absconding was locking them in the locked room. The majority of nurses who were interviewed stated they used this method. However, putting patients who were in a better mental status in a locked room could trigger another problem. They would be angry and could become destructive in the ward and disturb other patients. I was told of a time when a patient who was in a better mental status burnt his bed because he was put in a locked room.

A few of the nurses interviewed said they faced a dilemma when they knew that patients were ready for discharge. They felt sorry for patients who had been in hospital a long time and who had not been picked up. They did not see the point in preventing these patients from leaving for home. They understood their desire to go home, and were in a dilemma about the best action to take in the patients' best interest. Evan expressed his feeling:

> *It's difficult to know*[what] *the safety limit*[s] *are the problem is, if we*

lock him/her in the room for too long, later at night he/she will wonder up and down and scream continuously

Batas amannya dimana itu susah.…… masalahnya kalau dia itu terlalu di kurung itu dia nanti malamnya mungkin dia teriak teriak terus mondar mandir (Rec 36/ 75-77).

Evan told me that he let patients in better mental status leave the hospital, and he told them to return back to the hospital by a certain time. He said that this was a better decision than having nurses battle to restrict patients who became angry every time nurses tried to prevent them from leaving. He showed his frustration with measures employed to prevent patients from absconding, and expressed a view that nurses should not have to take care of patients who are in better mental status. He thought they were the responsibility of their family and should be picked up by them. He also mentioned the difficulty he had in getting job satisfaction due to there being no standards of improvement for the patients to reach. He said patients take drugs as prescribed, and nurses give communication, and there appears to be no other therapy:

I work here, yes if we wanted to get a satisfaction, I could not get it, because there is no target, maximal standard, what does the standard look like, because patient already taken a drug, we also have conducted communication with patient ….
Saya itu di sini kerja ini ya nek dinilai ndak bisa mencari kepuasan itu masalahnya nggak ada target sing standar sing maksimal sing kepiye pasien ngombe obat yo sudah, ya kan komunikasi sudah itu … (Rec 36/145-148).,

There is a holiday program that was introduced as the solution for patients who missed their family, and particularly for those who have been in hospital for a long time. The family picks the patient up then returns them to hospital after three days. One patient (Wiwid) told me he did not mind this process and after

three days would return to hospital again. However, nurses told me that some families were reluctant to follow this program because of the difficulties associated with bringing the patient back to hospital. Some patients might not want to return to hospital after having experienced being home again:

> *He eh … if family if holiday is not ... how ... yes the problem is if they have to bring patient back here later, it is difficult … Mrs … so many families are not willing to apply for holiday program'*
> *He eh memang … kalau cuti itu kurang gimana … ya … masalahnya kalau disuruh membawa pulang ke sininya lagi nanti susah itu loh bu jadi keluarga banyak yang males kayak gitu untuk cuti itu (Rec 72/115-118).*

The cost to families of the holiday program does not appear to have been considered, and this may be a reason it is not taken up. Some families could not afford to have the person home even for a short period. Resources are needed to pick up and bring patients from hospital to home – it may take a day to get to the hospital and travel home, involving the expense of transport (public, private vehicle or taxi) and time away from work.

The female ward which had the lowest number of patients absconding had a different strategy for preventing patients from absconding. They have a policy on the ward to minimize time patients spend without activity. They have a daily schedule which includes activities such as group therapy activity in the evening, gym, or watching television and so on. The activities which help patients feel better and more involved with life may be effective in decreasing the motivation of patients to abscond. The policy on this ward presumably reduces the proclivity for boredom which is likely to have a relationship to the desire to abscond. The activities organized during the month leading up to Independence Day appear to have reduced absconding in the month of August. An example found from the chart audit data shows that one patient was predicted to abscond but actually decided to join in a picnic activity. This is a

good example of diversionary activities which keep patients active and reduce absconding.

The Head of Nurses of this female ward told me that they have nursed people with a history of absconding, and these people have made no attempt to leave the ward without permission. As Natalie said:

> *Everytime he/she goes home he/she runsaway and not only here, before he/she still wasn't in intensive care downstrai but yes thank God when he/she returned here at 10.5 he/she did not runaway because yes he/she was here… which help a little*
> *… setiap pulang dia lari dan tidak hanya di sini dulu kan masih bukan uppi ya bu di bawah tapi ya alkhamdulillah kok udah di sini pulangnya 10.05 dia nggak pakai lari karena ya tadi ada tak ada itu mungkin ya agak membantu sedikit (Rec 32/238-242).*

On this ward any patient who is identified as being at risk of absconding is approached by a nurse and is included in a discussion about the advantages or disadvantages of absconding. This ward also has a list of patients' families who had a problem (meaning they never visit, or simply ignore the patient). The nurses actively sought families who had not picked up a patient; they sent a letter to patient's family, made a call or visited them. Nurses from this ward also had discussions with the doctor regarding the family's attitude.

Nurses in the interviews described different reactions to patients who returned to the hospital after absconding. There are no specific rules or protocols regarding what nurses should do when a patient returns, for example specific observations of the patient or debriefing. Nurses at interview said that they would move a returned patient into a locked room, isolation room or to the intensive ward – all places from which it was difficult to leave without being noticed. Rodney said that a patient would be monitored, and George reported that a patient was restrained due to his condition. Some nurses mentioned that

they made an effort to improve communication with patients after they were caught and brought back. Yvette said that she put a patient in the isolation room for a short time, which only for about less than four hours. One nurse explained that she would isolate the patient who had absconded to prevent him or her from influencing other patients and encouraging them also to abscond from the hospital.

5.3.7 Circumstances and contexts that enable patients to abscond

In the interviews, we explored the circumstances that created the opportunity for absconding to occur. Issues that were discussed have been organized and reported under the following headings: regulation, staffing, wrong procedure, communication between nurses, improper actions by nurses to prevent patients from absconding, different perceptions, activity, student nurses, hospital/ward lay out, absconding influenced by other patients, specific circumstances in the wards and regular process in hospital.

5.3.7.1 Regulation

It appears that in some cases where absconding occurred there were several regulations which were not abided by main players in a hospital. There were examples of improper handover of a patient from rehabilitation. An example of improper handover that I heard was when the nurse did not hand a patient over to the officer from rehabilitation, rather a student did it. Sometimes there was no handover at all between the nurse and the officer from the rehabilitation ward. In one case, a nurse found that patients who were sent to rehabilitation had already returned to the ward, and the nurse realized that she had not handed over to an officer from rehabilitation unit. The nurse was not sure whether all patients had already arrived back in the ward or not, but then found that one patient was missing at lunch time. Another contravention was that there was no record of the patient's name sent to the rehabilitation unit, meaning that it was impossible for staff in rehabilitation to check whether all the patients were present or indeed whether they had all returned at the end of the day. One nurse admitted that the rehabilitation officer did not send all

patients back to their wards. Lack of attention to these rules gave opportunities to patients who wanted to abscond. For instance one patient (Hadi) recognized that the officer did not bring all patients back to the ward and he chose to abscond during this time. Evan admitted that he did handover of a patient with the officer from rehabilitation, but he did not check all patients to see whether they had already come back or not. The nurses just believed the officer when he said "yes, all complete". However, the nurse realized that he should check the patients again. He also explained that the "trust culture" as he decribed it, caused him not to check the patient again.

Still on the process of handing patients over from rehabilitation to the ward, Rebeca, a junior nurse, said that the nurses who sent the patients to rehabilitation were responsible for receiving the patient back from rehabilitation. However, Jackson, Daniel, Natalie and Ivone said that not all nurses understood or indeed hold the same perception about the procedure for bringing patients to rehabilitation. In my observation I found that any nurse could receive patients from rehabilitation, not just the nurse who sent patient to the rehabilitation, so obviously there are differing opinions.

5.3.7.2 Staffing

Referring to a particular absconding event, one nurse admitted that s/he was the only nurse on duty. There should have been two nurses. However, the nurse did not mention where the other nurse was. Another nurse said that s/he was late so then there was no nurse to hand over to before the absconding event happened. S/he also mentioned that s/he had something to do on the previous shift so s/he could not go to work, resulting in a shift with only one nurse.

5.3.7.3 Wrong procedure

Not following procedures produced the opportunity for patients to abscond. For example, the assistant nurse should not send patients to rehabilitation, but she sent them without having discussion with the nurses who were on duty. It was a serious mistake because the patient was in a worse mental status and no discussion had been made as to whether this patient was suitable for

rehabilitation. No clear instruction regarding the condition of the patient and no communication among staff had been made. Hospital policy shows that assistant nurses have to collaborate with trained nurses to do their job; no information was passed to the assistant nurse saying that she should bring the patient to rehabilitation (PHD Assistant Nurse's job). However, even when the nurse realized the patient had been taken to rehabilitation inappropriately, the nurse did not act to bring him back to the ward. She just hoped nothing would happen:

> *I wasn't sure all of a sudden he/she was there D was in rehabilitation unit. That's what I did, I had already delivered the patient there oh well hopefully it would be allright. That's what happened*
> *He eh saya juga Kurang tahu saya tahu tahu udah si itu udah di situ loh D to kok ning rehab? Saya gitu toh tp sudah terlanjur di serahkan di Sana yo wis mugo mugo ndak papa ternyata kejadian itu (Rec 9/32-36).*

Respect for older people also influenced the way in which the nurses made decisions. One nurse felt uncomfortable when she needed to contradict the assistant nurse, who was an older woman. She said that her feelings of respect for the assistant were her predominant consideration and therefore she left the matter.

5.3.7.4 Error of judgment by nurses

Some actions by nurses helped the absconding event to occur. For example a nurse let a patient go outside the locked room even though the patient was identified as at risk of absconding. In one of the nurse's interviews, Robert gave a patient the opportunity to walk away from the ward without being accompanied by him. This patient offered to help the nurse preparing the patients' meal then he waited until he got a chance to fetch a meal from the kitchen which was in a separate building. Another error of judgment occurred when one nurse decided to handover a patient in a worse mental status to the student nurse. In another incident, a student nurse was asked to escort a

distressed patient to the emergency department. There the patient left the department and the student believed that he had returned to the ward himself: In reality, the patient had absconded.

5.3.7.5 Different perceptions between nurses

Differing opinions among staff in relation to where patients should be contribute to patients absconding. In one case, a junior nurse warned a senior nurse that a patient was at risk of absconding, nevertheless the senior decided to let the patient go outside. The junior was uncomfortable because, as a new nurse she felt that she could not protest. As she said:

> *Yes it's like this, I asked Mrs X – it's uncomfortable - the thing is because I'm aware because I'm still a Junior although sometimes, yes I do protest a little, but not much, because I'm not brave enough yet*
> *… ya itu saya nanya bu X kan ndak enak yo soale saya itu yo ngrumangsanani sek cah anyar gitu loh meskipun yo kadang yo tetep yo sok protes thithik tapi nek terlalu anu kan belum berani to (Rec 65/98-101).*

In another case, there were different judgments made among nurses regarding the condition of a patient who was required to be sent to rehabilitation. However, they did not discuss the subject of which patients should be sent to rehabilitation. The senior nurse who decided this patient should be sent rarely worked the morning shift, and as the junior nurse said, the senior nurse did not understand which patients usually went to rehabilitation and who did not. However, there were no clear criteria or protocols about sending or referring patients to rehabilitation.

Responsibility for deciding about referrals to rehabilitation was confused. A nurse told me that it was the doctors who recommended the patient to rehabilitation, but doctors rarely wrote in the medical records or made plans that stated that patients can be sent to rehabilitation. However, she said that was the procedure in the past.

5.3.7.6 Less activity for patients

Having nothing much to do with their day causes patients to become bored, and in some cases starts them thinking about absconding. This phenomenon was supported by chart audit data collection which showed that most patients absconded on a Sunday - a day on which there is no rehabilitation activity.

5.3.7.7 Student nurses

Nurses who spoke to me appeared to believe that student nurses could be blamed for some absconding events. One nurse said that students let patients out from their locked rooms and did not keep a close enough watch on patients who were their responsibility, they just left patients alone. The perception was that student nurses did not seem to understand which patients were in a high risk category for absconding:

> *He/she said the patient walked here in this direction but apparently he/she didn't get here. That's the way it was Miss*
> *I: … si si mahasiswanya ngomong alasannya ditinggal apa dia ngomong apa'*
> *Vicky: Katanya e pasiennya jalan ke sini kok mbak gitu e ke sini gitu loh ke arah ke sini tapi ternyata nggak sampai disini (Rec 71/3-38).*

Ivone said that many students did not pay attention to patients. For example, a student would take a patient from the locked room for a discussion, and afterwards would not put the patient back in the locked room.

5.3.7.8 Building layout

The hospital and the ward layout has been described in Chapter Four. In the interviews the nurses reiterated that the layout of the maintenance wards made close observation of patients difficult, and multiple exits also aided people who wanted to leave unnoticed. Owen also mentioned that the hospital's fence was too low making it easy to jump over.

> *I think the problem is the space is too open here hi hi. If it was like*

[name of other ward] there are boundaries aren't there. Ho oh. The exit door, you have to pass through several doors but here you just goes straight out.

Ho oh masalahnya kalau menurut saya kan sini ruangannya terlalu terbuka to yang sini hi hi hi kalau apa kayak (nama bangsal) itu kan ada batas batase … ho oh pintu keluarnya kan harus beberapa kali melewati pintu kalau sini kan langsung (Rec 35/73-77).

The Maintenance Ward had a wider space, and only a few officers were there, especially at meal times when all patients gathered in the meal room. Federer complained about the isolation room which was in the Maintenance Ward. He said that this isolation room was not as strong as the isolation room in the Intensive Ward. This view was supported by another nurse who said that a patient absconded from the isolation room by breaking the door.

5.3.7.9 Absconding influenced by other patients

Patients also influenced each other to abscond. Yvette said that absconding was contagious. Hadi admitted that he had absconded after another patient suggested that he could do so. Tian, Inung and Riri also said that they absconded together with other patients.

5.3.7.10 Specific circumstances in the wards

Nurses also mentioned in the interview that isolated events sometimes created opportunities for patients to abscond. These included black outs, when other patients were violent and screaming, and particularly when all the nurses were very busy in the mornings with many activities and families were visiting patients. This is matched with the interviews with nurses who said that most families visit patients on Sundays and data that shows that most absconding occurs on Sunday. The opportunity created by busy activity was admitted by Nia, who said that she absconded when the nurses were busy preparing medicines.

5.3.7.11 Regular processes in hospital

There were two regular processes in hospital which, in the nurses' views, may trigger patients to want to abscond. These are the dropping program[6] and the discharge process.

The dropping program may trigger patients to abscond. This program encourages patients to discharge themselves without waiting for their family to pick them up. However, not all patients can follow this program due to limited access to hospital vehicles to drop patients home. Patients who are ready for discharge but have not been chosen in this program may be triggered to abscond when they see that other patients can go home by this program. Noto, one of the patients who talked to me, expressed his disappointment at not being chosen, and so he absconded.

Patients see other patients' family cooperating with the discharge process and the nurses think that this may trigger other patients to abscond. As Yvette said :

> *Yes, ha … sometimes there is someone who processing patient to discharge … ouch you will go home, ehm ehm … he also wanted to go home.*
> *'Iya ha … kadang ada yang ngurus pasien pulang itu wah kok kowe wis bali to anu anu …gitu dia juga ada keinginan pulang gitu (Rec 4/238-240).*

5.3.8 Nurses' perspectives on patients, family and community

Some nurses in their interview showed negative attitudes about patients. For example, Carol said that patient Tian could not be trusted. Emeline said that patient X had not improved since he was brought to hospital. She said that the communication style of patient M was always incoherent. One nurse in his interview showed his pessimistic view about a chronic patient. He said that a

[6] The Dropping program is a program provided by the hospital to drop patients at home based on certain criteria; for example, patients who have been in hospital for a long time and are ready to be discharged but their family do not come to pick them up.

chronically mentally ill patient could only eat, sleep, smoke, and even needed help to take a bath. Such patients also could not do the simplest activity for example, broom the floor.

Most of nurses' opinions regarding family and community attitudes towards people admitted to a psychiatric hospital were negative. Evan said that he felt annoyed by families, and that some were as 'crazy' as the patient, and they never visited patients. He wondered who was really the craziest - the patient or the family.

Robert said he felt disappointed by one family because he thought that the hospital had tried very hard to help the patient recover but the family did not respond well to the improvement. There was also an opinion amongst participants that family members did not show good will either towards the patients or the hospital staff.

Emeline thought that families treated patients badly by being reluctant to accept patients at home, Rebeca, Carol and Robert said that some families did not want to pick a patient up from hospital. Robert got the impression that family members did not want to help when patients were getting well. Yvette gave me an example of one family who was unwilling to take care of a patient. She said that there was a patient who was put in the "*panti*" which is similar to the "home stay" rather than in their family's home. This is an alternative place to hospital where families can put patients they will not have at home, and is usually managed privately. Nurses complained that families did not visit patients, and sometimes insisted that they stayed in hospital even when they had permission to go home. As Robert said:

> *Yes, most of patients who stayed here was getting better on one month maximum but their family are not willing to bring the patient to return home. It was about 60% like that.*
> *Iya, kebanyakan pasien-pasien yang disini itu maximal 1 bln dah bagus*

tapi keluarga sendiri keinginannya untuk dibawa pulang itu ndak ada gitu. Paling gak sekitar 60% an seperti itu (Rec 1/239-242).

Nurses observed that families tended to send patients to hospital when religious events approached. Vicky and Betty said that a family did not want to take as patient home at the end of fasting month. Some families would have liked to take patients home to celebrate the end of fasting month, but more families were busy because of this event and would have felt stressed if they had to take care of the patient during this time. One nurse interviewed estimated that from total a 28 patients, only about five patient families had planned to take their relative home to celebrate the end of fasting month.

Robert expressed an opinion that a family abandoned a patient because the patient disturbed the family at home, and that they thought that the hospital was the place to throw the patient away.

Nurses admitted that some families were cooperative with nursing staff and followed the administration process regarding the absconding event, or they informed nursing staff by visit or telephone that the patient was home. Usually they brought the patient back to the hospital.

Furthermore, the nurses also tried to understand the family situation and why they sometimes appeared not to respond to nurses and patients. For example, a family might have a mental illness problem or be very busy because they are victims of the earthquake. It might even be because they do not have resources such as a phone or phone credit to contact nurses.

Community response was also viewed negatively by nurses. Robert had an experience where he found that the community rejected a patient when the patient was sent home. The reason given by the leader in the community to Robert was that the patient disrupted the environment.

It was expressed by Robert

> *Actually I was angry because the patient and his/her family want to go home. The patient wants to go home but the community rejects it. It was like that once in the XY region the one who rejected it was, in fact, the village chief.*
> *I was with the family and said to the parents, Sir, if you can, ask the village chief, chief to came here, I … dare to blame the village chief. I dare to argue with him*
> *Sebetulnya marahnya karena pasien itu dari keluarga sendiri ingin pulang, pasien dah mau pulang, tapi dari masyarakat sendiri menolak gitu. Pernah itu kebetulan didaerah KP, itu yang menolak itu malah kepala desanya sendiri, pernah saya dengan keluarganya itu orang tuanya itu, pak tolong kalo bisa kepala desanya suruh ke sini, saya yang … saya berani menyalahkan kepala desanya. Saya berani berargumentasi dengan kepala desanya gitu (Rec 1/317-321).*

5.4 Pattern matching

Where the interviews with the nurses corresponded to the propositions developed from the research findings in the West they have been included in the table above. The nurses views accentuated the big divide there is between the West and Indonesia and therefore this pattern matching exercise is limited. However there are weak associations that may be drawn regarding the clues that a patient may be considering absconding. There is agreement that nurses are the people who are responsible for patient safety and therefore limiting absconding. However as the profile of the patient in the West is of people who are acutely ill (otherwise they would not be admitted to a psychiatric setting) it is possible that lessons for the safety of patients in a poorer mental state could be learnt from the findings of research in the West.

Table 5.2 Pattern Matching

No*	Literature from the West	Finding in nurses' interviews	Note
2	That in some instances patients may give overt signals that they intend leaving (e.g., say they are going, put on outdoor clothing).	Clues based on specific absconding events: (verbal) - small changes in patient behaviour – usually recognised with hindsight as precursors to absconding. - history of absconding.	√
3	There is no one typical profile of patients who abscond, they may be relatively fit or on the other hand in a state of psychosis.	Nurses talk about the few patients that abscond in a poor mental state. Predominantly they believe most patient who abscond are those who are ready for discharge or in rehabilitation.	X
7	Patients who abscond are more likely to display high risk behaviors than patients who do not abscond.	Mostly ready for discharge, attending rehabilitation activity, able to follow routine activities in the ward independently.	X
15	Patients who abscond are at risk of being hurt or of hurting others.	People who abscond in a relatively good mental state are at less risk of harm than people with a poor mental status.	-X
8	Nurses are most directly responsible for identifying patients likely to abscond and for implementing preventative strategies.	Prevention by increasing surveillance, restricting patient access, maintaining hospital protocols.	√
9	That more observation of people who are identified as 'high risk' of absconding can reduce absconding.	Locked room are the predominant method of preventing absconding.	X
11	Nurses report that they feel worried and concerned when patients abscond, and they feel relief when people who have absconded return safely to the ward.	The nurses worry about the patients who are unwell when they abscond. Some concern was also expressed that nurses will be blamed for the event.	X
13	The majority of patients leave the institution on the evening shift from 13.00 to 21.00 (Western literature). The most common months were: May, June and August. Weekend is the lowest rate. The majority of patients who abscond do so in the first two weeks.	Nurses' views correspond with the audit data that most patients abscond at: - Meal time - Ramadan - Sunday - Depends on the nurses who are on duty	X

Note
* = Number of proposition

5.5 Discussion

The nurses in their interviews confirmed the outstanding finding so far in this study, namely that the patients who absconded were in a predominantly good mental health condition – that is, they were ready for discharge or at the least were in the rehabilitation phase of therapy. The eighteen nurses interviewed talked about nineteen absconding events, and of these, five related to patients who were still considered to be unstable and not ready for discharge. There was general agreement that it is usually the patients who are well that abscond.

The nurses said that they worried less about patients who absconded in a good mental condition because they believed that they had a reasonable chance of getting home unharmed. They said they were more concerned when a mentally unstable patient absconded. However, they did not appear to take extra precautions to prevent absconding with these unstable patients. This is evidenced in their descriptions of the circumstances prior to the absconding of the five patients who were mentally unwell. For instance, Putra was put in the room where a patient had already been able to escape through the drainage hole. In addition, the nurses did not appear to have a great respect for the hospital policies, as lack of attention to these appear to have created opportunities for patients to come and go unnoticed by staff, and in some instances just walk away from the hospital.

Much can be learnt from what the nurses did not say. Nurses tended to talk from experience or referred to rules. They did not appear to learn anything by drawing comparisons between areas or types of patients when talking about absconding. The two patterns that they did notice is that male patients tended to abscond more than female, and that it was well patients, or patients ready for discharge, who absconded. However, this realization did not appear to make any difference to their work practices. If anything, the male nurses talked of bending rules associated with close observations and supervision of patients more than the female nurses.

It also appears in the present study that nurses did not facilitate patients' recovery, even patients who were ready for discharge but had not been picked up. According to Stuart's theory (Stuart, 2005, p. 72), the nurse needs to apply specific intervention to patients who are in "maintenance treatment stage" such as reinforcement and advocacy to patients who are in the process of recovery. Townsend and Glesser (2003, p. 85) explain the role of each party in the process of recovery: " … recovery is what the individual does; facilitating recovery is what the clinician does; and supporting recovery is what the system and community does".

The nurses understood that a number of patients were ready for discharge and were relatively independent. These patients did not need assistance with activities of living, and therefore did not receive much attention from nurses. The nurses did not recognise that these patients were in need of preparation for discharge. There was no recognition, either in what the nurses said to me or from my observations, that living in hospital was different from living in the community. Education provided to patients related to the taking of medications rather than learning about their condition, or how to engage with family and friends and undertake household tasks at home.

The nurses appeared to understand why patients wanted to abscond and here they showed a degree of empathy for the patients. They did not believe that their desire to go home was unreasonable, and therefore they looked to the community and relatives to assume responsibility for the patients. They also tended to blame others for absconding events; for example relatives, students, the layout of the ward and patients. The nurses blamed the relatives for leaving the patients in the hospital, seldom visiting and neglecting their duty to come and take them home when they were ready for discharge. The patients were blamed because they disobeyed the rules and made life difficult for the nurses. This phenomenon shows that there does not appear to be a great deal of reflection by the nurses on the ways that they may contribute to help to prevent a situation where patients want to abscond.

It is interesting that nurses treated and cared for patients in a way that confirmed the patients' status as mental health patients (they conformed to the institution's regimens, they wore uniforms etc), but they expected the families to view the patients as ready for discharge. The methods that the nurses used to prevent absconding were not tailored to this fact. The nurses relied on custodial techniques such as counting the patients, increasing observation and locking the patients up. These sorts of strategies hardly fostered the independence of the patients or prepared them for discharge in the near future. The nurses on the female ward, with the lowest rate of absconding, filled the patients' days with activities, but at interview they did not necessarily associate these practices with lower rates of absconding. Thus, from the interviews, I can identify nurses who bent the rules with certain consequences, and also nurses who tried to keep the patients occupied. Both these strategies could be construed as being helpful: first, in avoiding oppressive regimes and applying institutional rules of control on people ready for discharge; and secondly, in preventing boredom in the patients. In neither case were these measures related by the nurses to the incidence or problem of patients absconding. However as positive acts they could be starting points for development and critical reflection work with the staff. Walsh et al. (2006) write about the benefits of working with nurses on strengths rather than problems.

The responses of nurses to an absconding event were mixed. On the one hand there was a general impression that most patients, particularly those ready for discharge, were not at risk and that absconding was one way for them to take matters into their own hands. They believed that the patient then became the responsibility of the community and the family. On the other hand, there was the possibility that the nurses may be in trouble when a patient absconded, particularly if the patient was considered mentally unstable. Nurses could be accused of not watching or checking the patient properly. This type of fear led the nurses to be annoyed with patients who absconded. The last matter they raised was the amount of work involved when a patient absconded. The nurse

responsible may have had to spend much time searching for the patient, contacting relatives and filling in paper work. There were nurses who expressed disappointment that the patient did not continue in the therapy, but they were the rare exception.

Overall the nurses had a nurse-centered approach. They talked to me about concerns they had in relation to preventing absconding, and how the absconding event affected them. They did not appear to view the world from the perspective of the patient, and they appeared to have little or no respect for the views of communities or relatives who were reluctant to take patients home. This lack of understanding was not a good basis on which to build trust or the therapeutic relationship described by Stuart (2005).

A better understanding of patients' experiences and perspectives may enable nurses to help patients who appear to be relatively independent while in hospital. This may be achieved by understanding patients' feelings, and listening to their voices in order to choose appropriate nursing interventions. In the maintenance stage (where recovery is a goal) the nursing role is termed by Stuart (2005, p. 72) as "reinforcement and advocacy". These patients do not typically need physical care, but they do still require help from nurses. A closer relationship between nurse and patient could be enhanced if the nurses recognised and appreciated the value of engaging with patients and spending time with them to learn about them as individuals.

CHAPTER SIX: THE PATIENTS' EXPERIENCES OF ESCAPING

6.1 Introduction

This chapter describes the patients' experiences of escaping, and consists of four sections. These are the patients' stories of escaping from hospital, the themes derived of the experience of escaping, a discussion of the findings, and pattern matching with the study's propositions. Throughout this chapter, the reader will note that the term 'escape' rather than 'abscond' has been used to describe the patients' experiences. This is because the term 'escape' has the closest meaning with '*lari*' in the Indonesian language. In our conversations, '*lari*' was used frequently by both patients and nurses to describe the patients' escaping behaviour. Although absonding is referred to in the rest of this thesis because it is the common name used in the literature, it is a medical term, and in fact there is no such equivalent term for it in Indonesia.

Initially, selected stories of four patients from a total of sixteen patients and seventeen interviews are presented. As noted previously, interviews were conducted in various rooms and settings throughout the hospital. The resulting stories have been chosen to illustrate the range of patients in the study and their varying experiences of escaping. All the patients in these stories had been diagnosed with undifferentiated schizophrenia.

The second section of the chapter presents the themes derived from the patients' experiences of escaping. As explained in the methods of analysing and theorizing, the interviews were transcribed verbatim in the original language phrases. The text was coded to label concepts, then the concepts have been examined and relationships explored. When relationships or links were found the concepts were clustered in sub themes and themes. The final part of this chapter is the discussion of the themes. Pattern matching between the study's propositions and the findings of the patients' interviews will be displayed in table form.

6.2 The Patients' Stories

It is now time for the voices of the patients who escaped to be heard, and this chapter is a testament to their experiences and their search for belonging in a somewhat disjointed and seemingly unfriendly world. The information that the patients who had escaped and returned to the hospital gave me during interviews was enlightening on a number of accounts. Not least the fact that some of them had more difficulty expressing themselves than others. Some of the interviews lasted just minutes. Each in their own particular way however, revealed some of their escaping experiences and the meanings that the journey away from and back to the hospital had in their lives.

The group of sixteen people who talked to me were an interesting and disparate group – some were sad, some happy, some confused, some disappointed, and most were struggling to be free from hospital. The emotions and thoughts related to escaping experienced by the patients will be re-presented in this chapter. First, I will give an overall view of their experiences through presenting four of the patients' stories, and then later in the chapter the views of patients will be presented according to the themes uncovered.

In this thesis, the participants' accounts of escaping have been re-presented as a journey. The stories are neither analysed nor interpreted. Although they are necessarily reconstructed from the raw data, they simply describe the patients' experiences as they related them to me. Pseudonyms have been used and identifying details changed throughout. These particular stories were chosen for a variety of reasons; some practical (eg., a few interviews were too short to construct a story from); and others to provide the reader with a range of patient perspectives and experiences of escaping. This process is described by Sandelowski and Barroso (2003, p. 909) as "data-driven and integrated discoveries ... " offered by researchers. After a selection of the stories has been

presented, a thematic analysis and interpretation of the interview data will be provided.

The first story told is a journey of confusion as recounted to me by Bayo. His story was chosen because in some ways he was the most 'successful' of the patients who talked to me as he stayed away the longest time. His story also showed that his journey was full of confusion and had a sad ending. Tian, who had an experience of multiple escapes, is the second story told. Tian's story was chosen because he retold the entire journey with great fluidity, he had multiple escapes and he had been interviewed twice. Nia's is the third story told. Her story was chosen because she was the only woman who agreed to speak with me. Her story was also chosen as her mental illness was particularly evident both when she was interviewed and when she escaped. The final story is Inung's, who told of his unique escaping experiences. He showed me how his struggle to escape was a fruitless effort.

In order to provide the reader with a sense of how the patients spoke to me, the information about the circumstances around the escaping experience is presented in normal text. The story itself is written in italics to indicate information derived from the patient. The following stories are presented in present tense as this may assist in bringing the reader into the situations where the escaping occurred.

6.2.1 Bayo – A journey of confusion

Bayo escaped about four months after his admission.
The nurse takes me to meet him in his room. He is alone in his room. He is tall and thin. He looks happy when he sees me. We walk together to the nursing room to have a chat. I ask whether he would prefer to have a chat in another place but he says that he does not mind being here.

Bayo looks older than his 42 years. "*Just call me Bayo*" – he says. He speaks and moves slowly but speaks clearly and his story flows well.

Bayo says that even though it was two months ago he still remembers when he 'escaped' and he can tell me the details of how he escaped and what happened after that. Bayo is keen to help me and is happy to be interviewed. He says it may help him to get better – I am uncertain whether he thought that telling his story was intrinsically therapeutic for him or whether he thought I might be more inclined to help him if I was sympathetic to his situation.

The day Bayo escaped

Bayo then starts to tell me about his escape experience:

He is not feeling 'at home' in the ward when he escapes. This is because he is aware that the hospital had already contacted his son and his older sister to pick him up from hospital. He is already 'normal', he says. He cites examples that he is able to follow and become involved in routine activities in his ward, and he is allowed to take a walk around and outside the hospital freely. Bayo had also sent a letter to his sister, but six weeks later; still no one had come to pick him up from hospital.

Bayo expresses his feeling of puzzlement and disappointment that no-one had come to claim him by shaking his head several times from left to right. These feelings prompt him and his room mate (Bowi), who are both housed in an unlocked room, to escape at midnight (00.00). Bayo smiles when he says that he realizes that in doing so he breaks the hospital rules, but on the other hand he has really not been feeling at home.

Bayo and Bowi escape on foot for about three hours then they catch a bus at about three o'clock in the morning. They have money for the bus because they had got money for a shirt they sold to a nurse. Selling the shirt is not a part of the escape plan but the money comes in handy. It seems Bayo had gotten the

shirt as a reward in a competition in the ward celebrating Independence Day four days earlier.

After a long trip they arrive in Bowi's house. Bayo stays one night in Bowi's house before he goes to his older sister's house.

Sadly, it is a disappointing reunion, as his sister treats him badly and tells him that the police kingdom is chasing him because he escaped from hospital. The police kingdom is a very old police force and reference to them means that his sister is lying to him and only wants to frighten and intimidate him. As Bayo says "*… she spoke very roughly'' "… dia ngomongnya kasar sekali" (Rec 80p/66-67)*. Bayo's eyes brim with tears, showing how hurt he is by his sister's attitude towards him.

After that, his sister gave him a measly 20 thousand rupiahs (about 3 Australian dollars) and the keys to his house. She then dismisses Bayo's request that he needs to get a Healthy card and tells him to go to his brother.

Unfortunately, when he meets his brother (who is a head of sub-district), his hope that his brother will help him to get a healthy card does not eventuate. He looks a bit disbelieving that his brother said that the healthy card should be given to poor people. *Bayo does not agree and he thinks that he cannot afford it. He feels his family just make him confused although it is not clear about what.*

It seems that Bayo does not have any choice except to go to the house that he inherited from his father. This is because he does not know where his son is and he feels afraid of his ex wife's family as he was divorced about fourteen years ago.

<u>The third day since escaping</u>

Two days living alone in his home seem to create an eagerness in Bayo to talk to someone as he then decides to go to Bowi's house.

On the way to Bowi's house, and while he stays there, he has some strange experiences. For example he meets a woman in the bus who chats and asks him to marry her. In his friend's house, he suddenly wakes up in the night and hears a radio voice persecuting him.

Bayo looks regretful when he tells me that his relationship with Bowi does not make him happy. *On the contrary, it only seems to make him upset and confused as Bayo thinks that Bowi's attitude is that he only cares for himself. He does not tell Bayo when he decides to return back to his own house the next morning.*

<u>One week later, the day Bayo returns to hospital</u>

After this Bayo feels very confused and lived like a street walker in his own house. He asks for food and drink from his neighbour like a beggar and does nothing all day. He starts destructive behaviours as well; for instance he throws a bed and his book in the nearby well. During this time he feels like he is in the hell. He feels that everything is opposite. In this experience, he thinks that he hears God saying that he would never reach his home. Bayo feels that staying in hospital is also a punishment from God.

Bayo is unsure who finally brings him back to hospital. However, information from medical records show that his sister and his son sent him to hospital about six weeks after he escaped.

He has already heard from people that the way to recovery is not dependant on taking medicine. However he does not understand how he can recover on his

own. He thinks that only God can help him to recover. When he says this he looks sad and has the faraway look of a daydreamer.

At the end of our time together Bayo says he is happy that he has been able to tell his story. Further information from the nurse on the ward reveals that Bayo had received a healthy card on 17th November 2006 (about one month after our interview), and he was then discharged by the 'dropping program'.

6.2.2 Tian – A tale of many journeys

This story is associated with three 'escapes' made by Tian over three months. Tian is a man aged 38 years who is married with one son. Working as a labourer, he is a poor man, and his life was made even more difficult when his house was lost in the earthquake recently. Tian agrees to talk with me after his first and second escape. At our two meetings we always have eye contact; he speaks quite clearly, logically and rationally.

<u>The first journey home</u>

It is about one o'clock in the morning when Tian escapes. He has been thinking of his son whom he had planned to take for circumcision. He wonders why he is prevented from going home and is put in a locked room. His disappointment appears when he tells me that every time someone visits him in hospital he/she does not want to take him home.

Tian hasn't planned to escape - he just goes out the door as at the time it is unlocked. He doesn't realize until he is on the street that three other patients (Bakri, Koko and Madi) have followed him. They do not talk each other. When they pass Madi's house, Madi splits off from the group.

It seems this odd little band is together by chance rather than choice. They do not speak to each other, and they stay together for no apparent reason other than they are there, and they are together in a joint mission to escape.

Tian and his two fellow patients successfully reach his home. According to Tian, somehow when they arrive at Tian's home, Koko is picked up by his family. By midday, some nurses come to take Tian and Bakri back to hospital. Tian does not resist the nurses. On return to the hospital he is hit by a nurse for no obvious reason – he feels dizzy and has a bleeding mouth, and is left in a locked room. He does not like to be there but he has to stay there about a month. Eventually he asks to be moved and is allowed to go back to the unlocked room and he feels relieved.

At the end of the interview Tian says he will be picked up soon. Tian wonders why he is still in hospital and why his family does not come to pick him up to go home.

But some days after the interview, Tian had still not been discharged.When he meets me in the ward he asks me to help him go home – I suspect that he perhaps thought I would be able to help him get home. Tian escapes again about eight days after his interview with me and returns to the hospital five days later. He agrees to speak with me again and gives me the following account.

<u>The second journey home</u>

Tian tries to make sense of his situation and says a range of things. Firstly, he does not know why he is brought to hospital. People consider that he is 'crazy' but he does not feel that he is crazy. He feels no one is concerned enough about him to pick him up from hospital. However, he realizes that people in the community and his family are afraid of him. He also realizes that his wife lives in poverty so she cannot afford to pick him up from hospital.

His concern about his father and his wife seems to haunt him. *His father is getting older and his wife has to live in a stable. His hope to spend time with*

his father and help his wife to build a house does not come true as he has to stay in hospital.

Tian feels 'normal' and he is able to eat, bath and pray on time. He thinks he does not need his medicines changed because they will not make him better, and also, he feels quite bored in hospital.

Sadness and frustration appears in his face when he tells me that the doctor does not accept his opinion that he has already recovered. When he asks the doctor to go home the doctor only asks him to have a rest for a while in hospital without explaining how long he should stay there. Tian then continues his story by telling me his next escape experience.

He has difficulty sleeping and hears his father's voice in the night (about 1 a.m). He then loiters around the hospital and when he drops in to the mosque he remembers his father again. It seems that this feeling is very strong and is the trigger for him to go home. He explains how he changes his dress and throws the patient's uniform away in the garden. He reaches his father in-law's house at about 7 o'clock in the morning. Here, he looks sad when he tells me that his wife, his father in-law and his family make him feel disappointed. *His wife does not even make him a drink. He feels like a foreigner in his home. She does not believe that he has recovered from his episode of mental illness.*

Even though he is disappointed with his wife, Tian understands that she has to work hard to earn money to live. He wants to lead his wife and his son and believes that a man should be self-reliant. What makes him even more disappointed is when he realizes that there is no one in his family who has been looking forward to seeing him. They are distant from him.

Nevertheless, Tian seems to have found a little happiness in his escapes as he looks pleased when he tells me that he can meet his father for a chat and make

him a cup of tea. He also seems cheerful when he says that only his father does not believe that he is 'crazy'.
However, his happiness is not to last long as, during this visit with him, his father dies. Tian tries to concentrate on leading a meeting for the funeral arrangements. He tries to convince people, including me, that he is capable of leading the funeral arrangements even if he is a 'crazy person'.

However, his family disappoints him again as they insist on sending him back to hospital. His belief in his own capability to lead the funeral arrangements does not make an impression on the attitude of his family. Tian is of the opinion that he can buy his medications from the place near his village rather than go back to hospital. His brother says that he can only recover if he takes medicine in the hospital. Tian bows his head down as he says he does not want to return to hospital, his family wants it. *He is very sad but he knows that he does not have any other choice*.

But his experience has not ended yet. When he returns to hospital he is hit by the nurse who also hit him in the first absconding experience. He tries to defend himself and say that he is not doing something wrong. He does not know why he is hit. However, he does not fight because he worries if he goes against the nurse, but he does not say what he is worried about.

In his conversation, Tian is also concerned about building a house before Ramadan, but now he is still in hospital. He feels confused because he is not allowed to go home and lead his family.

Two days after our interview, I received information that Tian escaped again. I did not meet him after this because he did not return to hospital until the end of the data collection period.

6.2.3 Nia – A journey to find 'happiness'

Nia is the only woman who agrees to speak with me after escaping. She is a thirty six year old single woman who escaped from the hospital six days after her admission. On the day that I meet her she is in a room that she shares with one other woman. When I walk into the room Nia is sitting on the bed with her head lowered doing nothing. She looks very pale and thin and her hair has fallen out. When I greet her she speaks softly and slowly. She keeps her head down as she speaks so there is no eye contact with her. She answers questions but rarely offers information unless she is given a direct question.

We walk away together to find a place to talk in the meal room. As she walks her back is bowed and we make slow progress. Nia spends only a short time talking to me. Her ideas are disjointed and it is difficult to start a conversation or keep her talking. After only six minutes she indicates that she has no more to tell me about her escape.

Nia says she remembers the time that she escaped but when she speaks it is hard to piece the story together. Her story is therefore supplemented by information that is as given to me by a nurse who was on duty when Nia escaped.

On the evening of her escape, Hari, a man known only to Nia, is sitting beside her and he tells her to go away and to leave him and stop following him. If she does not do what Hari says he will slaughter her and before she escapes she is frightened by him. In fact, Hari is in her room now - in the corner looking for cigarette stubs.

I cannot see Hari and so I ask Nia if Kiki (the roommate who has just entered the meal room) is Hari. Nia says that this person is Hari. But this person is a woman and Hari is a man's name – Nia insists that this is Hari.

When she escapes, the nurses are busy and Nia leaves without catching their attention. During the interview, she tells me about thieves in her village and the fact that she cannot go to university – Nia would like to study. She also says that she wants to go home to help her mother and on the way home she feels happy. But her mother has nothing at home. She does not even have vegetables. Nia is happy if she can help her mother. She is happier at home.

On the way home Nia meets a nurse and comes back to the hospital. She is a 'little happy' to be back but would be happier at home. Nia escapes a second time a month after this interview but it is not possible to talk with her again.

Rara, a new nurse, is on duty when Nia ran away. She explains that it is a very busy shift. She does remember now that Nia refused to be examined by the doctor on the day before her escape. Otherwise there were no clues that she would escape. Rara had not heard Nia express any desire to see her family. Indeed, she believes that Nia is too weak to run away. It appears that Rara thought that Nia was physically weak as Nia moved and did everything slowly. There is no information from her medical record that Nia has a specific physical problem. Rara speaks to Nia on her return and now realizes that she wants to go home to see her family.

6.2.4 Inung – A fruitless journey

Inung is a 23 year old man. He escaped once before this story begins, but was not interviewed at that time. In this story, however, he explains both of his escape experiences. His first escape was about six weeks after admission.

During our conversation, Inung looks relaxed and speaks clearly. Before I start to interview him, I ask him whether he minds being interviewed in the students' room. He asks me to sit down outside the room, so then we walk out and sit down in front of the room, which is on a footpath.

Inung escapes because he wants to see his parents. He misses them as he has

not been visited for a long time. Before he escapes, he just takes a walk, and then he wants to escape. At this time, he thinks that he is recovered from his illness but the doctor says that he has not recovered yet. Inung's family has a similar opinion. He says that after his escapes he was in a 'holiday program' at home for three days. He then tells me that after three days, his family brings him back to hospital. At this time, he thought that he was coming to hospital for an outpatient appointment only; he does not expect to be hospitalized. But then he has to stay in hospital.

A further time he escapes together with his friend. He is in a healthy condition at home, and as he says that there is no difference whether he is at home or in hospital as he takes his drugs regularly at home. After that he starts to tell me that when he is at home, there are many people who hit him continuously when they meet him. The people who hit him are his friends. They hit him because he refuses to drink liquor. Consequently, his mother brings him back to hospital to avoid him from being hit by other people.

Inung has a sense of humor and he and I both laugh when he says that he is naughty to have escaped twice. *However, his family brings him back to hospital every time he escapes. He says it is fruitless to escape.*

Inung seems enthusiastic when he tells me that he feels happy when he escapes. *It is such a feeling of freedom from the prison.* But then he looks gloomy when he talks about his sadness on returning to hospital. *Honestly, he does not want to return, he prefers to be at home. He feels that he does not want to be in hospital anymore, he is afraid of the devil. He says those patients who are screaming or speaking to themselves are devils.*

Inung's assumption that he has already recovered makes him sad as he still has to be hospitalized. I then ask him what being 'recovered' means. *He says that to be recovered means being quiet, not speaking a lot, obeying the doctor's instruction, helping the doctor to mop the floor, wash the dishes, take*

linen to the laundry unit, do sport, and eat. I then ask whether he has got permission from the doctor to go home. Inung replies that he has not met the doctor yet. He tells me that he will not escape anymore; he wants his family pick him up and believes that he only needs to wait for one month, although it is not clear why it is for this exact period of time.

6.3 The Themes of the Experience of Escaping

This discussion now moves to the themes derived from the interview data. These are; 'The call to 'home'', 'Hopes and realities', and 'Us and them'. An outline of the themes and sub-themes is provided below.

Table 6.1 Themes and sub-themes of the experience of escaping

Themes	Sub themes
The call to 'home'	Wanting to re-connect with others
	Wanting to feel safe
Hopes and realities	Hopes for a happier life
	Realities of life
Us and Them	The differences
	The consequences

6.3.1 The call to 'home'

The call to home was a strong theme that emerged during our conversations. Most patients mentioned 'home' as their central concern regarding their escaping experiences. The call to 'home' then, was a sense of needing to escape in order to attend to 'calls' that came from both within themselves, and in some cases, from the needs of their family.

Escaping seemed to be the last alternative patients had to reach home, as some patients had already struggled to be discharged. Suno and Bayo for instance, tried to send letters to their families in an effort to be picked up. Padi believed that if his family wanted him, they would pick him up. But no one came to bring them home. As Suno said:

… it was nine days ago that I told them to pick me up soon … yes [they] in fact they have not visited or picked me up.
… niku sangang dinten kepungkur kulo kan pon ngomong ken ndang methuk … nggih malah ra ditiliki ra dipethok malah ra ditiliki barang (Rec 78p/107-109).

"Home" had a strong magnetism for patients who escaped from hospital. No matter how hard it was to reach home or whether or not they were in better or worse mental condition, the call to home seemed to override other considerations. Ari, said that he felt it was impossible for him to reach his house because his feet were hot (he did not wear sandals). Wiwid escaped from the hospital, but was confused about where his house was:

Wiwid: Yes yes, wanted to go home but where is my house …?
Iya iya pengen maunya pengen pulang tapi rumahnya di mana itu saya
I: Where is your house
Rumahnya dimana
Wiwid: I am from [name of area] far away
Saya [nama daerah] (Rec 44p/58-60).

Padi, who escaped because of auditory hallucinations he was having, said they *"Whisper - want to go home, want to go home …" "Bisikan mau pulang, mau pulang …"(Rec 87p/6-7).*

'Home' therefore had many meanings for these patients. It was imagined to be a perfect, or at least better than in reality; a place where they could re-connect with their family, friends, or others, and where they felt they would be safe.

6.3.1.1 Wanting to re-connect with others

For these patients, wanting to re-connect emotionally and physically with their family included the feeling of wanting to have a relationship, just as a 'human being' should. It included feelings of missing their family and concerns about

family circumstances, and even for simple things, such as one patient, who just wanted to inform his family that he had already recovered and needed to be picked up.

As Wiwid said, human beings who have a balance in life need to have a relationship with other people:

> *… as a human being whatchamacallit … has balance like (mix) with friends or something else it, should be like that.*
> *… kan sebagai manusia yang opo jenenge … punya keseimbangan ya bergaul sama teman atau apa itu kan seharusnya kan gitu (Rec 44p/55-58).*

The desire to see close family members who they loved was a powerful need for most patients. As Padi said:

> *…[I] miss parents, [my] father mother, miss all younger brothers and sisters family family including aunties, including my uncles ….*
> *… kangen orang tua, sama bapak ibu, adek semuanya kangen keluarga sak mbokde mbokde sak pakde pakde kulo … (Rec 87p/7-9).*

This need for connection helps explain why any stimuli related to 'home' triggered these patients to escape. For example, Noto escaped because he was not being chosen for the dropping program (he had already been in hospital for 10 months). Most patients also missed special events with their family, which included the fasting months in Ramadan. Tian, Koko, Padi and Suno expressed their desire to be at home for the fasting month. They did not want to miss this event with their family, especially because Ramadan and the celebration at the end of Ramadan takes place only once a year. As Koko said, with much feeling, *"I miss fasting …" "Aku kangennya sama puasa itu …" (Rec 40p/79).*

Concern about their family's particular circumstances was another reason why patients were eager to re-connect with them. Tian's first escaping experience, for instance, was because he was concerned about his son who would soon be circumcised: *"Because the plan was for my son's circumcision" "Karena rencananya mau supitan anak saya" (Rec 26p/20).* The concern about his family remained when he escaped the second time. This time, he was concerned about his father who was getting older, and his wife who had to live in a stable. Inang too was concerned about his mother who was sick, " … *because my mother was ill, so I visited her there the house there". " … ibu saya kan sakit lha saya menengok di sana menengok ke rumah sana" (Rec 58p/2-3).*

For a few patients, escaping was the only way they could contact their family if the family had not responded to their letters or could not be contacted by phone. In fact, these patients had not intended so much to escape as to make contact with their family. As Bakri said:

> *Actually, I will contact (my son) at home so then (he) can pick me up soon …. Sejatosipun kulo ajeng hubungan teng wangsul kulo supados ndang dijemput maksude … (Rec 24p/31-33).*
>
> *… (I) did not intend to escape.*
> *… maksude mboten kok ajeng mlayu (Rec 24p/46).*

6.3.1.2 Wanting to feel safe

Another aspect of the call to home for some patients related to their sense of insecurity while in hospital. The words 'holy sacred', 'devil', and 'afraid' were mentioned quite frequently. Escaping the hospital in order to reach home seemed in part to be an effort to find a feeling of safety which had been lacking in hospital. As Koko said: " … *The ward was eerie" " … bangsalnya angker"* (Rec 40p/72-73). In saying this, Koko, along with other patients, referred to the hospital as being a haunted place. Not only the ward made patients feel unsafe, but also other people in the ward made them feel insecure. Inung wanted to go

home as he was afraid of many devils in hospital. In this instance, 'devil' for him meant other patients ('crazy people') who were screaming or speaking a lot.

Inung said of his experience in hospital,

> *I do not want to be in [name of area-hospital] afraid of devil there are a lots of devils Miss, people who are crazy are devil….*
> *Ndak pengen sudah kapok di [nama daerah-rumah sakit] takut (Rec 88p/83) Sama setan setannya banyak mbak orang yang masih gila itu setan … (Rec 88p/84-85).*

Feeling afraid and wanting to go home was also experienced by Nia just before she escaped. She was scared of her hallucinations as they threatened her by saying: *"[you] will be slaughtered" "arep tak beleh ngonten"* (Rec 57p/23-24).

6.3.2 Hopes and realities

In escaping from hospital, patients also talked of hopes they had which were all linked in some way to their hope to be happy. The word 'happy' is used here because this word was used by patients themselves. Although 'happy' can have many meanings in the Indonesian language, in this context it seemed patients were using it to describe their desire to be happy considering where they were at the moment. The word 'happy' was just an indicator that they were not completely grounded and as they said, [I] *"just wanted to be happy"*.

The patients' hopes for happiness and all issues that related to being happy can be considered those that we all might have as human beings. In particular, their hope to be happy related to fulfilling their role in their family, for example Nia said "*I wanted to go home to help mother" "Ajeng mantuk mbantu ibu" (Rec 57p/54).*

However, some hopes were dashed by the realities of their lives at home and in hospital. These realities included the hope to be happy at home being dashed as they failed to reach home, or not feeling happy when they did finally get there.

6.3.2.1 Hopes for a happier life

As mentioned, through their escaping patients had hopes for a happier life. Many of them had experienced an unhappy life in hospital. Escaping was seen by them as one of the ways to be free from hospital. They thought it might be possible to feel happier if they were able to leave and go home.

Wanting to be happy was mentioned by a number of patients, for example Nia said that she felt happier at home. She felt only *"A little happy" "Remen sekedek*" (Rec 57p/60) in hospital. Inung said he felt sad in hospital and felt happier at home. As he said *" …[I am] happy at home"" … seneng di rumah" (Rec 88p98).*

Some particular circumstances in hospital had created unhappiness for patients. Jito, for example, had his food stolen by another patient. Hadi had a problem with an officer in the ward, *" … they (officers) said that they wanted to take (me) home -just lie, the officer just lied …"" …muni di terke ming ngapusi ngono petugase ming muni ming ngapusi ngenten niku …" (Rec 33p/27-28).*

Wiwid showed his unhappiness in hospital because he felt he did almost nothing there except for sleeping, eating and taking medicine every day. As he said

> *Yes, my feelings, why I only eat, sleep, take a medicine every day, why only do like that …?*
> *Ya memang perasaan saya selama ini kok di rumah sakit aja kerjanya cuman makan tidur, minum obat tiap hari masak melulu gitu terus … (Rec 44p/53-55).*

These meaningless activities in hospital seemed to cause feelings of boredom and fatigue in hospital, as mentioned by Tian " … *actually I am bored" " … saya sudah bosan sebenarnya" (Rec 39p/37).* Jito agrees, *" … yes I am already I am already tired of being in hospital"" … ho oh ngonten saya sudah saya sudah lelah di di rumah sakit" (Rec 84p/50-51).*

Hopes to have a different life that might give them happiness also seemed to get stronger as their mental status improved. Patients, who were not unwell at the time of escape, said they felt better and had permission to go home. Feelings like "*I do not belong here"*, and that "*I have stayed in hospital for a long time"* were also triggers for them to leave and try to find happiness in their life. As Bakri said, *" … actually I already had permission to go home …""…dadosipun kulo niku pun angsal wangsul …" (Rec 24p/52-53).*

For some patients, happiness was associated with the feeling of freedom in their escape. They felt unhappy in hospital as they experienced the hospital atmosphere using terms such as "*felt in prison*", "*always locked", "not felt free", "too tight in the ward*", "*and locked in isolation like an animal"*. Freedom as a source of happiness was also described by Hadi as; *"Happy at home … do everything I like (freely)" "Seneng teng ngomah … nopo nopo bebas" (Rec 33p/67-68).*

While many of these hopes for happiness were eventually dashed, some of the patients' hopes were met. Tian for instance, hoped that he could accompany his father who was getting older. Just after he escaped, he was able to meet his father and have time chatting and spending time with him just before his father passed away. He seemed to feel satisfaction at being able to be a son to his dying father.

However, as noted, most of the patients' hopes were dashed, and in the reality of both home and hospital they had to face the fact that their hopes for happiness might not come true.

6.3.2.2 Realities of life

The hope that being at home would make them feels happier than being in hospital was unfortunately dashed for most patients. Nine of the patients interviewed failed to reach home because nurses caught them or people did not want to help them to reach home. Padi expressed his disappointment that people on the way home were unwilling to help him to get there. As he said *"People Mrs … yes they did not want to help" "Uwong uwong bu … nggih do emoh nulung" (Rec 87/24-25).*

As a consequence of not being able to get home, patients had to return to their unhappy hospital life, which included doing almost nothing, or being put in the locked room after being caught, as described by Padi; *" … unhappy … was put in cage …" " … susah … di kurung niku"* (Rec 87p/116-117).

Unfortunately, six patients who successfully reached home also did not get their hopes to have a happier life met even when they got there. Koko expressed it this way: "*Happy [at home] happy, now not happy anymore … because since the while ago only like that, nothing changes …" "Seneng seneng, sekarang sudah nggak seneng lagi … sebabnya dari dulu cuman gitu aja gak ada perubahan …" (Rec 40p/88-91).*

So, patients often did not feel happy in hospital but they also did not feel at home in their 'own home'. Bayo for instance still could not live happily at home. He felt even more confused there than in hospital. During his escape he lived alone and was like a street walker in his house. He described it like this:

> *Yes I myself, I , I myself am still confused … yes until…[pause] … like a street walker but a street walker at home, asked the neighbour for food, drink, never do anything until at home in [the name of area] I threw mattress to the well.*
> *Ya saya sendiri saya saya sendiri itu bingung masihan … ya sa sampe… pause ... seperti gelandangan tapi gelandangan di rumah itu*

loh, minta tetangga makan, minum itu, tidak pernah ngerjain apa apa sampe … dirumah [nama daerah] itu kasur itu saya masukkan sumur (Rec 80p/136-141).

In contrast to their hopes for being happier with their family, the families attitudes toward patients was also a source of sorrow to them. Six patients who successfully reached home felt that their family rejected them when they got there. Tian who escaped many times admitted that he felt like a foreigner when he was at home: *"Frankly, my wife is an ordinary person, and at home I was not respected Mrs, like I am a stranger …" "Istri saya itu terus terang dianya orang awam dan saya itu kalau di rumah nggak ditanggapi kok mbak seperti orang asing itu … " (Rec 39p/70-72).*

Inung had a particularly unpleasant experience when he arrived home as he was hit by people he had considered friends:

… [I] did not know why Mrs, all of a sudden someone was looking for me and hit me everyday hitting [me] [I] did not know if [they] had a grudge or what
… ndak tahu kenapa mbak tiba tiba ada orang sedang nyari saya mukulin setiap hari saya mukulin nggak tahu dendam atau kenapa itu (Rec 88p/27-29).

Families also seemed to reject patients by treating them unkindly or just sending them back to hospital. Inung explained that he felt his escape was fruitless because his family sent him back straight away to hospital, "*Family brought [me] here again seriously Mrs, useless to escape" "Sama keluarga dianter lagi ke sini parah e mbak, percuma larinya" (Rec 88p/57-58).* Other family members treated patients more kindly, but even so, they often still rejected them. Inung's family for instance let him stay in his house two days after he escaped. But then his father persuaded him to return to hospital by

promising that Inang would be bought a golden ring if he wanted to go back to hospital:

> *Yes ha I would be bought a ring yes … [my] father, [said] tomorrow you go back to [hospital] I will buy you a ring.*
> *Nggih ha kulo ajeng ditukokne cincin ngentene … bapak, sok kowe ndono tak tukokke cincin (Rec 58p/79-81).*

However, as seemed to be the case for a number of patients and their families, while his family may have sent him back to hospital to give him the opportunity to receive treatment, this was unfortunately not in keeping with Inang's goal to be at home. This was a further reality of the patients' experience of escaping.

6.3.3 Us and them

Throughout our conversations, it was also apparent that each patient, health professional, family and even community had their own priorities or interests with respect to the care and hospitalization of the patient. Unfortunately, patients, who were not in a position of power in these differences in views/opinions, felt like the 'underdog' as they could not make their own choices. These differences, the 'Us' and 'Them' between the patients and others, included whether or not they had a mental illness, whether they should stay in hospital, and whether or not they had recovered from their illness. Therefore, the differing views and opinions of each party created not only a conflict between the patient and those person/s but also created negative feelings for the patients such as confusion, disappointment, unpleasantness or frustration. This was because tension between their and others' opinions influenced what decisions the patient was or wasn't able to make about life.

6.3.3.1 The differences

A particularly strong difference of opinion with others concerned whether or not the patient had a mental illness. Tian said that people around him thought that he was crazy even though he thought he was not. He had to struggle to

confirm with people that he was not 'crazy'. As he said " … *they said I was crazy, but since the beginning, I was not crazy, I was normal … "*" … *katanya saya itu edan tapi saya sejak pertama kali justru saya tidak edan saya normal … " (Rec 39p/45-46).*

The difference in opinion between patients and health professionals can be seen also in Bakri's and Inung's experience. Although Bakri was admitted for an acute episode of psychosis, he stated that he went to hospital just to find help for his leg which was hurt; *"[I] only need one week [stay] here [in hospital] … I only came here for my leg wound" "Wong kulo jarak setunggal minggu mawon … kulo kan riyen namung ngaturke le niki luka" (Rec 24p/51, 54)*. Inung said he was brought to hospital because he had too much magic, *" … I have too much magic Mrs … so much magic, I am possessed [by the devil spirit]"" … saya kebanyakan ilmu mbak … kebanyakan ilmunya kesurupan" (Rec 88p/125-129).* He had, however, been brought to the hospital because he had schizophrenia.

A further difference between the patients and others were conflicting opinions about their hospitalization. This included differences of opinion with their family as well as health professionals. Issues related to hospitalization included the reasons for hospitalization, the dropping program, the treatment as a consequence of escaping, and which patients were considered to deserve a healthy card.

Most patients questioned why they had to be hospitalized. It seemed to them that there was often no reasonable reason for them to stay in hospital. For instance, Tian thought that he did not need to be hospitalized to take medication; he preferred to get medicine from a small health centre service nearby his home. As he said:

Well, what I wanted was no need to come back here [hospital], about the medicine there is also medicine there [at the medical centre near his house].

Ya kalau karep saya itu nggak usah kembali ke sini masalah obat di rumah sakit sana jug juga ada obatnya (Rec 39p/481-483).

However, he had to be hospitalized as his brother wanted to bring him to hospital to take his medication after he escaped. The families of other patients also showed their intention to keep the patient in hospital. As Padi said: *" … I wanted to be at home, but my father wanted me to stay here … " " … teng ngomah karep kulo tur karepe bapak ben neng kene sikek …" (Rec 87p/125-126).*

The differing opinions about hospitalization between the patients and doctors is succinctly described by Tian, who stated that he wanted to go home but the doctor said that he needed a rest in a hospital, without adding how long he would need to stay in hospital for this 'rest'. As Tian said: *" … It is like that but the doctor said rest here for a little while like that [he] said … "" … udah gitu tapi dokter nya ya kamu istirahat disini sebentar aja gitu katanya …" (Rec 39p/38-39).*

Conflicting opinions were also evident about issues to do with staying in hospital. These differences included whether or not the patient should be in the dropping program, and the consequence of their escaping from hospital. Noto, for instance, revealed his disappointment when an officer in the hospital did not choose him to follow the dropping program. After his escape, Suno struggled not to be put in a locked room: *" … [they-nurse] wanted me to sleep [stay] in the west room [locked room] but I did not want to … [I] swore that I would not escape anymore"" … Nggih pun biasa maleh karepe ajeng ken tilem teng kilen niku neng kulo mboten purun … sumpah wani sumpah nek mboten ajeng mlajar maleh" (Rec 78p/57-61).*

Another major difference in view/opinion between patients and family members was about who deserved to get a healthy card. As Bayo said:*" … He thought I was wealthy in fact I am not … " " … Dianggap opo ya saya orang mampu dianggap mampu padahal saya nggak mampu … " (Rec 80p/69-73).*

A final issue which had generated much conflict between the patients and others was whether or not the patients were considered to have recovered from their illness. From the patients' perspective, 'recovery' was understood in varying ways, many of which did not necessarily comply with those of others, including family and health professionals. Inung for instance, clearly stated that the doctor thought he had not recovered from his mental illness. However, he thought he had: *" … [I] escaped as I thought that I had already recovered but had not recovered yet as doctor said … " " … lari kan udah pikiran saya sudah sembuh tapi ternyata belum sembuh kata dokter … " (Rec 88p/66-67).*

He then explained his understanding of recovery to be:

> *[patient who are recovered] are quiet, not talkative anymore, obey the doctors, able to help the doctor, mopping by himself, washing dishes by himself and then taking [laundry] to the laundry room, exercise, eat.*
> *Sembuh tahu yang diem sudah nggak cerewet lagi manut sama dokter bisa mbantuin dokter ngepel sendiri cuci cuci piring sendiri trus tugasi ngantar ke laundry, olah raga, makan (Rec 88p/89-92).*

Bayo though, thought that only God that could make him recover. He said that *" … Only God who who who who want who can who can make me as before" " … Cuma tuhan yang yang yang yang mau yang bisa yang bisa mengembalikan seperti semula itu" (Rec 80p/281-283).* He disagreed with other people such as his family who thought that his recovery depended on Bayo himself.

Some patients felt they had already recovered. Tian, for instance, had explained to his wife that he was recovered. He tried to prove to her that he had already recovered and said he wanted to build a house for his family, but his wife still insisted that he was sick:

> *… and in the evening I have spoken bluntly, yes I actually have recovered, but my wife thought I have not recovered, is like that, if I have not recoverd yet why would I want to build a house? That's how it is ….*
> *… saya … sudah bicara blak blakan gitu aku ki jane wis mari ning nek kepahamane istri saya itu belum sembuh gitu katanya lha, kalau belum sembuh kok mau buat rumah itu gimana gitu itu loh … (Rec 39p/288-291).*

Tian's brother also denied that Tian had recovered as his brother said that he would not recover if he did not take medicine while in hospital, *"Well he said you if you were not take medicine there [hospital] you wil not recovery that's, my brother said" "Ha katanya kowe ki nek ora ngombe obat neng kono hurung mari ngonten loh katanya ka kakak saya" (Rec 39p/360-362).*

6.3.3.2 The consequences

The disconnection between 'Us and them' over these many differences seemed to create a barrier to the patient's development and growth during hospitalization. The conflict between them and others also created negative feelings in the patients. Tian felt confused about this disconnection, and said, *" … I was confused I wanted to go home from here not allowed, wanted to organize family not allowed, what should I do I was confused … " " … saya malah bingung to mau pulang dari sini nggak boleh, mau ngatur keluarga ya nggak boleh ha saya harus gimana saya bingung … " (Rec 39p/382-385).*

Padi too, revealed the negative feelings he had about a nurse's attitude to him after he escaped. As he said, " … *I could not accept it, [I] was hit here (pointing to his neck) what about if hit him too, how about that" " … ha kulo*

mboten trimo diantel teng mriki njajal nek wonge kulo antem genti pripun ngonten lho" (Rec 87p/48-49).

The tension between their own and others' opinions about their recovery status also led to confusion for the patients. In this respect, Wiwid acknowledged that he was confused about the meaning of recovery. He said:

> *What exactly is called recovery, I do not really know, recovery according to the doctors opinion, or recovery according to society's opinion. I have to freely associate with society or how or am I recovery according to the doctor's opinion, is it doctor's rules?.*
> *Sebetulnya itu sembuh yang gimana itu saya ya kurang tahu sembuh menurut masyarakat apa sembuh menurut dokter sembuh menurut ma masyarakat saya harus bergaul bebas dengan masyarakat begitu atau gimana apa saya sem sembuh menurut dokter aturan dokter itu?* (Rec 44p/91-96).

Jito was equally confused:

> *I confused Mrs, … my family how I can be recovered … so then I have to be recovered like what because I have already recovered ….*
> *Aku ki ngangsi bingung bu, … keluarga ku ki piye men aku ki iso mari … ki le njut aku kon le mari ngasi ko ngopo ngono loh wong aku ki saiki wis mari … (Rec 84p/186-188).*

These different perspectives appeared to create feelings of frustration for patients. Tian said that the doctor did not accept his opinion that he had already recovered and this circumstance made him feel confused and frustrated, *"If the doctor also did not want to accept my statement that that I have recovered … " "Kalo dokter juga tidak mau menerima ucapan saya kalau saya sudah sembuh … "(Rec 39p/33-34).* Unfortunately, for many patients, their overall feeling as

a result of their experiences of escaping from hospital was that they were left with a sense of ‘no place to go’.

In conclusion, these patients’ experiences of escaping from a psychiatric setting included a call to ‘home’, their hopes and subsequent realities, and the tensions and differences of opinion around illness, hospitalization, and recovery between them and others. The following section will be the pattern matching between these and previous findings and ends with a discussion of the major new findings in this study.

6.4 Pattern Matching

Although this study was conducted in a different cultural and psychiatric service context from those of the West, there were some similarities in findings between these patients’ experiences and those of other studies. These are outlined in the pattern matching below.

Table 6.2 Pattern matching

No *	Literature from the West	Finding in the present study	Note
2	That in some instances patients may give overt signals that they intend leaving (e.g., say they are going, put on outdoor clothing).	Some patients showed clues before absconding such as changing clothes, using pretending behavior and loitering.	√
3	There is no one typical profile of patients who abscond, they may be relatively fit or on the other hand in a state of psychosis.	Most patients were well in terms of their mental status when they absconded. This was characterized by feelings of normalcy, and ability to perform routine activities in the ward.	X
12	People who absconded return to the ward for a variety of reasons: feeling cold, hungry, unwell and in need of medication and treatment for medication side effects.	Patients returned to ward for different reasons, for example they did not know where to go, they were caught by nurse or because their family wanted them to return to hospital.	X
14	The majority of patients who abscond go home after absconding.	The majority of patients wanted to go home but they were caught by nurses.	-
16	The absconding mostly causes no harm to self or others.	The majority of patients who absconded recorded no harm to self or others after they absconded.	√
19	Patients who abscond return to the ward mostly on their own or with police or hospital staff.	The majority of patientse who absconded were returned to the ward by hospital staff (caught by staff).	√
20	The most common situation for the patient to abscond is when the ward is open.	The majority of patients absconded when the ward was open.	√
21	The most common patient reaction to being back to the ward is anger or unhappiness.	The majority of patients felt unhappy/sad when they returned to hospital.	X √
23	There is no single reason for absconding; however, the reasons can be divided into: 'Unpleasant hospital life': anger with staff, food, ward, being disturbed by other patients , feeling trapped, stigma, reason to be hospitalized, delay to discharge. Concern for home: feeling cut off from relatives and friends, home, household responsibility. Abnormal belief or experience. Due to others: the desire to carry out some activity outside the hospital, reward for absconding.	Mostly the reasons for absconding were wanting to re-connect with others, wanting to feel safe, and hopes for a happier life.	√

.

6.5 Discussion

Discussion in this section, therefore, focuses on the new findings generated from this study, many of which relate to the specific and unique context within which these patients had escaped.

One issue of note in this study is that in contrast to what may be argued as the generally negative construct of absconding in the literature, the patients' escape from hospital can be seen to contain a number of positive or functional aspects. In this study, patients' escaping was often an indication that they were in the recovery process. As evident in many of their comments, patients often took the initiative and showed self-determination in seeking to fulfil some of their hopes through the act of escaping/absconding as a way out of their current dilemma.

Certainly, a consistent issue evident throughout much of the accounts given by patients was that of recovery. Various aspects relating to 'recovery' in the present study are threaded through all the themes, particularly the last theme, 'Us and them' which describes recovery from patients' perspectives. Certainly, it seems the disconnection between these patients and others may be considered a factor that hampered their process of recovering from their episodes of mental illness.

'Us and them' also raises the issue of what 'recovery' is, and who has the right to determine whether the patient has 'recovered'. Recovery is a term that is understood in various ways, and so it is perhaps not surprising to find that there were differing views in this study as to what constitutes recovery when a person has mental illness. Patients' subjective experience of mental illness and psychosis is important here in terms of attempting to reach a definition of the meanings of recovery. Schiff, a consumer-survivor (2004), explains that:

> To me, being recovered means feeling at peace, being happy, feeling comfortable in the world and with others, and feeling hope for the future. It involves drawing on all my negative experiences to make me

> a better person. It means not being afraid of who I am and what I feel. It is about being able to take positive risks in life. It means not being afraid to live in the present. It is about knowing and being able to be who I am (p. 215).

Schiff (2004), however, explains recovery as it might be understood from a Western perspective, and this is considerably different in many respects from that of the participants in the present study. Congruent with the somewhat more limited treatment and contextual circumstances of their hospitalization, patients in the present study saw recovery in terms of behaving in ways that made them acceptable to others (e.g., performing daily activities and household chores and being compliant with treatment). They also considered themselves to be 'recovered' if they were able to perform their usual roles within their family and community. This may be seen as reflecting what Bellack (2006) describes as a notion of recovery based on a medical model/scientific perspective which focuses on the patients' outcomes from their illness, in contrast to recovery as a process that takes place over time.

In terms of outcome, Stuart (2005, p. 72) advocate for "recovery" as the goal of treatment in the 'maintenance' stage of rehabilitation from mental illness. In this phase, attention to connections with others and respect for subjective experience are combined with activities designed to facilitate patients' ability to self-care and function within their community. In these ways, both process and outcome can be attended to, so that patients such as those in the present study can feel that their perspectives are understood by health professionals, while also being helped to build relationships and structures that will assist them in functioning effectively in their daily life.

The differing views as to what constitutes recovery which is evident in 'Us and them' may also be seen as relating to the lack of involvement in the recovery process these patients have in this setting. If people with mental illness are to recover, it is important they are able to participate in the mental health service (Connor, 1999), and work 'side by side' with health professionals, rather than simply being subject to their directions (Fekete, 2004). In order, therefore, for

these patients to feel they are recovering well, they would need to be viewed by health professionals not as passive objects of treatment, but active agents in their own recovery.

The importance of respectful and warm relationships between these patients and health professionals and family is highlighted in 'The call to home'. The need for re-connection with family and home for instance, can be seen as part of the recovery process when a person has mental illness. As Forchuk et al. (2003) also found, recovery from psychosis is a process that can start with improvements in thinking and feeling, and extend to a series of reconnections in relationships with the person's environment. These reconnections often include those with staff and family. Although 'The call to home' is not a theme in other studies on absconding, patients' relationships and need for support has also been found by Granerud and Severinsson (2006). Their study concluded that people with mental illness consider social integration – the need to connect with family, to belong and integrate back into the community after being hospitalized – to be a vital factor in their successful transition from hospital to home. As with the current study, however, it can also be a need that is difficult for health professionals to fulfil.

In terms of recovery and the experience of absconding, a further fresh finding was the many hopes expressed by these participants. In this study, hope appeared to indicate that patients had started the journey of recovery, as it can be considered a critical factor in the recovery process (Adams & Partee, 1998). Pepper (2002) explains that hope is one of the internal resources the person has that they can use to promote recovery for themselves. Schiff (2004) also argues that feeling hope for the future is part of recovery. It appears that one of the main factors precipitating absconding for participants in this study was their hope for a better future. However, it is apparent in both this study and the literature that hope on its own is not enough for successful recovery, as there are many other internal factors (acceptance, responsibility, spirituality, coping skills) and external factors (social support, meaningful activity, medication,

professional assistance) that are needed (Pepper, 2002). Again, many of these factors were absent for these participants and so, as many of them identified, their ability to 'recover' was impaired.

In 'Us and them', the conflicts patients experienced with others was not evident in previous studies related to the absconding experience. However, the term 'Us and them' has been used by Fekete (2004), who has written on his own recovery experience, where he acknowledges that there can be a schism or lack of understanding between the 'Us' of the client and the 'Them' of the health professional.

One issue that contributed to these differences between the patients in this study and others, including family and health professionals, was the patients' awareness, or lack, of their illness state. This was a contributing factor to misunderstandings about their illness and treatment. Lack of patient awareness/insight into their illness is an issue often cited in the literature. However, as Munetz and Frese (2001) explain, most people with mental illness do come to acknowledge their illness over time and particularly after treatment, although there are some individuals, who, even after achieving remission of an acute or chronic psychotic episode still do not appreciate being ill or having been ill. Amador & Paul (2000) suggests that health professionals need to understand that in some cases, patients with schizophrenia who have a lack of awareness or 'poor insight' may be understood as having a neurological deficit related to the disorder which is characterized by a lack of awareness of their illness. This re-constructed understanding of 'lack of awareness' may assist health professionals to understand these patients' behaviours differently and so reduce conflict with them about whether or not they have an illness.

Further, in part, patients' lack of awareness can also be seen as resulting from a lack of information regarding their illness and treatment, which Connor (1999) describes as patients/consumers often being 'information poor'. Certainly, it appears that participants in this study struggled to gain information about their

illness and showed limited understanding of their treatment, which was primarily medication-based. Patients also demonstrated a lack of understanding regarding mental illness in general, and this seems to have contributed to their stigmatization of both themselves and other patients, described by Fekete (2004) as 'internalised stigma'. Families in this study also showed a lack of understanding and knowledge concerning the patients' illness and recovery needs. Therefore, this finding is important in terms of recognizing the need for psychoeducation for both patients and their families. Psychoeducational strategies have been recognized as a treatment of choice for major mental illness for a number of decades (McFarlane, Kixon, Lukens, & Lucksted, 2003), addressing stigma and the social isolation of clients and families with a range of strategies which aim to improve their knowledge and understanding, coping, problem-solving and communication skills (Reid, Lloyd, & de Groot, 2005).

The theme 'Us and them' also highlights the length of hospitalization of patients in the current study, and is a further key finding. In this setting, patients were hospitalized for an average of 26 days (in 2006), as compared with many Western psychiatric settings, where the average length of stay is about 6 days for treatment in acute care psychiatric hospital (Maree, 2005). This concurs with the finding by Meehan et al. (1999) that patients who abscond often have longer lengths of stay. It was evident from these patients' experiences that some of them had been kept in hospital for far longer than necessary, and they were in fact mentally well at the time of escape. As noted earlier in the discussion, for these patients, absconding could be viewed as a functional way of managing what had become an unnecessary imprisonment which offered little benefit to them.

Finally, it needs to be recognized that for most patients the process of recovery from mental illness evolves beyond hospitalization and continues over a period of time when they return to the community (Sundeen, 2005). However, as shown in this study, the recovery of these patients was not supported by their

families nor mental health services in the community. In particular, social support for patients was clearly inadequate, although it is an important external resource to promote recovery .

In part then, the differences between patients, their family and health professionals could be predicted as the result of an inadequate mental healthcare system and lack of community mental health services and support for patients' recovery process. At present, when they are discharged, patients in Indonesia do not receive adequate follow up care or support from health professionals. In most cases they do not receive support from their families. However, it is important to acknowledge that their mental illness is occurring in a general context of poverty, lack of welfare support, and a widespread social prejudice against mental illness. It must also be recognised that lack of community and social support is not confined to Indonesia, as this is a factor that has also been found in studies in the West, in that social networks of people with schizophrenia are often very limited .

As identified, this lack of support for patients experiencing mental illness occurs in the context of widespread stigma toward mental illness. As Johnstone (2001) found, patients with mental illness are people who are "discriminated against, marginalized, disadvantaged and vulnerable members of society" (Johnstone, 2001, p. 200). As long as stigma remains, there will be the problem of harassment and victimization of people with mental illness in the community (Kelly & Mc Kenna, 1997), as experienced by some participants in this study.

In Indonesia, although there are '*puskesmas*' or 'community health centres' in each district, the priority focus of such centres is helping people with physical or general health. If people who come to this centre have a more severe mental illness then they will be referred to the hospital. Ideally, as Stuart (2005) suggests, these centres should also provide primary and secondary as well as tertiary prevention strategies.

In conclusion, the themes in the present study describe how these patients' recovery process is severely limited by a range of contextual factors. The vicious circles that may be seen in these findings mean that many patients in this setting remain disadvantaged in terms of their prospect of recovery, although there is potential for more positive outcomes if a range of educational and support strategies are implemented.

CHAPTER SEVEN

The purpose of this chapter is to draw the thesis to a conclusion by revisiting the research question and demonstrating that through a rigorous and systematic process the question has been addressed and answered. I will review the quality of the research process and relate the findings to contemporary mental health nursing and clinical research in Indonesia. This chapter will be divided into the following sections: research question revisited, summary of the research process and findings, the strengths and limitations of the study, recommendations and further research, and conclusion.

7.1 Research Question Revisited

The focus of concern in this study was the phenomenon of patients absconding from a psychiatric setting in Indonesia. It was shown in the literature review reported in Chapter Two that absconding from psychiatric settings is a problem that has been explored in the West. Several studies have been undertaken to determine the extent of the problem in a range of psychiatric institutions over discrete periods of time. While the evidence resonated with my experience as a psychiatric nurse in Indonesia I was aware of the great divide between my own country and the affluent West. It was evident that the culture and context of each setting has an influence on the number of absconding events and the reactions that nurses have towards the prevention and management of the phenomenon.

The aim of the study was to provide a profile of absconding over a period of one year in a psychiatric hospital in Indonesia that would provide a culturally sensitive understanding of the circumstances surrounding absconding. The study objectives were to:

- identify demographic patterns associated with all patients who abscond from one psychiatric hospital during a one-year period;

- describe the experience of patients and nurses related to incidents of absconding;
- identify the contextual factors that promote and obstruct absconding behaviour; and
- discuss the ways in which absconding events in this case differ or are similar to reports of absconding in the West.

The research question was: In what kind of circumstances does absconding occur in one psychiatric setting in Indonesia?

7.2 Research Process

The studies on absconding in the West showed a variety of research designs and varying standards of reporting. In all cases the researchers collected data from just one institution, so even though they do not stipulate that their work is a case study, it is possible to review the studies as such. In this study, a case study approach is applied to the research as this approach helps to explore in depth and detail an absconding event in context (Mariano, 2003). Furthermore, in a process of pattern matching it is possible to compare results with other case studies.

The work of Yin (2003) informed the case study methodology. Mixed methods (Creswell, 2003; Tashakkori, 2006) were used to ensure the study design included provision for a pluralistic view of the phenomenon collected through a concurrent triangulation design (Creswell et al., 2006). This is the first time both case study and mixed methods have been used in absconding research. The triangulation of data ensured that multiple perspectives were incorporated into this predominantly descriptive case study. Given that no research around this topic has been undertaken in Indonesia, a descriptive study is an appropriate way to begin to generate understandings of the particular circumstances surrounding absconding in Indonesia (Sandelowski, 2000).

A literature review of research related to absconding from psychiatric settings formed the starting point for this investigation in two ways: first, it established a need for contextual research in Indonesia with no preconceived theory; and secondly, it informed the protocol for the collection of objective data regarding patterns of absconding over a twelve-month period. A list of propositions developed from the accumulated research findings are detailed in Chapter Two and form the basis for the audit protocol. Data were collected from an audit of absconding events from April 2006 to April 2007. This data set contains objective details regarding the patients who absconded during the period. The study has both objective and subjective data which were used to describe and compare patterns of absconding with the evidence to date in the West. A short period of observation using event sampling was undertaken to collect information that provides for a description of the place from which patients absconded and the daily routines, behaviours and attitudes of professional staff. Lastly, semi-structured interviews were conducted with patients who returned after absconding and nurses who were on duty when these patients absconded.

7.3 Summary of Research Findings

In this study there are two main groups of patients who absconded. The majority group is comprised of patients who are either ready for discharge or in the rehabilitation phase of recovery, and the minority are patients still in a worse mental state. These groupings are based on the audit data that showed that most patients (93.23% n=106) absconded from the maintenance wards. The nurses in their interviews were adamant that the patients who abscond are usually ones that are preparing for discharge. Of the sixteen patients interviewed, thirteen were in rehabilitation or ready for discharge.

The minority group of patients in a worse mental state have more in common with the profile of patients who abscond from psychiatric settings in the West. The findings are summarised below and relate predominantly to the majority group. For the minority group who are in a worse mental state it is probably unsafe for them to leave the hospital unattended, and interventions that have

been shown to be successful in the West will be discussed in relation to the safe care of patients in Indonesia (Bowers et al., 2003; Conroy & Jorgensen, 1995; Richmond et al., 1991). The findings are summarised below under the following headings that correspond to the research question and sub-questions (circumstances, patterns and perspectives).

The research question was created to test the study propositions[7], while at the same time being open to the development of new understandings and findings of absconding events in context[8].

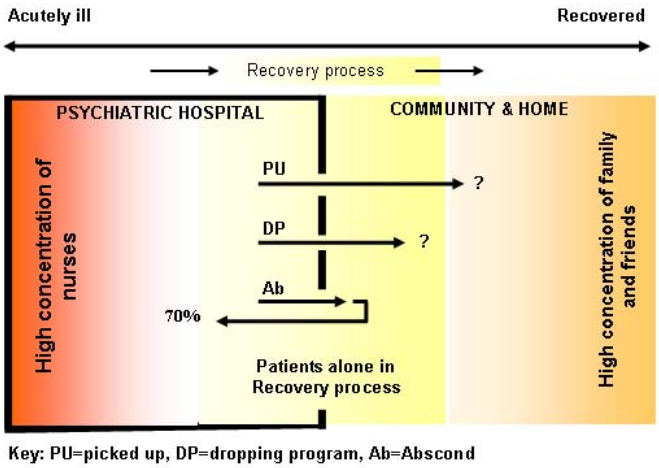
7.3.1 Circumstances related to absconding

The results of this study show that the absconding events occurred in circumstances where there are inadequate systems within existing psychiatric services to meet demonstrable patient and family needs. There are unmet needs for psychiatric services in both psychiatric setting (i.e., hospital) and in the community. In relation to absconding examined in this study services are inadequate for patients who are in the process of recovery.

Figure 7.1 depicts the boundary that divides the hospital and the community with an arrow at the top that show a continuum from worst mental state to complete recovery. The recovery phase in yellow spans the boundary between hospital and community and it is in this time that patients do not appear to be getting the support they need to recover from either professional psychiatric staff or family and community. There are three ways home: being picked up by family, the dropping program or absconding. The usual consequence of absconding is to return to the hospital.

[7] Deductive part of the study.
[8] Inductive part of the study.

Figure 7.1 Patient's recovery process



7.3.1.1 Psychiatric service in hospital/institution

The observation data, reported predominantly in Chapter Four, provided an overview of the structure, processes and atmosphere in the hospital. The nurses' work within a traditional hierarchy and according to norms and routines in a way that is primarily custodial rather than therapeutic. Protocols are relaxed for patients who are ready for rehabilitation, and it is relatively easy for these patients to walk around the hospital and even leave when they feel inclined. However, the wards are not designed for close observation of patients and nurses tend to spend time that is not taken up in direct care away from the patients. This means that patients who are in the locked rooms in the maintenance wards spend much of their time without an opportunity for engagement with professional staff.

Nursing duties in this hospital are directed at helping patients to do their activities of living independently in the hospital. Interactions between nurses and patients occurred predominantly when the nurses needed to do their routine tasks. The rehabilitation activity that is provided for patients is also concentrated on the resumption of working skills, for example use of job tools.

It appears that the psychiatric services do not accommodate the whole preparation that is needed by patients before they return to the community – by this I mean a range of communication and functional skills related to re-engaging in daily roles and relationship with others including family and in taking up a place within the community (Sundeen, 2005). Nurses appear not to recognize that living in hospital is different to living in the community, and as a result, the nursing support appears to be essential care only, until the patient is able to do their functional daily activities independently. The failure to appreciate the patients' psycho/social needs in the last stages of their stay in hospital means that valuable opportunities to help them integrate successfully into the community are lost.

Nurses acknowledge that most patients who abscond are in a better mental state and ready to go home, but they also complain that most families are not willing to come and pick patients up. The hospital responds to the accumulation of patients who are waiting to be picked up by its 'dropping program'. A limited number of patients are conveyed in hospital transport and deposited at home. These patients have no more preparation for discharge than those who abscond. However, at present there is no information that tells us whether patients fare differently in the community if they are picked up, abscond or are dropped off.

7.3.1.2 Psychiatric services in the community

As well as not being picked up by their family, the lack of community psychiatric services means that many patients are left in hospital beyond the time they feel they are at a stage of recovery and ready for discharge, and as a function of this they eventually decide to leave without permission. The resultant lack of community (including family) support and preparation for the patient's return home is also apparent in the cases where absconding patients do not get support at home from their family and community and are simply taken back to hospital. This happens due to a combination of factors: lack of financial, vocational rehabilitation, housing, and other psychosocial support for the patient and family, and poor attitudes and lack of knowledge about mental

illness by nurses, patients, family and community. This evidence comes from the accounts given by the nurses and patients. Indeed, there are instances where the patients either stigmatize themselves or their fellows' patients. More evidence is required regarding community and family attitudes to people with mental illness. From the nurses' general disapproval of the behaviour of families towards patients, it is clear that they do not appreciate the families' lack of understanding of psychiatric illness or the processes of recovery. The nurses have little understanding of the perspective of the families even though they do show signs of empathy for the patients.

7.3.2 Patterns of absconding

7.3.2.1 The patterns

This study reveals two significant patterns related to absconding in this psychiatric setting: patients who are in better mental state – i.e., are mostly in stage of recovery process, is the first pattern to emerge in this study. The second pattern of absconding is that 75.47% patients who abscond have to return to hospital, an indication that there is scant successful returning home.

7.3.2.2 Pattern matching

In the present thesis, the literature about absconding is reviewed. Most of the findings are derived from Western literature; only one paper comes from a developing country. In fact, the Western literature did not address the majority of patients in the present study, i.e., those in a stage of recovery. In circumstances where patients have similar conditions in Indonesia, it may be appropriate to adapt and adopt the techniques for preventing patients from absconding which have been reviewed in the Western literature.

Despite the different contexts of the West's literature and that of Indonesia, there are similarities in the demographic pattern of absconding patients, for example their age, gender, marital status, diagnosis, history of admission and

the high proportion of patients who return to hospital. Patient expressed desires to go home and reconnect with family are similar also.

7.3.3 Absconding viewed by key stakeholders

Nurses and patients view absconding from vastly different perspectives, and yet they do share some similarity in views. For the nurses, absconding is viewed as a behavior that creates a dilemma for them. In some cases, nurses believe that the desire of patients to go home is reasonable when patients are in a better mental state. Nurses see absconding behavior as one way for patients to take matters into their own hands, and this construed as a sign of empathy for the predicament of the patients waiting to be picked up. On the other hand, nurses are aware that they may be in trouble and held responsible when a patient absconds, so they blame others for absconding events. Predominantly, they blame families for either not visiting the patients, or for not picking them up when they are ready for discharge. They recognize how disconnected the patients feel when they are abandoned.

Patients view absconding as ‘a way out’ from their current dilemma, even though by doing so they know they are breaking the rules. This dilemma emerges when they are ready to be discharged and yet failure by their family to pick them up blocks their legitimate passage home. In this respect both patients and nurses are united in their view that families’ lack of support for the patient is a major factor in patients absconding. Patients who abscond take the initiative and demonstrate a degree of self-determination in seeking to fulfill some of their hopes by going home. From a positive point of view, this self-determination and hope may be viewed as signs of their recovery. It is just unfortunate that by leaving the hospital without official preparation they are most likely to be returned to the hospital in a disappointed state of mind, if not a worse mental state. In contrast, the patients in a worse mental state described their decision to abscond as coming from irrational thoughts or hallucinations.

7.3.4 A concept of recovery: a new finding related to the absconding phenomenon

A consistent finding in this study is that the patients who abscond are predominantly those who are progressing towards recovery. This study also highlights a journey towards recovery that has not been revealed in other studies related to absconding from psychiatric settings. In the theme 'Us and them' the fact that patients believe they hold different perceptions about the degree of recovery from that of their family and health professionals is a significant finding, because the importance of recovery as a shared goal is neglected in the hospital and the community.

This study also shows how the process of recovery is delayed or even fails, as there is inadequate support from the health professionals, family and the community. The patients' interviews show how their struggle to get home by absconding when they feel they are recovering; however, on their return to hospital they have to face the reality that they have been rejected by their families or caught by nurses and returned to hospital. Not surprisingly, the absconding behaviour reported by patients who returned to hospital in this study shows that absconding is a threat to recovery, as in doing so patients may lose the possibility of support from others to achieve their goal for recovery and being 'legitimately' discharged.

It appears that the patients who are recovering from their mental illness in this context do so in a 'no man's land'. They are in hospital but receiving limited psychiatric nursing care, and are nearly home but unable to connect with their community. This is a period when it should be possible for them to begin to hope and make plans for their future. But in reality it becomes a space where they are alone and vulnerable. In most cases, without appropriate support from either their family or health professionals the patient's recovery is interrupted. There is a distinct lack of shared responsibility between the hospital and the family. When patients are in hospital the family expects the hospital to do

everything (causing great frustration for the nurses and distress for patients) and in return, the hospital has a similar attitude once the patient is discharged (leaving the patient and family to cope alone).

7.4 The Strengths and Limitations of the Study

The strengths and limitations of the study are dealt with separately. The strengths of the study are reported first under the headings of research quality assurance, completeness of the research, and the distinctive features of the study. The limitations are addressed together.

7.4.1 Research quality assurance and completeness of the research

In the present study, the credibility of qualitative data was enhanced through a range of techniques: a seven-month period of data collection, multiple sources of data, triangulation method of data (subjective and objective data), dual analysis of the data, methodological and transparent translation techniques, retention of original language in quotations, and critical reflection to review the researchers' credibility within the process of data collection.

7.4.2 The distinctive features of the study

This study is distinctive, as absconding is a topic that has not been explored in Indonesia. For this reason, this study has a great value in terms of understanding the significance of contextual factors and culture in respect to absconding behavior and supporting change in psychiatric nursing practice in Indonesia.

The patients' voices are given special attention in this study. Even in the West this is unusual. There is very limited prior research on the subjective experience of patients who abscond. In Indonesia patients are usually not encouraged to speak up for themselves. The patients in this study were pleased to be able to contribute, and their perspective has given an 'inside' or human view of absconding from the perspective of those that, arguably, matter the

most – the patients. This may be a starting point from which to promote consumer rights in the future.

Although the research from the West has investigated single institutions and collected data from a number of sources none of the studies explicitly include theories of case study or mixed methods together. The use of mixed methods in this study increases its validity through use of the concurrent triangulation method described by Creswell (2006).

All other research continues to view absconding as a behaviour to be prevented, and suggests a range of interventions to keep the patient in hospital. In contrast, the findings in this study show that the best prevention in this contextual circumstance would be make sure that they returned in the best possible shape to the best possible place – to let the patients go home.

7.4.3 Limitations of this study

Despite the strengths of this study there are some limitations, as shown in the list below:

- The different culture and context of the present study from that of the West renders the pattern matching between Western literature and the study data very difficult.
- The earthquake and volcano eruption were abnormal events which affected the context of the study. However, it should be said that the people of Indonesia are unfortunately, quite used to natural disasters as they occur frequently there.
- It was not possible to interview the patients' family members as no-one responded to the invitations that were sent out. It is likely that they were distracted by the disasters, and perhaps did not understand the research. It was considered unsafe for me to visit outlying villages and towns, however the relatives' perspective is an important element of this study and this will be undertaken in the near future.

7.5 Recommendations

1. That nurses review observation protocols for patients in a worse mental state to prevent them from absconding.
2. That medication rounds are spaced more evenly.
3. That the Stuart Stress Adaptation Model (Stuart, 2005) and/or the CARE framework for mental health practice (McAllister & Walsh, 2003), (depending on their respective suitability for practice from the nurses' perspective) be reviewed for adaption and gradual adoption as a guide in the delivery of psychiatric nursing services, either in hospital or in the community in Indonesia.
4. That a formal process of discharge planning which includes both patient and family be developed and implemented from the admission of a patient, through to their discharge from hospital.
5. That a basic training program to introduce nurses to skills for communicating and engaging with psychiatric patients be developed and provided for all nursing staff.
6. That the recovery process as a concept be reviewed by senior professional staff in the hospital in order to extend therapy to the recovery/rehabilitation phase:
    a. In hospital, nurses may help patients who are in the recovery/rehabilitation phase by assessing patient and family needs and helping the patients prepare for return to their family and community as an integral component of discharge planning.
    b. In the community, community nurses[9] will show an example to the community by accepting and helping people with mental illness. Community nurses should be included in the psychoeducation of community members.
7. That the government support for a nation-wide program of psycho-education on mental illness for lay people and professional people of Indonesia.

[9] These are diploma nurses who work in the community health centres. They do not have psychiatric training

7.6 Further Research

There is so much further information that is needed it is hard to decide what should be the priority. The following are research areas to which I am committed:

1. Relatives' perspectives of their family member's mental illness, and receiving the family member home from hospital.
2. The social construction of recovery from mental illness in Indonesia be explored from the perspective of: patients, nurses, family, community and other health professionals.
3. Comparison of recidivism amongst three groups of patients, i.e., those who abscond, those collected by family, and those dropped home by the dropping program.

7.7 Conclusions

The absconding phenomenon in Indonesia is related to specific contextual factors and culture in this case. This study has shown that systems and resources for the care and treatment of people who have psychiatric problems in Indonesia are restricted, and this makes the comparison of absconding with psychiatric settings in the West difficult. However, this description of the situation in one psychiatric setting in Indonesia is helpful in highlighting the differences. It is now possible to see what is happening and where it will be possible to emulate progress in psychiatric care in the West. In particular, the theory of recovery and notions of therapeutic care will be examined by nurses in Indonesia and considered for possible adaption and adoption with due respect for our particular culture and circumstances.

Despite the finding that absconding in certain circumstances may be a sign of recovery, the act of absconding is still considered as a threat to the recovery process of patients. In doing so, they act alone when they abscond, without adequate support from health professionals, family and community. It is now clear that the problems that need to be addressed are much more complex than

changing and adhering to protocols, important as these may be, but that there needs to be widespread change in attitudes towards people with psychiatric illness. Strategies that support communication and engagement between professionals and the community and people with mental illness is to be encouraged, for this is the hope for the future. Our aim is that people who are ready to go home will be welcomed home and that there will be adequate preparation for their discharge, and they will find a safe home to which to return.

The psychiatric hospital which has shown a willingness to be the setting where the research was undertaken should be congratulated for this and they have thrown open their doors to external scrutiny. This is their first step on the road to providing better services for people in Indonesia with psychiatric illness, and the organisation and the people who agreed to participate in this study are a testament to hope for the future.

References

Adams, S. M., & Partee, J. (1998). Hope: the critical factor in recovery. *Journal of Psychosocial Nursing and Mental Health Service, 36*, 29-32.

Amador, X. F., & Paul-Odouard, R. (2000). Defending the Unabomber: anosognosia in schizophrenia. *Psychiatric Quarterly, 71*(4), 363-371.

Amin, S. (2005a). *Pasien Rumah Sakit Jiwa Banyak Tak Bayar*. Retrieved 25th July, 2007, from http://www.tempointeraktif.com/hg/nusa/jawamadura/2005/12/23/brk,20051223-71108,id.html

Amin, S. (2005b). *Penderita Sakit Jiwa di Yogyakarta Makin Banyak*. Retrieved 23rd July, 2007, from http://www.tempointeraktif.com/hg/nusa/jawamadura/2005/02/21/brk,20050221-55,id.html

Bardwell, M., & Taylor, R. (2005). Schizophrenic Disorders. In R. Elder, K. Evans & D. Nizette (Eds.), *Psychiatric and Mental Health Nursing*. Australia: Elsevier.

Bellack, A. (2006). Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, and Implication. *Schizophrenia Bulletin, 32*(3), 432-442.

Bowers, L., Alexander, J., & Gaskell, C. (2003). A trial of an anti-absconding intervention in acute psychiatric wards. *J Psychiatr Ment Health Nurs, 10*(4), 410-416.

Bowers, L., Jarret, M., Clark, N., Kiyimba, F., & McFarlane, L. (1999b). Absconding: how and when patients leave the ward. *Journal of Psychiatric and Mental Health Nursing, 6*(3), 207-211.

Bowers, L., Jarrett, M., & Clark, N. (1998). Absconding: a literature review. *J Psychiatr Ment Health Nurs, 5*(5), 343-353.

Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane, L. (1999a). Absconding: outcome and risk. *J Psychiatr Ment Health Nurs, 6*(3), 213-218.

Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane, L. (1999c). Absconding: why patients leave. *J Psychiatr Ment Health Nurs, 6*(3), 199-205.

Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane, L. (2000). Determinants of absconding by patients on acute psychiatric wards. *J Adv Nurs, 32*(3), 644-649.

Bradshaw, T., & Haddock, G. (1998). Is befriending by trained volunteers of value to people suffering from long-term mental illness? *Journal of Advanced Nursing, 27*, 713-720.

Bull, R. (2002). *Threatre Wear Must be Worn Beyond this Point.* University of Adelaide.

Burgess, R. (1982). *Field Research: A Sourcesbook and Field Manual*. London: Allen & Unwin.

Clark, N., Kiyimba, F., Bowers, L., Jarrett, M., & McFarlane, L. (1999). Absconding: nurses views and reactions. *J Psychiatr Ment Health Nurs, 6*(3), 219-224.

Cleary, M., & Edwards, C. (1999). 'Something always comes up': nurse-patient interaction in an acute psychiatric setting. *Journal of Psychiatric and Mental Health Nursing, 6*, 469-477.

Closkey, J. C., & Bulechek, G. M. (1996). *Nursing Intervention Classification*. St. Louis: Mosby, Inc.

Connor, H. (1999). Collaboration or chaos: A consumer perspective. *Australian and New Zealand Journal of Mental Health Nursing, 8*, 79-85.

Conroy, T., & Jorgensen, J. (1995). Decreasing elopement through interdisciplinary teamwork. *Nurs Qual Connect, 5*(3), 30.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Thousand Oaks, California: Sage Publications.

Creswell, J. W., Plano Clark, V., Gutmann, M., & Hanson, W. (2006). Advanced mixed methods research design. In A. Tashakkori & C. Teddie (Eds.), *Handbook of Mixed Methods in Social and Behavioural Research* (pp. 209-241). Thousand Oaks: SAGE.

Daftar Rumah Sakit Indonesia. (2007). Retrieved 27th July, 2007, from http://www.yanmedik-depkes.net/statistik_rs_2007/daftar_rs/menuRS.htm

Denzin, N., & Lincoln, Y. (2000). *Handbook of Qualitative Research*. Thousand Oaks, California: Sage Publications.

Dickens, G. L., & Campbell, J. (2001). Absconding of patients from an independent UK psychiatric hospital: a 3-year retrospective analysis of events and characteristics of absconders. *Journal of Psychiatric and Mental Health Nursing, 8*(6), 543-550.

Eli. (2005). *Waspada Online*. Retrieved 6th September, 2007, from http://perawatoverseas.blogspot.com/2006/08/seratus-ribu-perawat-di-ri-nganggur_17.html

Falkowski, J., Watts, V., Falkowski, W., & Dean, T. (1990). Patients leaving hospital without the knowledge or permission of. *Br J Psychiatry, 156*, 488-490.

Fekete, D. (2004). How I Quit Being A "Mental Patient" and Became A Whole Person With A Neurochemical Imbalance: Conceptual and Functional Recovery From A Psychiatric Episode. *Psychiatric Rehabilitation Journal, 28*(2), 189-194.

Fitriawan, R. (2005). *Banyak Pasien Penyakit Jiwa Tak Mau Pulang*. Retrieved 25th July, 2007, from http://www.tempointeraktif.com/hg/kesehatan/2005/10/10/brk,20051010-67795,id.html

Forchuk, C., Jewell, J., Tweedell, D., & Steinnage, L. (2003). Role changes experienced by clinical staff in relation to clients' recovery from psychosis. *Journal of Psychiatric and Mental Health Nursing, 10*, 269-276.

Granerud, A., & Severinsson, E. (2006). The struggle for social integration in the community-the experiences of people with mental health problems. *Journal of Psychiatric and Mental Health Nursing, 13*, 288-293.

Hidayat, T. (2005). *Masyarakat Dilarang Sakit Jiwa*. Retrieved 25th July, 2007, from http://www.pikiran-rakyat.com/cetak/2005/1205/18/0901.htm

Hoskins, C. N., & Mariano, C. (2004). *Research in Nursing and Health Understanding and Using Quantitative and Qualitative Methods*. New York: Springer Publishing Company, Inc.

Hsieh, P., Cholowski, K., & FitzGerald, M. (2005). Obesity: translation and testing of a survey instrument for use in Taiwan. *Journal of Clinical nursing, 14*, 830-844.

Johnstone, M. (2001). Stigma, social justice and the rights of the mentally ill: Challenging the status quo. *Australian and New Zealand Journal of Mental Health Nursing, 10*, 200-209.

Kelly, L. S., & Mc Kenna, H. P. (1997). Victimization of people with enduring mental illness In the comunity. *Journal of Psychiatric and Mental Health Nursing, 4*, 185-191.

Maree, E. (2005). Hospital-Based Psychiatric Nursing Care. In G. Stuart & M. Laraia (Eds.), *Principles and Practice of Psychiatric Nursing*. St Louis, Missouri: Mosby, Inc.

McAllister, M., & Walsh, K. (2003). CARE: a framework for mental health practice. *Journal of Psychiatric and Mental Health Nursing, 10*, 39-48.

McFarlane, WIlliam, R., Dixon, L., Lukens, E., & Lucksted, A. (2003). *Family psychoeducation and schizophrenia: A review of literature*. Retrieved 28th October, 2007, from http://findarticles.com/p/articles/mi_qa3658/is_200304/ai_9230544

McGorry, P. (2004). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia adn related disorders. *Australian and New Zealand Journal of Psychiatry, 39*, 1-30.

Meehan, T., Morrison, P., & McDougall, S. (1999). Absconding behaviour: an exploratory investigation in an acute inpatient. *Aust N Z J Psychiatry, 33*(4), 533-537.

Molnar, G. F., & Pinchoff, D. M. (1993). Factors in patient elopements from an urban state hospital and strategies for prevention. *Hospital and Community Psychiatry, 44*, 791-792.

Munetz, M., & Frese, F. (2001). Getting ready for recovery: Reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal, 25*(1), 35-42.

Nurjannah, I. (2004). *Perbedaan lama rawat inap berdasarkan sistem kategori pasien pada klien gangguan jiwa di RS Dr Sardjito dan RSUD Banyumas Jawa Tengah*. Yogyakarta: Nursing School Gadjah Mada University.

Nurjannah, I. (2004). *Treatment Guideliness for Mental Illness Patient: Management, Nursing proces and nurse-patient relationship (in Indonesia languange)*. Yogyakarta: Mocomedia.

Ogulensi, A., & Adamson, T. A. (1992). Absconders from the Nigerian National Neuropsychiatric Hospital: a case. *West Afr J Med, 11*(4), 297-303.

Pearson, A., Vaughan, B., & FitzGerald, M. (2005). *Nursing Models for Practice*. Philadelphia: Elsevier Limited.

Pepper, S. (2002). Psychosocial Rehabilitation. In S. Pepper (Ed.), *Psychosocial Rehabilitation working with people with a psychiatric disability*. Victoria: New Paradigm Press.

Polit, D., & Beck, C. (2006). *Essential of Nursing Research Methods, Appraisal, and Utilization*. Philadelphia: Lippincot Williams & Wilkins.

Reid, J., Lloyd, C., & de Groof, L. (2005). The psychoeducation needs of parents who have an adult son or daughter with a mental illness. *Australian e-Journal for the Advancement of Mental Health, 4*(2), 1-13.

Richmond, I., Dandridge, L., & Jones, K. (1991). Changing nursing practice to prevent elopement. *Journal of Nursing Care Quality, 6*(1), 73-81.

Schiff, A. (2004). Recovery and Mental illness: Analysis and Personal Reflections. *Psychiatric Rehabilitation Journal, 27*(3), 212-218.

Siswono. (2001). *Sangat Besar, Beban akibat Gangguan Jiwa*. Retrieved 25th July, 2007, from http://www.gizi.net/cgi-bin/berita/fullnews.cgi?newsid1002779805,55571.

Stevens, B. (1998). *Nursing theory: Analysis, Application, Evaluation*. Philadelphia: Lippincot.

Stuart, G. (2005). The Stuart Stress Adaptation Model of Psychiatric Nursing Care. In 8th (Ed.), *Principles and Practice of Psychiatric Nursing*. St. Louis: Mosby, Inc.

Stuart, G. W., & Sundeen, S. J. (1995). *Principles & Practice of Psychiatric Nursing*. St. Louis: Mosby Year Book.

Sundeen, S. (2005). Psychiatric Rehabilitation and Recovery. In G. Stuart & M. Laraia (Eds.), *Principles and Practice of Psychiatric Nursing*. St Louis, Missouri: Mosby, Inc.

Taylor, B. (2000). *Reflective practice*. Sydney: Allen & Unwin.

Tok. (2007). *Pasien RSJ Menur mayoritas akibat broken home*. Retrieved 25th July, 2007, from http://www.d-infokom-jatim.go.id/news.php?id=4458

Townsend, W., & Glasser, N. (2003). Recovery: The Heart And Soul of Treatment. *Psychiatric Rehabilitation Journal, 27*(1), 83-85.

Vijver, F. (1997). *Methods and Data Analysis for Cross-cultural Research*. London: Sage.

Walsh, E., Rooney, S., Sloan, D., McCauley, P., Mulvaney, F., O'Callaghan, E., et al. (1998). Irish psychiatric patients who abscond: characteristics and outcome. *Psychiatric bulletin, 22*, 351-353.

WHO. (2007). *International Statistical Classification of Disease and Related Health Problems 10th Revision Version for 2007*. Retrieved 29th September, 2007

Whyte, W. (1984). *Learning from the Field: A Guide from Experience*. Beverley Hills: SAGE.

Wilujani, A. (2001). *Pemahaman Baru, Harapan Baru*. Retrieved 25th July, 2007. From http://www.tempointeraktif.com/hg/nusa/jawamadura/2005/02/21/brk,20050221-55,id.html

Yin, R. K. (2003). *Case Study research: Design and methods*. Thousand Oaks California: Sage Publications.

APPENDICES

Appendix 1 Time table

No	Activity	Month/Year												
		Aug- Sep 2005	Oct 2005	Nov – Dec 2005	Jan 2006	Feb 2006	Mar 2006	April – August 2006	Sept 2006	Oct 2006 - Feb 2007	Mar 2007	April 2007	May -June 2007	July- Oct 2007
1	Study literature													
2	Writing proposal													
3	Ethic application in JCU													
4	Ethic application in Indonesia													
5	Research permission													
6	Confirmation candidature													
7	Exercise for collecting data													
8	Collecting quantitative data													
9	Collecting qualitative data													
10	Qualitative data transcribed													
11	Qualitative data analysis													
12	Quantitative data analysis													
13	Writing report													
14	Seminar exit													
15	Preparing oral presentation													
16	Publication process													

Appendix 2 Protocol of data collection A, B and C

A. Chart Audit (In excel form)

DATA COLLECTION FORM (A)

Date									
Record No		1	2	3	4	5	6	7	8
Medical record No									
Patient abscond	Date								
	Time								
Ward									
Date of admission									
Age									
Gender	M								
	F								
Marital status									
Ethnicity	Java								
	Other								
Religion	Moslem								
	Christian								
	Catholic								
	Hindu								
	Buddha								
	Other								
Diagnoses									
Psychosis	Yes								
	No								
Number of nurses*									
Number of patients**									
Patient returned to hospital	Date								
	Time								

* on duty at time of absconding event
** on ward at time of absconding event

B. Interview

Interview with the nurse

a. Interviewees will be asked to recount the events that occurred on the day of absconding event with a broad question: **"please tell me everything**

you can remember about events that led up to the time you found (name) had left the ward without permission and what happened afterwards"

b. Researcher will use the following points as prompts if the participants need them:

- the clue/s of absconding
- condition when patient abscond
- history of patient behavior
- Intervention after patient back to the ward
- Intervention to reduce absconding (what nurse do to prevent of absconding)
- Nurse response to absconding (what did they do, what they feel)

Interview with relative

Researcher will ask a broad question to begin the interview: **"please tell me how you responded to the news that your relative (name) has leaving without permission from hospital?"**

Interview with patients who abscond

a. Researcher will ask the patient to recount the events that occurred on the day of absconding event with a broad question: **"Do you remember leaving the ward on (day)? If yes then**

b. "**Please can you tell me as much as you can remember about events that led up to you leaving and what happened to you afterwards"**

c. Researcher will use the following points as prompts if the participants need them:

- Consequence of absconding/what happened after absconding
- How he/she got back to the ward
- How the patient managed to abscond
- Reaction of patients who abscond when back on the ward (for patient who interviewed after they return to the hospital)

- Reason s/he returned to the hospital (for patient who interviewed in hospital after they return)
- How did they return to hospital (for patient who interviewed in hospital after they return)
- Where they went after abscond
- Why they abscond
- What did they do before abscond = interview to the nurse
- What was the feeling after abscond
- Frequency of abscond

C. Observation

Researcher will observe six wards. Each ward will be observed one hour per shift. The observations will focus on the nurses' routines and reporting systems. Data will be collected in the following ways:

a. Descriptive notes (people, setting/physical setting, atmosphere, activities, interactions/dialogues, events – what is happening, when activities occur, where they occur, why things happen, and to whom things happen, account of particular events, context, response to the researcher) and

b. Reflective notes (the researcher personal thought, such as "speculation, feelings, problems, ideas, hunches, impressions and prejudices (Bogdan & Biklen cit Creswell, 1992. p 189)

c. Demographic information (Time, place, and data of the field setting where the observation takes place)

Form of observation data collection

Time and date of observation:

Ward :

Item to observe	Time of observation From…to……am/pm	Reflective notes	Note (for add information)
People who involved ……			
Atmosphere			
Activities			
Interactions			
Events			
Where activities happen			
Why activities happen			
To whom things happens			

Appendix 3 Information sheet

PARTICIPANTS' INFORMATION SHEET
Nurses

Let me introduce myself. My name is Intansari Nurjannah. I am a nurse who is currently studying for a master's degree in Australia. As part of the program I am undertaking a research study that will investigate occurrences of absconding from Grhasia Hospital Yogyakarta, Indonesia. My reason for doing this is to improve our understanding of absconding and develop protocols for best practice in the future. Your participation, if you choose to help with the study, will provide information to increase awareness of this issue and may be of benefit for patient, relatives and nurses in the future.

The principal investigator for this research will be I, Intansari Nurjannah and the main supervisor is Professor Mary Fitzgerald, James Cook University, Cairns, Australia. The aims of this study are to explore circumstances surrounding absconding events.

Your perspective regarding absconding is important and I would like to talk to you. The interview will last up to 1hr during your shift, at your convenience. For the purposes of the research the interview will be tape recorded and transcribed. No names, addressees or any other identifying information is transcribed so your responses to questions in this study cannot be traced to you. You will only be given a pseudonym to ensure that the information you give me is confidential.

To be a participant you must meet the following criteria:

- A nurse who is on duty when a patient leaves without permission
- A nurse who has read this letter and who is willing to participate

Your participation is voluntary so you may refuse this invitation. Or you may withdraw your participation at any time during the study, without any reason. Refusal or withdrawal will have no adverse consequences for you in any way.

You can contact me at any time if you are willing to be participant or if you have any questions or concern about this study. My contact numbers are listed at the bottom of this page.

You are welcome to contact me at:
Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

If you have any questions regarding the ethical conduct of the research project, you can contact the Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

PARTICIPANTS' INFORMATION SHEET

Relative

Let me introduce myself. My name is Intansari Nurjannah. I am a nurse who is currently studying for a master's degree in Australia. As part of the program I am undertaking a research study that will investigate occurrences of patients leaving the hospital without permission. My reason for doing this is to improve our understanding of this phenomenon and develop protocols for best practice in the future. Your participation, if you choose to help with the study, will provide information to increase awareness of this issue and may be of benefit for patient, relatives and nurses in the future.

The principal investigator for this research will be I, Intansari Nurjannah and the main supervisor is Professor Mary Fitzgerald, James Cook University, Cairns, Australia. The aims of this study are to explore circumstances surrounding occurrences of patient leaving the hospital without permission.

Your perspective regarding this phenomenon is important and I would like to be able to talk to you about it for up to 1hr. The interview will be scheduled at your convenience. For the purposes of the research the interview will be tape recorded and transcribed. No names, addressees or any other identifying information is transcribed so your responses to questions in this study cannot be traced to you. You will only be given a pseudonym to ensure that the information you give me is confidential.

Your participation is voluntary so you may refuse this invitation. Or you may withdraw your participation at any time during the study, without any reason. Refusal or withdrawal will have no adverse consequences for you or your relative in any way.

You can contact me at any time if you have any questions or concern about this study. My contact numbers are listed at the bottom of this page. If you willing to be a participant please indicate this to the nurse who will phone you later in the week to ask how the family is, or you are welcome to contact me directly at:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)

School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)

School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

If you have any questions regarding the ethical conduct of the research project, you can contact the Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Note:
This week, the nurse will phone/contact to find out how the family is. Please let them know that you would like to speak to me about the research if you are interested to know about this research

PARTICIPANTS' INFORMATION SHEET

Patients

Let me introduce myself. My name is Intansari Nurjannah. I am a nurse who is currently studying for a master degree in Australia. As part of the program I am undertaking a research study that will explore occurrences of patient leaving the hospital without permission from Ghrasia Hospital Yogyakarta, Indonesia. My reason for doing this is to improve nurses understanding of absconding and to improve practice in the future.

The researcher for this research will be I, Intansari Nurjannah and the main supervisor is Professor Mary Fitzgerald, James Cook University, Cairns, Australia. The aims of this study are to explore circumstances surrounding absconding events.

Your perspective regarding absconding is important and I would like to be able to talk to you about it for up to 1hr. The interview will be scheduled at your convenience. For the purposes of the research the interview will be tape recorded and written down. No names, addressees or any other identifying information will appear in written form so your responses to questions in this study cannot be traced to you. You will only be given a false name to ensure that the information you give me is confidential.

Your participation will provide information to increase awareness of this issue and may be of benefit for patient, relatives and nurses in the future. Who will be looked after by people who know more about this matter.

Your participation is voluntary so you may refuse this invitation. Or you may withdraw your participation at any time during the study, without any reason. Refusal or withdrawal will have no adverse consequences for you in any way.

If you would like to meet me and discuss the project before making a decision whether you are willing or not to participate pleases ask one of the nurses to call me. I will be very happy to answer any further questions you may have.

You are welcome to contact me at:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)

School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)

School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

If you have any questions regarding the ethical conduct of the research project, You can contact the Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone:
(07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

PARTICIPANTS' INFORMATION SHEET

Head Nurse

Let me introduce myself. My name is Intansari Nurjannah. I am a nurse who is currently studying for a master's degree in Australia. As part of the program I am undertaking a research study that will investigate occurrences of absconding from Ghrasia Hospital Yogyakarta, Indonesia. My reason for doing this is to improve our understanding of absconding and develop protocols for best practice in the future.

The principal investigator for this research will be I, Intansari Nurjannah and the main supervisor is Professor Mary Fitzgerald, James Cook University, Cairns, Australia. The aims of this study are to explore circumstances surrounding absconding events.

To understand the circumstances that lead to absconding I would like to spend one hour of an early, late and night shift on each of a number of wards in this hospital and collect information about everyday occurrences. Although I will take notes during this time I will *not* identify any of the wards nor will I name people I observe. No names, addressees or any other identifying information is transcribed so observations in this study cannot be directly traced to you or your team. I will only observe nurses who agree to participate in this study. Nurses who prefer not to take part will not be disadvantaged in any way.

You can contact me at any time if you have any questions or concerns about this study. My contact numbers are listed at the bottom of this page. If you are prepared to hear more about this study and meet the researcher please contact me.

You are welcome to contact me at:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)

School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)

School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

If you have any questions regarding the ethical conduct of the research project, You can contact the Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

PARTICIPANTS' INFORMATION SHEET

To be distributed to Nurses

Let me introduce myself. My name is Intansari Nurjannah. I am a nurse who is currently studying for a master's degree in Australia. As part of the program I am undertaking a research study that will investigate occurrences of absconding from Ghrasia Hospital Yogyakarta, Indonesia. My reason for doing this is to improve our understanding of absconding and develop protocols for best practice in the future.

The principal investigator for this research will be I, Intansari Nurjannah and the main supervisor is Professor Mary Fitzgerald, James Cook University, Cairns, Australia. The aims of this study are to explore circumstances surrounding absconding events.

To understand the circumstances that lead to absconding I would like to spend some time on a number of wards in this hospital and collect information about everyday occurrences, you do not need to do anything except your daily work. Although I will take notes during this time I will *not* identify any of the wards nor will I name people I observe. No names, addressees or any other identifying information is transcribed so observation in this study cannot be traced directly to you or your team. I will only observe nurses who agree to participate in this study. Nurses who prefer not to take part will not be disadvantaged in any way.

If you decide to be a participant in this observation, I will visit your ward to observe daily routines for one hour. I will not interrupt your normal workday although I may ask you some questions for clarification every now and then.

You can contact me at any time if you have any questions or concerns about this study. My contact numbers are listed at the bottom of this page. If you are

prepared to hear more about this study and meet the researcher please contact me.

You are welcome to contact me at:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)

School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)

School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

If you have any questions regarding the ethical conduct of the research project, You can contact the Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Information sheet in Indonesian Language

INFORMASI UNTUK PERAWAT

Perkenalkan nama saya adalah Intansari Nurjannah. Saya adalah perawat yang sedang menempuh pendidikan master di Australia. Sebagai salah satu bagian dari program pendidikan saya, saya melakukan penelitian yang akan mengeksplorasi kejadian pasien melarikan diri di Rumah sakit Grhasia Yogyakarta. Alasan saya untuk memilih topik ini adalah untuk meningkatkan pemahaman mengenai kejadian melarikan diri dan untuk dapat mengembangkan protocol untuk penanganan melarikan diri di masa depan. Partisipasi anda, jika anda memilih untuk membantu penelitian ini, akan memberikan informasi untuk meningkatkan kesadaran mengenai issu ini dan mungkin akan memberikan manfaat bagi pasien, keluarga atau perawat di masa yang akan datang.

Peneliti utama untuk penelitian ini adalah saya, Intansari Nurjannah dan supervisor saya adalah Professor Mary Fitzgerald, James Cook University, Cairns, Australia. Tujuan dari penelitian ini adalah untuk mengeksplorasi situasi disekitar kejadian pasien melarikan diri.

Perspektif anda mengenai ‘melarikan diri’ adalah penting dan saya ingin dapat melakukan wawancara dengan anda mengenai hal ini. Wawancara akan dilakukan selama paling lama satu jam pada jam shift anda, pada saat dimana anda merasa nyaman. Untuk tujuan penelitian, wawancara akan direkam dan ditranskrip. Tidak ada nama, alamat atau petunjuk lain dalam transkrip sehingga respon anda terhadap pertanyaan dalam penelitian ini tidak dapat dilacak kepada anda.

Anda akan diberikan nama samaran untuk menjamin bahwa informasi yang anda berikan adalah merupakan suatu hal yang rahasia (konfidensial).

Untuk berpartisipasi anda perlu memenuhi kriteria berikut ini:

- Perawat yang sedang bekerja di bangsal pada saat pasien meninggalkan bangsal tanpa ijin

- Perawat yang telah membaca informasi ini dan bersedia untuk berpartisipasi

Partisipasi anda adalah sukarela. Anda boleh menolak undangan untuk berpartisipasi ini. Atau anda boleh mengundurkan diri dari partisipasi anda kapan saja selama penelitian ini tanpa memberikan alasan. Penolakan atau pengunduran diri tidak akan mengakibatkan konsekuensi apapaun pada anda.

Anda bisa menghubungi saya kapan saja anda bersedia untuk berpartisipasi dalam studi ini atau jika anda memiliki pertanyaan atau hal hal lain tentang penelitian ini. Alamat dan nomor telepon saya terdapat di bahagian bawah halaman ini.

Anda dipersilahkan menghubungi saya di:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

Jika anda mempunyai pertanyaan terkait dengan etik yang dilakukan dalam penelitian ini silahkan menghubungi Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Halaman Informasi
Keluarga

Perkenalkan nama saya adalah Intansari Nurjannah. Saya adalah perawat yang sedang menempuh pendidikan master di Australia. Sebagai salah satu bagian dari program pendidikan saya, saya melakukan penelitian yang akan mengeksplorasi kejadian pasien meninggalkan rumah sakit tanpa ijin di Rumah sakit Grhasia Yogyakarta. Alasan saya untuk memilih topik ini adalah untuk meningkatkan pemahaman mengenai kejadian meninggalkan rumah sakit tanpa ijin dan untuk dapat mengembangkan protocol untuk penanganan pasien meninggalkan rumah sakit tanpa ijin di masa depan. Partisipasi anda, jika anda memilih untuk membantu penelitian ini, akan memberikan informasi untuk meningkatkan kesadaran mengenai issu ini dan mungkin akan memberikan manfaat bagi pasien, keluarga atau perawat di masa yang akan datang.

Peneliti utama untuk penelitian ini adalah saya, Intansari Nurjannah dan supervisor saya adalah Professor Mary Fitzgerald, James Cook University, Cairns, Australia. Tujuan dari penelitian ini adalah untuk mengeksplorasi situasi disekitar kejadian pasien melarikan diri.

Perspektif anda mengenai ‘pasien meninggalkan rumah sakit tanpa ijin’ adalah penting dan saya ingin dapat melakukan wawancara dengan anda mengenai hal ini. Wawancara akan dilakukan selama paling lama satu jam. Wawancara akan dijadwalkan pada waktu dimana anda merasa nyaman. Untuk tujuan penelitian, wawancara akan direkam dan ditranskrip. Tidak ada nama, alamat atau petunjuk lain dalam transkrip sehingga respon anda terhadap pertanyaan dalam penelitian ini tidak dapat dilacak kepada anda.

Anda akan diberikan nama samaran untuk menjamin bahwa informasi yang anda berikan adalah merupakan suatu hal yang rahasia (konfidensial)

Partisipasi anda adalah sukarela. Anda boleh menolak undangan untuk berpartisipasi ini. Atau anda boleh mengundurkan diri dari partisipasi anda

kapan saja selama penelitian ini tanpa memberikan alasan. Penolakan atau pengunduran diri tidak akan mengakibatkan konsekuensi apapaun pada anda.

Anda dapat menghubungi saya kapan saja jika anda mempunyai pertanyaan atau hal lain mengenai penelitian ini. Alamat dan nomor telepon saya terdapat di bahagian bawah halaman ini. Jika anda bersedia untuk berpartisipasi mohon memberitahukan pada perawat yang akan menelepon anda nanti dalam minggu ini untuk mengetahui bagaimana kondisi keluarga atau atau anda kami persilahkan untuk menghubungi saya langsung di

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

Jika anda mempunyai pertanyaan terkait dengan etik yang dilakukan dalam penelitian ini silahkan menghubungi Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Halaman Informasi

Pasien

Perkenalkan nama saya adalah Intansari Nurjannah. Saya adalah perawat yang sedang menempuh pendidikan master di Australia. Sebagai salah satu bagian dari program pendidikan saya, saya melakukan penelitian yang akan mengeksplorasi kejadian pasien meninggalkan rumah sakit tanpa ijin dari Rumah sakit Grhasia Yogyakarta. Alasan saya untuk memilih topik ini adalah untuk meningkatkan pemahaman mengenai kejadian melarikan diri dan untuk dapat meningkatkan penanganan melarikan diri di masa depan

Peneliti utama untuk penelitian ini adalah saya, Intansari Nurjannah dan supervisor saya adalah Professor Mary Fitzgerald, James Cook University, Cairns, Australia. Tujuan dari penelitian ini adalah untuk mengeksplorasi situasi disekitar kejadian pasien melarikan diri.

Perspektif anda mengenai 'melarikan diri' adalah penting dan saya ingin dapat melakukan wawancara dengan anda mengenai hal ini. Wawancara akan dilakukan selama paling lama satu jam. Wawancara akan dijadwalkan pada waktu dimana anda merasa nyaman. Untuk tujuan penelitian, wawancara akan direkam dan dituangkan dalam bentuk tertulis. Tidak ada nama, alamat atau petunjuk lain dalam bentuk tulisan sehingga respon anda terhadap pertanyaan dalam penelitian ini tidak dapat lacak kepada anda.

Anda akan diberikan nama samaran untuk menjamin bahwa informasi yang anda berikan adalah merupakan suatu hal yang rahasia (konfidensial).

Partisipasi anda akan menyediakan informasi untuk meningkatkan kesadaran mengenai issu ini dan mungkin memberikan manfaat pada pasien, keluarga dan perawat di masa yang akan datang. Yang akan dirawat oleh orang yang lebih tahu mengenai masalah ini.

Partisipasi anda adalah sukarela. Anda boleh menolak undangan untuk berpartisipasi ini. Atau anda boleh mengundurkan diri dari partisipasi anda kapan saja selama penelitian ini tanpa memberikan alasan. Penolakan atau pengunduran diri tidak akan mengakibatkan konsekuensi apapaun pada anda.

Jika anda ingin menemui saya dan mendiskusikan mengenai penelitian ini sebelum membuat keputusan apakah anda akan berpartisipasi atau tidak mohon disampaikan pada perawat untuk menelepon saya. Saya akan sangat senang untuk menjawab pertanyaan yang mungkin anda miliki.

Anda dipersilahkan untuk menghubungi saya di:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

Jika anda mempunyai pertanyaan terkait dengan etik yang dilakukan dalam penelitian ini silahkan menghubungi Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Halaman Informasi
Kepala Ruang Perawatan

Perkenalkan nama saya adalah Intansari Nurjannah. Saya adalah perawat yang sedang menempuh pendidikan master di Australia. Sebagai salah satu bagian dari program pendidikan saya, saya melakukan penelitian yang akan mengeksplorasi kejadian pasien melarikan diri di Rumah sakit Grhasia Yogyakarta. Alasan saya untuk memilih topik ini adalah untuk meningkatkan pemahaman mengenai kejadian melarikan diri dan untuk dapat mengembangkan protocol untuk penanganan melarikan diri di masa depan

Peneliti utama untuk penelitian ini adalah saya, Intansari Nurjannah dan supervisor saya adalah Professor Mary Fitzgerald, James Cook University, Cairns, Australia. Tujuan dari penelitian ini adalah untuk mengeksplorasi situasi disekitar kejadian pasien melarikan diri.

Untuk memahami situasi sekitar yang menyebabkan melarikan diri. Saya ingin meluangkan waktu selama satu jam pada shift pagi, siang dan malam di beberapa bangsal di rumah sakit ini dan mengumpulkan informasi mengenai kejadian sehari-hari. Meskipun saya akan melakukan pencatatan selama waktu ini saya TIDAK akan mengidentifikasi bangsal mana dan juga nama orang yang saya amati. Tidak ada nama, alamat atau informasi identitas dalam transkrip sehingga pengamatan ini tidak akan dapat langsung dilacak pada anda atau tim anda. Saya hanya akan mengobservasi perawat yang setuju untuk berpartisipasi pada penelitian ini. Perawat yang lebih suka untuk tidak berpartisipasi pada penelitian ini tidak akan dirugikan dengan jalan apapun.

Anda bisa menghubungi saya kapan saja anda memiliki pertanyaan atau hal lain dalam penelitian ini. Alamat dan nomor telepon saya ada di bahagian bawah dari halaman ini. Jika anda ingin mendengar mengenai penelitian ini lebih lanjut, dan ingin menemui peneliti mohon menghubungi saya.

Anda dipersilahkan menghubungi saya di:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

Jika anda mempunyai pertanyaan terkait dengan etik yang dilakukan dalam penelitian ini silahkan menghubungi Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Halaman Informasi

Untuk di distribusikan pada perawat

Perkenalkan nama saya adalah Intansari Nurjannah. Saya adalah perawat yang sedang menempuh pendidikan master di Australia. Sebagai salah satu bagian dari program pendidikan saya, saya melakukan penelitian yang akan mengeksplorasi kejadian pasien melarikan diri di Rumah sakit Grhasia Yogyakarta. Alasan saya untuk memilih topik ini adalah untuk meningkatkan pemahaman mengenai kejadian melarikan diri dan untuk dapat mengembangkan protocol untuk penanganan melarikan diri di masa depan

Peneliti utama untuk penelitian ini adalah saya, Intansari Nurjannah dan supervisor saya adalah Professor Mary Fitzgerald, James Cook University, Cairns, Australia. Tujuan dari penelitian ini adalah untuk mengeksplorasi situasi disekitar kejadian pasien melarikan diri.

Untuk memahami situasi sekitar yang menyebabkan melarikan diri Saya ingin meluangkan waktu di beberapa bangsal di rumah sakit ini dan mengumpulkan informasi mengenai kejadian sehari-hari. Sehingga anda tidak perlu melakukan apapun kecuali pekerjaan anda sehari-hari. Meskipun saya akan melakukan pencatatan selama waktu ini saya TIDAK akan mengidentifikasi bangsal mana dan juga nama orang yang saya amati. Tidak ada nama, alamat atau informasi identitas dalam transkrip sehingga pengamatan ini tidak akan dapat langsung dilacak pada anda atau tim anda. Saya hanya akan mengobservasi perawat yang setuju untuk berpartisipasi pada penelitian ini. Perawat yang lebih suka untuk tidak berpartisipasi pada penelitian ini tidak akan dirugikan dengan jalan apapun.

Jika anda memutuskan untuk berpartisipasi dalam pengamatan ini, Saya akan mengunjungi bangsal anda untuk mengamati rutinitas harian selama satu jam. Saya tidak akan menginterupsi kegiatan anda sehari-hari meskipun mungkin saya menanyakan beberapa poin untuk klarifikasi saat ini dan nanti.

Anda dapat menghubungi saya kapan saja anda mempunyai pertanyaan atau hal lain mengenai penelitian ini. Alamat dan nomor telepon saya terdapat di bahagian bawah halaman ini. Jika anda ingin mendengar lebih lanjut tentang penelitian dan ingin menemui peneliti mohon menghubungi saya.

Anda dipersilahkan menghubungi saya di:

Intansari Nurjannah
Master Candidate
Telephone: 08562916613 (Indonesia) and 0431268240 (Australia)
School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia)
School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia
E-mail: intansari_nurjannah@jcu.edu.au

Jika anda mempunyai pertanyaan terkait dengan etik yang dilakukan dalam penelitian ini silahkan menghubungi Human Ethics Sub-Committee, Contact details are: Tina Langford, Ethics Administrator, Research Office, James Cook University, Townsville Qld 4811. Phone: (07) 4781 4342 Fax: (07) 4781 5521 Email: Tina.Langford@jcu.edu.au

Appendix 4 Informed consent

INFORMED CONSENT FORM FOR NURSES (INTERVIEW)

PRINCIPAL INVESTIGATOR	*Intansari Nurjannah*
PROJECT TITLE:	*Patients absconding from Mental Health Institution in Indonesia: A Case study*
SCHOOL	*JCU School*
CONTACT DETAILS	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

I _____ agree to participate in the research project *Patients absconding from mental health institutions in Indonesia: A case study* being conducted by Intansari Nurjannah for her Master studies at James Cook University, Australia.

I understand that the aim of the study is to explore absconding behavior from the stakeholders' perspective. I understand that the researcher will conduct an interview and also I agree that the interview will be audio-taped and take a maximum of 1 hour. I also understand that the researcher will keep my identity confidential in the data collection period, analysis and also in the products (master thesis, journal articles) of this research by giving me a pseudonym.

I understand that I can contact Intansari Nurjannah, at any time if I have concerns about this study. I also understand that my participation is voluntary so that I can withdraw my participation without giving any reason and it will not have adverse consequences for me in anyway. I also agree that Intansari Nurjannah has answered my questions clearly.

Name: *(printed)*	
Signature:	**Date:**

INFORMED CONSENT FORM FOR NURSES (OBSERVATION)

PRINCIPAL INVESTIGATOR	*Intansari Nurjannah*
PROJECT TITLE:	*Patients absconding from Mental Health Institution in Indonesia: A Case study*
SCHOOL	*JCU School*
CONTACT DETAILS	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

I _____ agree to participate in the research project *Patients absconding from mental health institutions in Indonesia: A case study* being conducted by Intansari Nurjannah for her Master studies at James Cook University, Australia.

I understand that the aim of the study is to explore absconding behavior from the stakeholders' perspective. I understand that the researcher will spend three hours (one hour each shift) in the ward to collect information about everyday occurrences. I also understand that the researcher will keep my identity confidential in the data collection period, analysis and also in the products (master thesis, journal articles) of this research by giving me a pseudonym.

I understand that I can contact Intansari Nurjannah, at any time if I have concerns about this study. I also understand that my participation is voluntary so that I can withdraw my participation without giving any reason and it will not have adverse consequences for me in anyway. I also agree that Intansari Nurjannah has answered my questions clearly.

Name: *(printed)*	
Signature:	**Date:**

INFORMED CONSENT FORM FOR RELATIVES

PRINCIPAL INVESTIGATOR	*Intansari Nurjannah*
PROJECT TITLE:	*Patients absconding from Mental Health Institution in Indonesia: A Case study*
SCHOOL	*JCU School*
CONTACT DETAILS	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

I _____ agree to participate in the research project *Patients absconding from mental health institutions in Indonesia: A case study* being conducted by Intansari Nurjannah for her Master studies at James Cook University, Australia.

I understand that the aim of the study is to explore occurrences of patient leaving the hospital without permission. I understand that the researcher will conduct an interview and also I agree that the interview will be audio-taped and take a maximum of 1 hour. I also understand that the researcher will keep my identity confidential in the data collection period, analysis and also in the products (master thesis, journal articles) of this research by giving me a false name.

I understand that I can contact Intansari Nurjannah, at any time if I have concerns about this study. I also understand that my participation is voluntary so that I can withdraw my participation without giving any reason and it will not have adverse consequences for me in anyway. I also agree that Intansari Nurjannah has answered my questions clearly.

Name: *(printed)*	
Signature:	**Date:**

INFORMED CONSENT FORM FOR PATIENTS

PRINCIPAL INVESTIGATOR	*Intansari Nurjannah*
PROJECT TITLE:	*Patients absconding from Mental Health Institution in Indonesia: A Case study*
SCHOOL	*JCU School*
CONTACT DETAILS	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

I _____ agree to participate in the research project *Patients absconding from mental health institutions in Indonesia: A case study* being conducted by Intansari Nurjannah for her Master studies at James Cook University, Australia.

I understand that the aim of the study is to explore occurrences of patient leaving the hospital without permission. I understand that the researcher will conduct an interview and also I agree that the interview will be audio-taped and take a maximum of 1 hour. I also understand that the researcher will keep my identity confidential in the data collection period, analysis and also in the products (master thesis, journal articles) of this research by giving me a false name.

I understand that I can contact Intansari Nurjannah, at any time if I have concerns about this study. I also understand that my participation is voluntary so that I can withdraw my participation without giving any reason and it will not have adverse consequences for me in anyway. I also agree that Intansari Nurjannah has answered my questions clearly.

Name: *(printed)*	
Signature:	**Date:**

Informed Consent in Indonesian Language

PERSETUJUAN MENJADI RESPONDEN UNTUK PERAWAT (WAWANCARA)

PENELITI UTAMA	*Intansari Nurjannah*
JUDUL PENELITIAN	*Pasien melarikan diri dari institusi kesehatan mental di Indonesia: Sebuah studi kasus*
SEKOLAH	*School of Nursing JCU*
KONTAK DETIL	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

Saya _____

menyetujui untuk berpartisipasi dalam penelitian dengan judul *Pasien melarikan diri dari institusi kesehatan mental di Indonesia: sebuah studi kasus* yang dilaksanakan oleh Intansari Nurjannah untuk studi S2 yang bersangkutan di James Cook University Australia.

Saya memahami bahwa tujuan dari penelitian ini adalah untuk mengeksplorasi perilaku melarikan diri dari perspektif stakeholder. Saya memahami bahwa peneliti akan melakukan wawancara dan saya juga menyetujui bahwa wawancara akan direkam dan akan memerlukan waktu maksimal satu jam. Saya juga memahami bahwa peneliti akan menjaga kerahasiaan saya selama periode pengumpulan data, analisis dan juga hasil dari penelitian (tesis S2, artikel jurnal) dari penelitian ini akan diberikan nama samaran.

Saya memahami bahwa saya akan dapat menghubungi Intansari Nurjannah kapan saja saya mempunyai kekhawatiran mengenai penelitian ini. Saya juga memahami bahwa partisipasi saya adalah sukarela sehingga saya dapat menarik diri dari partisipasi ini meskipun tanpa memberikan alasan apapun dan tidak akan mempunyai konsekuensi apapun pada saya. Saya juga setuju bahwa Intansari Nurjannah telah menjawab semua pertanyaan saya dengan jelas.

Nama:	
Tanda tangan:	Tanggal:

PERSETUJUAN MENJADI RESPONDEN UNTUK PERAWAT (PENGAMATAN)

PENELITI UTAMA	*Intansari Nurjannah*
JUDUL PENELITIAN	*Pasien melarikan diri dari institusi kesehatan mental di Indonesia: Sebuah studi kasus*
SEKOLAH	*School of Nursing JCU*
KONTAK DETIL	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

Saya _____ menyetujui untuk berpartisipasi dalam penelitian dengan judul *Pasien melarikan diri dari institusi kesehatan mental di Indonesia: sebuah studi kasus* yang dilaksanakan oleh Intansari Nurjannah untuk studi S2 yang bersangkutan di James Cook University Australia.

Saya memahami bahwa tujuan dari penelitian ini adalah untuk mengeksplorasi perilaku melarikan diri dari perspektif stakeholder. Saya memahami bahwa peneliti akan meluangkan waktu selama tiga jam (pada setiap shift) di bangsal untuk mengumpulkan informasi mengenai kejadian sehari-hari. Saya juga memahami bahwa peneliti akan menjaga kerahasiaan saya selama periode pengumpulan data, analisis dan juga hasil dari penelitian (tesis S2, artikel jurnal) dari penelitian ini akan diberikan nama samaran.

Saya memahami bahwa saya akan dapat menghubungi Intansari Nurjannah kapan saja saya mempunyai kekhawatiran mengenai penelitian ini. Saya juga memahami bahwa partisipasi saya adalah sukarela sehingga saya dapat menarik diri dari partisipasi ini meskipun tanpa memberikan alasan apapun dan tidak akan mempunyai konsekuensi apapun pada saya. Saya juga setuju bahwa Intansari Nurjannah telah menjawab semua pertanyaan saya dengan jelas.

Nama:	
Tanda tangan:	Tanggal:

PERSETUJUAN MENJADI RESPONDEN UNTUK KELUARGA

PENELITI UTAMA	*Intansari Nurjannah*
JUDUL PENELITIAN	*Pasien melarikan diri dari institusi kesehatan mental di Indonesia: Sebuah studi kasus*
SEKOLAH	*School of Nursing JCU*
KONTAK DETIL	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

Saya _____ menyetujui untuk berpartisipasi dalam penelitian dengan judul *Pasien melarikan diri dari institusi kesehatan mental di Indonesia: sebuah studi kasus* yang dilaksanakan oleh Intansari Nurjannah untuk studi S2 yang bersangkutan di James Cook University Australia.

Saya memahami bahwa tujuan dari penelitian ini adalah untuk mengeksplorasi kejadian pasien meninggalkan rumah sakit tanpa ijin. Saya memahami bahwa peneliti akan melakukan wawancara dan saya juga menyetujui bahwa wawancara akan direkam dan akan memerlukan waktu maksimal satu jam. Tetapi saya tidak berkeberatan apabila peneliti menyampaikan pada yang berwenang apabila informasi yang saya berikan berkaitan dengan kejahatan yang serius. Saya juga memahami bahwa peneliti akan menjaga kerahasiaan saya selama periode pengumpulan data, analisis dan juga hasil dari penelitian (tesis S2, artikel jurnal) dari penelitian ini akan diberikan nama samaran.

Saya memahami bahwa saya akan dapat menghubungi Intansari Nurjannah kapan saja saya mempunyai kekhawatiran mengenai penelitian ini. Saya juga memahami bahwa partisipasi saya adalah sukarela sehingga saya dapat menarik diri dari partisipasi ini meskipun tanpa memberikan alasan apapun dan tidak akan mempunyai konsekuensi apapun pada saya. Saya juga setuju bahwa Intansari Nurjannah telah menjawab semua pertanyaan saya dengan jelas.

Nama:	
Tanda tangan:	Tanggal:

PERSETUJUAN MENJADI RESPONDEN UNTUK PASIEN

PENELITI UTAMA	*Intansari Nurjannah*
JUDUL PENELITIAN	*Pasien melarikan diri dari institusi kesehatan mental di Indonesia: Sebuah studi kasus*
SEKOLAH	*School of Nursing JCU*
KONTAK DETIL	Intansari Nurjannah Master Candidate Telephone: 08562916613 (Indonesia) and 0431268240 (Australia) School of Nursing Faculty of Medicine UGM, Sekip Bulaksumur Yogyakarta, 55281 (Indonesia) School of Nursing Faculty of Medicine Health and Molecular Science, James Cook University, Cairns Campus, Australia E-mail: intansari_nurjannah@jcu.edu.au

Saya _____ menyetujui untuk berpartisipasi dalam penelitian dengan judul *Pasien melarikan diri dari institusi kesehatan mental di Indonesia: sebuah studi kasus* yang dilaksanakan oleh Intansari Nurjannah untuk studi S2 yang bersangkutan di James Cook University Australia.

Saya memahami bahwa tujuan dari penelitian ini adalah untuk mengeksplorasi kejadian pasien meninggalkan rumah sakit tanpa ijin. Saya memahami bahwa peneliti akan melakukan wawancara dan saya juga menyetujui bahwa wawancara akan direkam dan akan memerlukan waktu maksimal satu jam. Saya juga memahami bahwa peneliti akan menjaga kerahasiaan saya selama periode pengumpulan data, analisis dan juga hasil dari penelitian (tesis S2, artikel jurnal) dari penelitian ini akan diberikan nama samaran.

Saya memahami bahwa saya akan dapat menghubungi Intansari Nurjannah kapan saja saya mempunyai kekhawatiran mengenai penelitian ini. Saya juga memahami bahwa partisipasi saya adalah sukarela sehingga saya dapat menarik diri dari partisipasi ini meskipun tanpa memberikan alasan apapun dan tidak akan mempunyai konsekuensi apapun pada saya. Saya juga setuju bahwa Intansari Nurjannah telah menjawab semua pertanyaan saya dengan jelas.

Nama:	
Tanda tangan:	Tanggal:

Appendix 5 Curriculum vitae

INTANSARI NURJANNAH

Current Address:
Program Studi Ilmu Keperawatan
Fakultas Kedokteran UGM
Sekip Bulaksumur
Yogyakarta, 55281, INDONESIA

Permanent Address:
Jl. Wijaya Kusuma No 150 A
Belakang TVRI Sta. Jogjakarta
Jogjakarta, 55284
INDONESIA

Birth date : August 26, 1972
Citizenship : Indonesian
Marital Status : Married, 2 sons

EDUCATION

1979 – 1988: Primary and Secondary School, Yogyakarta, Indonesia
1988 – 1991: Senior High School, Jember West Java, Indonesia
1992 – 1998: Bachelor Science in Nursing, Indonesia University (UI)
Subject: Nursing

WORK EXPERIENCES

1998 – now: Lecturer at School of Nursing Faculty of Medicine, Gadjah Mada University
Field of Study: Communication in Nursing
Psychiatric Nursing
1999-now : As a nurse at Sardjito Hospital Centre at Psychiatric Unit

TRAVEL EXPERIENCE

1994: Hongkong
1995: Singapore

2005: Australia

TRAINING :

Clinical instructure at psychiatric unit :
August 1998 at Faculty of Nursing Indonesia University

Therapeutic Communication Skills :
September 1998 at Faculty of Nursing Indonesia University

Research Methodology :
June 2000 at Faculty of Medicine Gadjah Mada University

Professional Nursing Practice Model :
March 2001 at Faculty of Nursing Indonesia University

Workshop in Problem Based Learning :
January, 2003 at Faculty of Medicine Gadjah Mada University

Training of trainer in mental health nursing :
Indonesia National Nurse Unity (PPNI), February 2004

RESEARCH

1999 (The first researcher) : The continuum coping responses of patient that is the prior reason to be inpatient at psychiatric unit

2000 (The first researcher) : Increasing nurse ability to determine the nursing problems by using the assessment and nursing problem guidance

2001 (The first researcher) : Depression Scale before and After Electroconvulsive therapy (ECT) in Patients who receive ECT at Sardjito Hospital Yogyakarta, Indonesia

2003 (The first researcher) : Influence of Cognitive-Proactive therapy for depressed patient at psychiatric unit

2004 (The first researcher) : Analysis length of stay of patient who suffered from mental illness based on Categorization System of Mental Illness's Patient

PUBLICATION

Book :

Therapeutic relationship between nurse and client (in Indonesian language)
Publisher: Program Studi Ilmu Keperawatan, Yogyakarta, Indonesia
Year: 2001 ISBN 979-96493-0-7

Journal Title :

Increasing nurses' ability to determine the nursing problems by using the assessment and nursing problem guidance (in Indonesian language)
Berita Kedokteran Masyarakat XVII (3) 2001, National journal,
(National accreditation) ISSN 0215-1936

Journal Title :

Depression Scale before and After Electroconvulsive therapy (ECT) in Patients who receive ECT at Sardjito Hospital Yogyakarta, Indonesia
Berita Kedokteran Masyarakat XVII (2) 2001, National journal,
(National accreditation) ISSN 0215-1936

Book :

Treatment guidelines for mental illness patient: management, nursing process and nurse-patient therapeutic relationship
Publisher: Mocomedia, Yogyakarta, 2004

Book :

Nursing process application to Nursing diagnosis: Risk violence: directed to others and disturbed sensory perception (in Indonesian language)

Publisher: Mocomedika, Yogyakarta, 2005

Book :
Communication in Nursing: Basic communication for Nurse (Including CD) (in Indonesian language)
Publisher: Mocomedika, Yogyakarta, Indonesia, 2005
Book :
Fast Methods of Formulating Nursing Diagnoses (Mix in English and Indonesian language)
Publisher: Mocomedia, Yogyakarta, 2006

Poster :
Case study with mixed methods: The design at Mixed Methods Conference (in English) 2007, UK

AWARDS

1994 – 1997: PPA Scholarship (University of Indonesia)
1996 – 1997: The best student (University of Indonesia)
2001: The most favorite teacher (Faculty of Medicine, Gadjah Mada University)
2002: The most favorite teacher (Faculty of Medicine, Gadjah Mada University)
2005 – 2007: ADS Scholarship Australia

ORGANIZATION EXPERIENCE

2001 – 2003: Assistant coordinator if Nursing Profession Program at School of Nursing Facutly of Medicine GMU
2002 – 2003: Leader of Training of Trainers at School of Nursing Faculty of Medicine GMU
2003 – 2004: Coordinator of Research and Publicatin at School of Nursing Faculty of Medicine GMU