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PHENOMENOLOGY OF 'ESCAPE' FROM A MENTAL HOSPITAL IN INDIA

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SUMMARY

Escape phenomenon is studied in a mental hospital in a retrospective design. From among the 3892 admissions of 1977, 128 case files of patients who were escapees according to the definition used, were picked up. The incidence of escape for the year 1977 was 3.3%. Results on different variables were compared with hospital admission statistics for the year 1977 to draw inferences. Using a Chi-aquare test it was found that escape incidence was significantly high in the below 30yr. age group, males, free voluntary boarders, manics and schizophrenics. The type of ward from where escape was made, the duration of their stay in the hospital before escape, and the clinical status at the time of escape were also examined. The implications of the results are discussed.

"Abscondences" from mental hospitals are conventionally labelled 'escapes' due to the legal implications involved. Thus escape forms one of the important phenomena that occur in mental hospitals. Muller (1962) and Antebi (1967) have dealt with the subject of 'abscondence' from mental hospital. From India there has been a study of personality and related factors of absconders from a psychiatric unit attached to a medical college hospital (Lal *et al.*, 1977). There are no such studies conducted in a mental hospital in India. The present study aims to examine the various characteristics of escapes from a mental hospital in our country where closed, open and family ward facilities are available.

The Hospital :

This hospital is the psychiatric clinical section of National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, which is a service, teaching and research Institute. It has a bed strength of 805 of which 256 beds are in the closed wards. Majority of the acute psychotics are admitted into closed wards. It also has open and special wards into which neurotics and less disturbed psychotics are admitted. Often, improved psychotic patients are transferred from closed to open wards. There is also a family psychiatric centre with 20 units, where the patient with at least one family member is admitted.

The majority (95%) of the hospital admissions are voluntary either free voluntary boarders (FVB) or paying voluntary boarders (PVB). There are also 'regular' cases—sent by the magistrates for admission and treatment. For convicted and undertrial prisoners accommodation is available in one of the closed wards where there is police supervision. After improvement voluntary patients are discharged and sent home either alone or with a relative. Female patients are sent home either with a relative or with a hospital attendant or social worker. The 'regular' cases are similarly discharged after decertification by the official board of visitors.

MATERIAL AND METHOD

In this hospital a patient is suspected to have escaped when he or she has left

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the ward and hospital premises without informing the ward staff. In all such cases an intimation is sent to the local police station and also to the relatives of the patient within 24 hrs. of escape. Taking the hospital policy into consideration, an escapee was operationally defined as "a patient missing from the ward for a period of more than 24 hrs. without informing the ward staff" The copy of the official intimation to the local police and to the relatives was taken as an additional evidence of escape. Patients going with relatives without permission of the ward staff (against medical advice) and patients not returning from parole (leave) were not considered as escapees in our study.

3892 patients were admitted in the year 1977. The case files of all these patients were scrutinized. 128 patients were found to have escaped, as per criteria mentioned above. This list was cross-checked with the 'escape register' of the hospital and escape intimation register maintained by local police, to ensure that no escapee was omitted from the study. The data from these case files were recorded on structured proforma and analysed. Findings were compared with hospital inpatients statistics for the year 1977 and inferences drawn.

RESULTS

(*a*) *Incidence*

The incidence of escape was 3.3%. 75% of escapees were literates with various levels of formal education. 56 male (47% of male escapees) and 7 female (88% of female escapees) escapees were married. Comparative data on different variables like age, sex, status at admission, number of admissions and diagnostic groups are given in Tables I and II. Significantly high incidence was found in the patients below 30 years of age (4.2%). There were no escapees in the age group below 15 years. Escape incidence was also high in males (4.9%) and free voluntary boarders (4.4%), low in females (0.56%) and paying voluntary boarders (1.2%). Manics and schizophrenics had higher incidence of escape (6.9%) and 5.3 % respectively) than patients in other diagnostic groups (p in all cases <0.001).

TABLE I—*Distribution of Escapees with reference to age, sex, status and number of admissions*

	No. of Escapees	No. of non-escapees	Total admissions	Incidence
Age (in yrs)				
Up to 30 ..	83	1,876	1,959	4.2%*
30-60 ..	41	1,767	1,808	2.3%
Above 60 ..	4	121	125	3.2%
Sex				
Male ..	120	2,346	2,466	4.9%*
Female ..	8	1,418	1,426	0.56%*
Status of Admission				
FVB ..	108	2,346	2,454	4.4%*
PVB & Special Wards	17	1,382	1,399	1.2%*
Regular ..	3	36	39	7.7%
Criminal ..	Nil	Nil	—	—
No. of Admissions				
1st ..	84	2,586	2,670	3.15%
Re-admission ..	44	1,178	1,222	3.6%

*$p<0.001$

TABLE II—*Diagnostic Groups and Escape*

Diagnosis	No. of Escapees	No. of non-escapees	Total	Incidence %
Mania (296)*	34	454	488	6.97**
Depression (296)*	1	189	190	0.52**
Schizophrenia (295)*	77	1,378	1,455	5.29**
Neurosis (300)*	5	511	516	6.97**
Organic Psychosis (290—294)*	5	214	219	2.28
Alcoholism (303)*	1	133	134	0.75
Others	5	885	890	0.56**
Total ..	128	3,764	3,892	3.3

*Diagnosis made according to ICD-8th Revision. In the case of Affective Psychosis, the clinical condition in which patient was admitted is given.

**$P<0.001$

(b) Types of wards and escape

The patients were grouped for convenience into the following groups :

Group I—Patients admitted to closed wards and escaped from there (n=57)

Group II—Patients admitted to closed wards and escaped after being transferred to open wards (n=47)

Group III—Patient admitted directly to open wards and escaped from there (n=24)

(c) Clinical status at the time of escape

56% of total escapees had improved by the time of escape. In Group I, 28 out of 57 (50%), in Group II, 40 out of 47 (85%) and in Group III, 4 out of 24 (17%) patients had improved by the time of escape (Ref. Table III).

(d) Duration of hospitalization

Table III gives the mean number of days of stay in the hospital for each group of escapees. It also gives the number of days taken for improvement for the improved cases. There were no statistically significant differences between the groups in the number of days spent in the hospital before escape or in the number of days of overstay after improvement. The mean number of stay for all inpatients discharged in the year 1977 was 55 days. It can be inferred from Table III that escapees stayed for a shorter duration.

TABLE III—*Duration of Hospitalization*

	Group I	Group II	Group III
Mean number of days of stay in the hospital before escape (total number of escapees=128) ..	28 (n=57)*	29 (n=47)*	13 (n=24)*
Mean number of days taken for improvement (Improved category total number=72)	30 (n=28)*	30 (n=40)*	19 (n=4)*
Mean number of days spent in the hospital after being declared as improved (over stay) ..	8	10	4

*Number of patients in each group.

Using analysis of variance there were no statistical differences between these groups in the mean number of days of hospitalization or number of days, of overstay after improvement.

DISCUSSION

Our study differs from other studies in the very definition of an escapee. Lal *et al.* (1977) in their study of absconders, included patients, who had gone with relatives without permission of the hospital staff and also patients who had gone on leave and did not return. Studies conducted in mental hospital by Antebi (1967) and Muller (1962) have used similar definitions.

The escape incidence in our study is 3.3% as compared to abscond incidence of 11.6% observed by Lal *et al.* (1977). The differences in the operational definition of escapee could account for this.

The facilities, such as occupational therapy, recreational activities like outdoor games, picnics, and open ward admission give opportunities for escape. Against this background the 3.3% incidence of escape in this hospital is negligible.

Increased frequency of escape in younger patients is consistant with findings in other studies on absconders (Lal *et al.* 1977, Antebi, 1967). The low incidence of escape in female patients (0.56%) needs to be viewed in a cultural perspective. In a British study Antebi, (1967) found that out of 166 absconders, 64 were females. On the other hand, the female to male ratio observed in another Indian study (Lal *et al.*, 1977) was 1 : 8.2. The major factor for this low incidence of escape in women may be the culturally inculcated restrictions in Indian women.

The greater incidence of escape in free voluntary boarders (4.4%) as compared to that in paying and special ward patients (1.2%) needs comment. Even a nominal payment can perhaps impose a greater sense of responsibility on the patient and

relatives. Another reason which appears more plausible may be the constant presence of and frequent visits by relatives.

A higher order of literacy among escapees could be interpreted as being due to greater confidence on the part of these patients to venture out alone.

Among the diagnostic groups schizophrenics and manics stand a high chance of escape (Table II). When mania is taken alone as a sub group, the escape incidence is highest (6.97%). It is likely that manic patient may have stronger desire to get out of the hospital both in illness and recovery Factors like cheerful mood, ability to establish good rapport and higher degree of manipulations also may have contributed to the difference between the incidence rates of escape in various sub-group and schizophrenic sub-group. The escape incidences in neurotics and psychotic depressives are significantly less.

It is worth noting that of 264 admissions to family ward, none escaped. Narayan *et al.* (1972) had reviewed the advantages of treatment in family ward and it may be the presence of a family member that prevented escape.

Data in Table III indicate that a good number of patients in the hospital stay for longer periods than required. Sharma & Hussain (1977) have already observed that patients stayed for a longer duration in mental hospitals than in general hospitals. In Group III (patients admitted to and escaped from open wards) unimproved patients formed a large percentage (83%). The mean number of days of hospitalization for this group was also less (13 days), when compared to other groups. This indicates that some amount of restraint in the form of 'closed ward' is justified in the active phase of illness, an issue which is highly debatable until various factors are systematically investigated.

The follow-up data we have on these escapees is beyond the scope of this paper. However, it is worth mentioning that no escapee was left untraced.

The study has concluded that males, younger patients, free voluntary stay, some degree of literacy, manic or schizophrenic illness are the factors found commonly among escapees as identified by our study. Being vigilant on such groups of patients can be of preventive value, especially so for unimproved patients.

In addition to insistence of involvement of family members in the therapy of mentally ill, we suggest that relatives could be informed of a probable period of hospital stay necessary for improvement, which is now possible because of availability of physical methods of treatment. This has to be worked out for each diagnostic group in each hospital. We cannot, however, overlook the various factors in the community and in the family and also the hospital atmosphere which give rise to the phenomenon of escape.

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