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Medicolegal Problems of Elopement from Psychiatric Units

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ABSTRACT: Elopements from psychiatric units are a frequent but usually low-grade risk. However, they are sometimes followed by harmful consequences, for which the psychiatrist and the hospital may be held liable. We describe management methods developed to reduce such liability. These include a structured observation system and procedures to return elopers to the hospital or to refer them for community-based treatment. Data on 105 elopers and 360 controls were gathered and analyzed. Acceptance of some risk of elopement is inevitable on wards that follow the principle of treatment in the "least restrictive alternative."

KEYWORDS: psychiatry, jurisprudence, elopements, psychiatric unit, liability, risk management

Patients who leave the hospital without permission constitute a pervasive but little acknowledged problem in psychiatric units. In the literature, this behavior is usually called an elopement and the patient an eloper; less frequently, terms such as absconds, AWOL, run-aways, and escapees are also employed. Wards that attempt to maintain a therapeutic environment and adhere to the principle of treatment in the "least restrictive alternative" are especially vulnerable to such unauthorized departures. Elopements are important because they disrupt treatment and produce difficulties and embarrassment for the hospital and the staff. Beyond that, they also have medicolegal, risk, and liability consequences that become prominent when the patient or others suffer harm following an elopement. Under such circumstances, legal actions to recover damages may ensue or be threatened. Typically, a plaintiff claims negligence by the psychiatrist or the hospital, which presumably had a duty to prevent the elopement.

Incidents drawn from the authors' clinical experience and from legal case citations exemplify the risks inherent to elopements. After leaving the hospital, some elopers have become involved in accidents or in offenses like assault, theft, and homicide; others have committed suicide or lesser acts of self-injury or have suffered from exposure. The list of possible com-

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plications is certainly not limited to the foregoing examples. In this study we are concerned primarily with the liability potential associated with each elopement and with methods of reducing the liability. The work was done on our unit in the context of a risk management program established to examine the causes of risk and to take action to reduce their frequency and severity, as mandated by Medicare regulations [1]. Risk management concepts also provided the framework for the problem analysis and the development of risk reduction policies [2].

Little research has been done on elopements. Since no generally accepted criteria for defining and reporting such incidents have been established, comparisons among different hospitals are not necessarily meaningful. Elopement rates of 2 to 15% of yearly admissions have been reported [3]. The frequency of elopements is understated because some reports include only elopers who have been automatically discharged at some set time after leaving the hospital. Elopers who return to the ward before the set time (usually midnight) are not counted if discharge is a necessary criterion for recording the incident as an elopement.

Legal Precedents

To form a crude estimate of the relative frequency and of the outcome of court cases involving elopement, we scanned *The Citation* for 1980 to 1983. This biweekly journal is a medicolegal digest prepared by the Office of the General Counsel of the American Medical Association. In the four-year period, five cases involving elopement were cited. In each instance the elopement was followed by harmful behavior. Two cases involved patients who were struck by automobiles after eloping [4,5], one a suicide attempt [6], one an assault where the plaintiff was assaulted by a patient five years after the latter's elopement from a mental hospital [7], and one a murder [8]. We found no lawsuits filed because of elopement unless it was followed by harmful behavior. Findings of negligence against the psychiatrist or the hospital have so far not been sustained by the courts in any of the above cases.

Characteristics of the Unit

The study was conducted in an 80-bed psychiatric ward in a 650-bed county general hospital with a major university affiliation. Its mission is to provide acute treatment to adults and it receives both voluntary and involuntary patients. The mean length to stay is 14 days and the occupancy rate 95 to 100%. Approximately 1900 admissions are handled each year.

A number of policy changes were instituted on the unit in 1981. Previously, doors had been frequently and, on one zone, always locked; the majority of patients had been admitted on involuntary status; and all had been obliged to wear hospital attire. The new policies established that doors would remain unlocked except for temporary high-risk situations, personal attire would be worn by all patients unless an order to the contrary was issued, and whenever possible, patients would be admitted on voluntary rather than involuntary status. These changes were instituted by the department administration to foster a more therapeutic atmosphere on the ward. Additional pressure was exerted by an accrediting agency which, in the course of a site visit, had identified a number of practices not in conformity with "the least restrictive alternative."

Clearly the design and philosophy of a psychiatric unit determine many of the problems that will arise. In our case the open-door transformation of the ward was followed by an increase in elopements. These escalated from a 1980 figure of 2.5% to a 1981 figure of 7% of admissions. Although even the latter figure is within the range reported in other studies, the acute nature of the patients, as well as the fact that 45% of the elopers were hospitalized involuntarily, caused concern. During 1981 to 1983 a study of the elopement problem was conducted. The following factors were considered: architecture of the unit, patient mix, characteristics of the elopement and of the elopers, and policies for dealing with elopement.

Since the architecture and patient mix could be subject to little modification, the major effort of analysis was concentrated on the remaining variables. It should be noted that this was a civil unit on a general hospital and that in New York State, where the study was conducted, involuntary admission to such units in the majority of cases is a medical decision with no court involvement.

Methods

Like all unusual and untoward occurrences in the course of a patient's hospital treatment, each elopement was routinely reported by unit staff and investigated by the department's risk management committee (called the Special Review Committee). Although the study began in 1981, the majority of the data reported here refer to 1983. By that time, definitions, criteria, and procedures regarding elopement had been sufficiently developed to allow the systematic collection and analysis of the data.

An elopement was defined as any unauthorized departure of a patient from the hospital grounds, regardless of whether the patient returned to the unit or was discharged. Elopers who did not return by midnight of the day of elopement were discharged. Elopements were also classified as minor or major incidents, according to the risk evaluation of the patient. On arrival to the unit each patient was assigned a level of observation, increasing from I to III according to the assessment of the severity of the risk of suicide, assault, escape, or other dangerous behavior. Any elopement involving a patient on Level II or III observation was classified as a major incident, regardless of whether or not dangerous behavior occurred. The elopement of a patient on Level I observation was classified as a minor incident if no dangerous behavior or other complication occurred.

Comparative data on a number of demographic and clinical variables for all the elopers in 1983 ($N = 105$) and 360 controls were collected. The controls were the first 30 nonelopers admitted to the unit for each month in 1983. The results were tested for statistical significance by *t* tests or chi-square tests corrected for continuity.

Results

In 1983 the elopement rate was 5.5% (105 elopements, 1914 admissions). A recalculation limited to the nonreturned (discharged) elopers gave an elopement rate of 2.7% of yearly admissions. The mean number and standard deviation of elopements per month was 8.75 ± 3.98 (range 3 to 17), with a July peak and January minimum, as might be expected given the climate. Eighteen (17%) of the elopements were classified as major and eighty-seven (83%) as minor incidents. Fifty-four (51.4%) elopers returned before midnight of the day of elopement and fifty-one (48.6%) were automatically discharged since they had not returned by midnight.

The frequency distribution of elopements by time of day, day of the week, and day of hospitalization had been analyzed in 1982. The peak time for elopements was between 1300 and 1400 hours and did not coincide with the lowest staffing level, which was during the night shift. Approximately one third of the elopements took place in the first three days of hospitalization. Data on these variables were not collected in 1983 as this information proved to be of limited utility and could not be applied to specific preventive measures.

Comparative demographic and clinical data for the 105 elopers and 360 controls are displayed in Tables 1 and 2. Statistically significant differences between the elopers and controls were found for the variables of age, legal status, and diagnosis. Elopers were younger, more likely to be involuntary, and to have a diagnosis of schizophrenic disorder.

In eight instances visitors colluded in the escape, for example by supplying street clothes. There were only two known incidents where some harm befell the eloper after the elopement. One patient suffered frostbite to the feet and was admitted to another hospital; another patient was readmitted to our hospital after overdosing.

TABLE 1—Characteristics of elopers (N = 105) and controls (N = 360).

Variable	Elopers	Nonelopers	Test
Age, mean years and standard deviation	27.03 ± 7.58	34.11 ± 14.77	$t = 5.24$, $df^a = 463$, $P < 0.001$
Sex, N (%)			
Male	57 (54.3)	166 (46.1)	$\chi^2 = 1.86$, $df = 1$, $P > 0.05$
Female	48 (45.7)	194 (53.9)	
Legal status, N (%)			
Voluntary	38 (36.2)	244 (67.8)	$\chi^2 = 32.67$, $df = 1$, $P < 0.001$
Involuntary	67 (63.8)	116 (32.2)	

^adf = degrees of freedom.

TABLE 2—Diagnoses of elopers and controls.

Diagnosis	Elopers, N (%)	Nonelopers, N (%)	Test
Schizophrenic disorder	56 (53.3)	130 (36.1)	$\chi^2 = 9.34$, $df^a = 1$, $P < 0.01$
Affective disorder	35 (23.8)	89 (24.7)	$\chi^2 = .004$, $df = 1$, $P > 0.75$
Personality disorder	10 (9.5)	18 (5.0)	$\chi^2 = 2.19$, $df = 1$, $P > 0.05$
Substance abuse	9 (8.6)	23 (6.39)	$\chi^2 = 0.31$, $df = 1$, $P > 0.25$

^adf = degrees of freedom.

Reducing Liability

As the study advanced, administrative procedures were reviewed in order to reduce the number of elopements and to minimize the liability associated with each incident. The observation process was restructured, routinized, and linked to defined time intervals: the whereabouts and activity of each patient were monitored at intervals of 1 h for routine (Level I) observation, 30 min for Level II, and 15 min or less for Level III. Staff were required to maintain a written record of the observations, thus fixing accountability. The precautions noted on the admissions order sheet, for example suicide or escape precautions, were linked to the system of levels of observation according to clinical need and estimated risk. After these measures were introduced, elopements declined from 7% of yearly admissions in 1981 to 5.5% in 1983 (2.7% if the elopers who returned are not included). Equally important, staff were quickly alerted to the absence of any patient and could promptly initiate steps to locate and recover the missing individual.

Although the elopement rate was reduced by these preventive measures, the problem could not be eliminated entirely without resulting in some regressive changes in the ward milieu. To further reduce the risk of harmful behavior and the liability, we instituted procedures to maximize the return of runaway patients to the hospital or to refer such individuals for community-based treatment. A checklist of procedures to be executed and documented by staff on discovery of an elopement was developed. If the patient is considered dangerous, the police and any potential victims are notified. The assistance of family or friends to locate and return the patient to the hospital is always sought and frequently obtained. The police assist in returning involuntary patients.

Structural architectural changes were not feasible and in any case would have contributed little to preventing elopement, in view of the open-door policy. However, the number of exits was reduced to one bank of elevators; two additional exit routes had been available. The

stationing of personnel to monitor closely the flow of patients, staff and visitors into and out of the unit was considered but rejected as impractical.

Prediction and Outcome of Elopement

A plausible approach to elopement prevention is the identification of those patient variables most likely to be associated with elopement. Thus, Altman et al [3] reported that elopers tended to be single, male, 15 to 19 years old, nonwhite, Catholic, and to carry diagnoses of acute brain syndrome, personality disorder, mental retardation, or schizophrenia. Other investigators have used sophisticated statistical techniques that suggested predictions could be made regarding the likelihood of escape [9]. Using a discriminant function analysis, they found that individuals with the diagnoses of depression or substance abuse were more likely to elope and that elopements were more likely to occur in the first few days of hospitalization.

Other studies refer to the broader category of irregular discharge and include patients discharged against medical advice (AMA) as well as elopers. Low staffing and poorly motivated patients were found to be associated with irregular discharge [10]. A comparison of the outcomes of regularly discharged patients one and two years after discharge showed only slight differences between the two groups of patients upon follow-up assessment of social and clinical functioning [11]. However, the management and medicolegal issues associated with elopements differ substantially from those associated with AMA discharges, where the patient is presumed to be competent and the departure often has staff sanction.

Discussion

Elopements from psychiatric wards are common. Although the behavior is not adaptive, from the patients' perspective the escape from an unwanted detention is often existentially understandable. From the viewpoint of the psychiatrist, elopements should be prevented because they interrupt treatment prematurely and are a source of liability. To our knowledge, only elopements which were followed by harmful consequences have provided grounds for tort claims.

Eloper profiles generated by analysis of eloper data do not appear to be sufficiently specific to be useful for elopement prevention and control. The issue in elopement prediction is not so much the elopement itself but the occurrence of harmful behavior following the elopement. The problems associated with the prediction of elopement are thus similar to those of forecasting violent behavior. The practical limitations of such prediction even by careful clinical assessment are well known [12]. Some of the clinical cues used to make these predictions have been reported to be unreliable [13]. A data base on the frequency of the dangerous outcomes of elopement is not available. In our experience the majority of elopements are relatively benign incidents without major untoward consequences. However, an attitude of complacency is not warranted, because an incident that ordinarily is regarded as a low-grade risk occasionally escalates into an event with major medicolegal and liability implications.

In practical terms, the dilemma of elopement prevention is the marginal trade-off between the risks of elopement, or more precisely of dangerous behavior after elopement, and the cost of elopement prevention [14]. The costs are represented by the effects on a ward milieu of the restrictive measures necessary to curtail elopements. On a locked ward, the freedom of movement of all patients is restricted and staff time and effort expended on security are not available for therapeutic endeavors.

The court cases we have sampled, though few in number, clearly show that the prospect of lengthy and expensive legal proceedings exists when an elopement is followed by harmful consequences. This remains true even when the connection between the elopement and the harmful behavior is remote, as it was in *White v. Montana* [7]. Moreover, recent trends in tort law have been found to favor granting some compensation whenever harm is incurred and thus to expand psychiatrists' liability for the violent acts of their patients [15]. As a

reflection of a generally and increasingly litigious society, an increase in tort claims related to elopements may be anticipated.

To develop a defensible position in case of lawsuits or quality-of-care investigations arising from elopement-related incidents, it behooves psychiatric wards to conduct a risk assessment of this problem. Policies can then be formulated that are aimed at reducing the liability by preventing elopements, returning elopers to the hospital, or arranging referral for community-based treatment. Although exposure to liability can be diminished through the above measures, some risk of elopement must be accepted on units where treatment is according to "the least restrictive alternative."

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