Crisis, trauma and loss: an exploratory study into those who ‘come to notice’ to police and health services and subsequently abscond

Francis Pakes‡, Karen Shalev-Greene† and Connor Marsh‡

‡(Corresponding author) Institute for Criminal Justice Studies, University of Portsmouth, St George’s Building, 141 High Street, Portsmouth PO1 2HY, UK. Tel.: +44 (0)2392 843607; Fax: +44 (0)2392 843972; email: Francis.pakes@port.ac.uk

†Institute for Criminal Justice Studies, University of Portsmouth, UK

Submitted 16 April 2014, accepted 10 August 2014

Keywords: homeless, trauma, autonomy, illness, police, hospital

Francis Pakes is Professor of Criminology at the University of Portsmouth. He has published extensively on psychology, mental health and criminal justice. Another strand of research considers crime, law and social change in his native Netherlands.

Karen Shalev-Greene is the Director of the Centre for the Study of Missing Persons at the University of Portsmouth. She collaborates on various research projects with police agencies, police forces, NGO’s and other academics in the field from the UK and internationally.

Connor Marsh is a Criminology and Sociology graduate from the University of Surrey and a previous employee of the UK Missing Persons Bureau.

ABSTRACT

This article considers a phenomenon of which the prevalence, as well as the causes are quite unclear. It refers to individuals who contact the police, or check into hospital (or who are found by members of the public) with real or imagined emergencies only to leave or abscond before any intervention can be implemented. These individuals frequently refuse to give their name or use aliases. They tend to engage repeatedly in this behaviour. This article reports on a thematic analysis of the case notes that are kept in the UK Missing Persons Bureau database, in order to shed light on the question of what it is that brings these people to ‘come to notice’ (in police jargon) and why they subsequently seek to evade the attentions of health care and criminal justice agencies. Some thoughts on the reporting and recording and on successful interventions are discussed.

INTRODUCTION

Judy frequently phones the police to say that she is about to kill herself. She may be standing on a bridge, a railway platform or on the edge of a river or lake. At other times, she may check into a hospital under a false name, complaining of chest pains or saying that she has taken an overdose. However, she has a habit of leaving these establishments before any diagnosis can be made or treatment put in place. Judy has done this many times over many years across the UK. She often mentions her children and speaks of visiting them, but it is unclear whether there is any contact.

Judy seems to have a history of mental health problems. She has been the subject of various interventions under the Mental Health Act 2007. Altogether, the Act has been invoked in her case at least 35 times, utilising sections 2, 3 and 136. She has 14 known aliases.

In policing terms, Judy is a person who frequently ‘comes to notice’. People who come to notice in this way are usually in
An exploratory study into those who ‘come to notice’

severe need of support and frequently require a crisis intervention response. But then, prior to the establishment of diagnosis, treatment plan or other form of provision, the person has left, only to reappear in a different area, suffering from another emergency situation and quite possibly utilising yet another alias. This article seeks to further our understanding of the seemingly paradoxical behaviour of these individuals.

The UK Missing Persons Bureau, part of the National Crime Agency, holds the so-called ‘Come to Notice’ database, which contains information on approximately 140 of these individuals. For operational purposes, the Bureau holds a national database of missing and found persons of which the Come to Notice database forms a part. When a police report comes in that resembles the circumstances or behaviour of an individual contained in the latter database, a connection can be made. Thus, the identity of a missing person or someone classed as ‘unidentified alive’ can established. The database contains case notes and photographs, but not usually any specific medical information because this is not available to the police.

This article seeks to make sense of the behaviour of these individuals through a thematic analysis. We selected the case notes of 15 prominent individuals. The first five individuals were selected because they had the most ‘come to notice’ episodes documented within their case notes on the UK Missing Persons Bureau database. Within these five individuals, the number of ‘come to notice’ episodes varied from 14 to 28. Ten further individuals were selected on the basis of concerning whom most information was available for this project to analyse. These 15 form the basis of this article. This is a purposeful sample that allows no strong claims in terms of random selection, representativeness or generalisation. However, it can be surmised that this group displays behaviour patterns that may well typify the behaviour exhibited by many of the ‘come to notice’ population. The thematic analysis seeks to shed light on two questions: first, what prompts these individuals to come to notice; and second, what prompts them to leave or abscond before any intervention that is seemingly required can be provided?

By tackling these questions it is hoped this project will raise awareness of the very existence of this group, particularly to those that tend to attend to them, the police and health agencies. Although there is some literature on those who abscond from mental health facilities, the come to notice group seems to be different from regular ‘absconders’ from medical establishments. The profile of hospital absconders is typically male, relatively young and often suffering from schizophrenia, and when they abscond, they typically go home or visit the home of a friend or relative (Bowers, Jarrett, Clark, Kiyimba, & McFarlane, 1999a; Dickens & Campbell, 2001; Mosel, Gerace, & Muir-Cochrane, 2010; Muir-Cochrane, Mosel, Gerace, Esterman, & Bowers, 2010). The strongest predictor for hospital absconding is, unsurprisingly perhaps, previous absconding (Bowers, Jarrett, Clark, Kiyimba, & McFarlane, 2000). The reasons why individuals abscond have been researched as well. Bowers, Jarrett, Kiyimba, and McFarlane (1999b) interviewed 52 absconders and found that the principal reasons given included boredom, fear of other patients, feeling trapped and outside responsibilities. In Australia, Meehan, Morrison, and McDougall (1999) interviewed patients after they returned and found six principal reasons for their absconding behaviour. They are boredom, lack of interesting activities, disturbed ward environment, perception of a lack of need for hospitalisation, concerns about issues at home and the perceived rewards for absconding (Clark, Kiyimba, Bowers, Jarrett, & McFarlane, 1999). An earlier small-scale qualitative study by McIndoe (1986) considered reasons for absconding through interviews with five absconders, finding that a
‘sense of meaninglessness’ was an important factor for them to leave. Patients reported that they did not feel that they should be hospitalised, that others on the ward were in a worse state than they were and that they could manage their condition themselves outside. Clearly, there are any number of reasons that may prompt individuals to leave the setting in which they are looked after. However, it must be borne in mind that the ‘come to notice’ group is different in two respects. First, they are not in-patients, and second, they initially seek attention, only subsequently to evade it. This study, therefore, explores whether a better understanding of the dynamics that prompt individuals to come to notice will also improve our understanding of why they subsequently leave.

**METHOD**

This research project, through scrutinising cases notes, looked for themes that seem to inform or typify the behaviour of ‘come to notice’ individuals and that occur broadly across the sample. It does not mean that all 15 persons will share all characteristics. Instead, there is a twofold purpose to describing these dominant emerging themes. First, they aim to shed light on the behavioural pull-and-push factors that cause these individuals to come to notice on a more or less regular basis and their frequent subsequent disappearance. Second, it is believed that knowledge of this will help health and police professionals identify these individuals and gain a frame of reference that may help in understanding them and their seemingly incongruous or incomprehensible behaviour. This may go some way towards creating a response to these individuals that increases their willingness to engage with treatment or other forms of help.

Thematic analysis (Bryman, 2012) is a method for identifying, analysing and reporting patterns (themes) in data. Braun and Clarke (2006) highlight the flexibility of this qualitative method. Among other advantages of thematic analysis, Braun and Clarke note that it can usefully summarise key features of data and offer a ‘thick description’ of what is contained in the data. It allows for social, as well as psychological interpretations and can be useful for producing qualitative analyses suited to informing policy development.

The first level of analysis was aimed at arriving at themes that emerge through scrutinising the case notes. This is in accordance with an inductive approach to thematic analysis in which the themes identified are strongly linked to the data. Six themes were identified in the course of this part of the analysis. In the second phase, an underlying pattern of meaning was established by looking for themes at a latent or interpretative level (Boyatzis, 1998), as advocated by Braun and Clarke (2006). This part of the analysis seeks to examine underlying ideas that are less obviously manifest in the data, but may explain these themes. This led to the postulation of three underlying or semantic themes.

Some limitations of the data and of the method to make sense of the data must be acknowledged. The first is the obvious fact that the analysis cannot be based on first-hand accounts of these individuals in their own words. Instead, it relies on notes provided by police officers, and their accounts may be influenced by their professional perspective. However, these notes were forwarded to ascertain whether other police officers would recognise these individuals either by name or alias or through a description of their behaviour and the relevant circumstances. Those descriptions are therefore meant to be informative and individualised and form a useful basis for analysis.

**The 15 individuals**

In this section, the 15 individuals that form the basis of this article will be introduced. Eleven of these are women, the other four
men, and they range in age from their 20s to their 70s. To preserve their anonymity, crucial details have been omitted or changed. In order to give the reader a good impression of the type of behaviour and individuals contained in the database, three individuals are described in detail (this includes Judy who was introduced at the beginning of this article). The other 12 are more summarily introduced. All names are fictitious to ensure the confidentiality of the individuals involved.

Kim
Kim is a woman in her 30s. She frequently threatens to kill herself. She has exhibited this behaviour in numerous locations including England, Scotland and Northern Ireland. She says that she has been raped or sexual assaulted in the past, sometimes by her father. Kim talks about her baby or her children frequently. She has made statements to the effect of she has left or killed her baby or that her child has been taken away by social services. She has been found carrying photos of a child, or a foetal scan photograph. Kim is often found in a dishevelled state. Seemingly accustomed to sleeping rough, she has been found without shoes and with personal hygiene neglected. She is thought to have been hallucinating and she seems to hear voices at times. She tends to give false names and dates of birth; there are 45 known aliases. Case notes detail that she has been frequently sectioned under the Mental Health Act 2007 or detained under section 136. She has displayed violent and threatening behaviour, especially when drunk.

Kristian
Kristian is in his 70s. He is frequently found at airports or bus stations. He suffers from depression and leads a nomadic lifestyle. He says that he has no family or friends and that now he is retired he likes to travel the country and frequently stays in guesthouses. He tends to mention a head injury, which causes him to forget to pay for things. When approached at arrivals in airports, he usually says he is waiting for a fictitious relative on a flight that doesn’t exist. He can get quite angry and agitated when challenged. He has sought medical help on numerous occasions for a variety of complaints. However, he refuses to give medical information because he says he does not trust doctors. There are at least 10 known aliases. According to the case notes, he has tried to commit suicide at least once and has been hospitalised in a mental health facility in the past.

The 12 others
Chloe is a lady in her 60s. She is often found disorientated or collapsed or complaining of stomach pains. This happens regularly on trains and at railway stations, but she is also repeatedly found walking into busy traffic. She has had spells of homelessness and has been frequently detained under the Mental Health Act 2007. She has five known aliases.

April is a lady in her early 60s. She has communication difficulties but is able to use sign language. She is regularly found wandering in a dishevelled state or found collapsed. She seems to be suffering from cerebral palsy and is quite possibly regularly homeless. She has at least 19 known aliases.

Kelly is in her 40s. She tends to feign epilepsy or another form of illness to gain access to hospital. She is often found on trains, and has been a patient in a large number of hospitals. She is usually unwilling or unable to give personal details.

Michelle is in her 30s. She tends to wander into traffic. She has communication issues and may be deaf and or mute. She tends to be picked up by the police when she is threatening to kill herself. She frequently alleges having been raped by her father.

Hannah is in her 30s. She tends to enter hospitals with a variety of complaints. She has been known to be suicidal and has a history of giving false details.

Nicky is in her 30s and has a habit of entering hospitals saying that she has taken an
overdose, which is often non-lethal in dosage. She has also threatened to commit suicide by throwing herself under a train. She has a history of depression and drug abuse.

Elizabeth is in her 40s. She enters hospitals with a variety of complaints such as chest pain, epilepsy or having a blood clot. She tends to take overdoses and she may be suffering from schizophrenia and/or bipolar disorder. There are no fewer than 53 aliases on record for Elizabeth.

Brenda is in her 40s. Brenda is sometimes found covered in blood after self-harming with razor blades. She is diabetic and may collapse if she neglects that condition. She tends to make allegations of rape, and has in the past attempted suicide.

Ben is in his 30s and has been found in various parts of the country with burns or self-inflicted wounds. He is thought to have mental health difficulties.

Helen is in her 20s. She tends to present at Accident & Emergency with breathing problems or stomach pains. She sometimes claims that these injuries are as a result of domestic or sexual abuse. She has 16 known aliases.

Clive is in his 60s. He is frequently homeless and apparently struggles to cope after the death of his wife. He tends to leave hotels, bed and breakfasts and hospitals unexpectedly where he often checks in with chest pains, but at some point simply walks off the ward. He is thought to suffer from angina, anxiety and panic attacks.

Jim is in his 40s. He regularly checks into hospital for epilepsy, having fits, collapsing or high blood pressure. Jim has a long arrest history including for violent offences and theft. He has four known aliases.

FROM CRISIS TO LOSS: A CASE ANALYSIS THROUGH SIX KEY THEMES

The stories of those who ‘come to notice’ are obviously varied. However, it is also quite clear that their personal narratives and life histories, as relayed, display a degree of consistency over time, as do the ways in which they come to notice. The same can be said for some of their behaviour patterns and emotional preoccupations. It must be made clear that the case notes tend to document the behaviour and stories of these individuals and much of this cannot be independently verified. It is therefore important to bear in mind that, to a degree, they will reflect the way these individuals (choose to) present themselves, ie, their subjective reality. It cannot make claims to the veracity of their versions of events.

However, this circumstance does not preclude an analysis to identify pattern and meaning in how these individuals present themselves, not only as individuals, but also collectively. The nature of the data allows for a meaningful semantic analysis because the data comprise summary notes written down by police officers rather than the individuals’ own words. Through this method, six themes that underlie the patterns of behaviour have been identified and they may help in understanding what moves these individuals to come to notice at certain times and why they fail to become mainstreamed into care at the same time. The themes are: crisis, anonymity, mobility, loss, illness and trauma. These are the manifest themes; they help in recognising these individuals and their behaviour. Subsequently, a deeper level of analysis is engaged in. It uncovers three themes that may not be as evident from the data, but that help us to better understand the behaviour of these individuals because they refer to psychological drivers that place their behavioural patterns in context.

Crisis

The first theme to note is that of crisis. Appropriately, crisis is the first theme identified because it is typically as a result of a personal crisis that individuals come to official notice in the first place. Such crises can take many forms. Frequently, they involve
suicide intention or ideation. Individuals may be found on railway lines or stations, walking onto motorways or standing on bridges. They may involve instances of victimisation. For others, they are real or imagined medical emergencies and for outsiders it is usually not possible to distinguish between the two. These may be communicated through emergency calls or by voluntary checking into services. Others are mostly found in a confused or dishevelled state and are brought to official attention through a member of the public.

The specific crisis is remarkably consistent over time within the same individual. Judy is a good example with her frequent announcements of suicides. Other examples include April, who regularly checks into hospital for imagined appendicitis, and Chloe who has a tendency to endanger herself by walking into busy traffic situations. Helen frequently reports breathing problems. Nicky often takes large amounts of pills and is admitted urgently into hospital. Ben tends to present with a variety of injuries some of which may stem from self-harm. These examples demonstrate that there is a degree of consistency in how these individuals experience crises.

It tends to be a crisis that prompts our individuals to come to notice. But what is it that makes them disappear? Quite often individuals have left before any interventions can take place or even before the need for any intervention can be established. This suggests that these individuals do not seek long-term engagement with services. Perhaps on many occasions, the sense of crisis that caused the person to come to notice recedes after a few meals, some sleep and a degree of empathetic human contact. Perhaps from that moment onwards, other human needs take precedence. From analysis of both the temporal and spatial patterns of the crisis situation, we suggest that ‘crises’, although frequently occurring, represent atypical situations. In fact, crises endanger two facets of their lives that the come to notice group of individuals seem to hold very dear, those of mobility and anonymity. These two themes are discussed in turn.

**Anonymity**

Of the 15 individuals that form the basis for this paper, most have a habit of providing false information to conceal their identity. The use of false identities is rife: Hannah has been known to use 35 aliases, Judy 13 and Elizabeth no fewer than 53. From that it can be inferred that lying about their identity is of great importance to them as it serves the purpose of securing their anonymity. The sample of individuals was also found to deploy a range of other behaviours to protect their identity. Kim tends to bury her head when her photo might be taken. April was reported to feign amnesia so that she could not remember who she was or where she lived. Several indicate that they have communication issues and are therefore unable to provide details. Michelle is thought to feign a seizure or another medical emergency when pressed for personal details. Others lash out. Elizabeth, for instance, has repeatedly become aggressive, particularly when paperwork was to be filled out. It is clear that the threat of losing anonymity or being encapsulated into ‘the system’ brings about fear and that may result in volatile behaviour.

Perhaps the most typical behavioural manifestation that can be interpreted under the theme of ‘anonymity’ is that of sudden departure. Kristian has a history of leaving establishments suddenly and tends to claim memory problems for that. Clive, who has a history of homelessness, tends to leave medical establishments quietly before being discharged. Helen tends to do the same. Kim has done the classic ‘going out for a cigarette’ and not returning. All of the 15 individuals display similar behaviours. Suddenly they are gone, much to the frustration of care professionals.
The desire for anonymity quickly seems to gain the upper hand when an immediate crisis has been resolved but prior to securing long-term engagement. Such developments may seem threatening to these individuals who clearly prefer to fly under the official radar when they can and only in times of crisis seem prepared (or forced) to give up that anonymity. A research project on ‘geographies of missing’ (Stevenson, Parr, Woolnough, & Fyfe, 2013; see also http://www.geographiesofmissingpeople.org.uk/) noted that a personal crisis is frequently a precursor for going missing. In our sample, the opposite occurs, as a crisis instead serves as the circumstance or reason to stick their head above the parapet and come to notice.

Mobility
A further way in which anonymity can be secured is through mobility, the third theme. Many of the individuals are seemingly of no fixed abode or at least frequently mobile. Kristian tends to travel from place to place and frequently lives in guesthouses. Clive tends to be homeless, but on occasion seeks shelter and also frequents bed and breakfasts. Most of the sample, like Judy, have come to notice to a large number of police forces or hospitals, which is further evidence for their mobility. Chloe has frequently come to the notice of the British Transport Police. April has been picked up in various parts of the country. Hannah has been checked into hospitals all over England, Wales and Scotland claiming appendicitis. It could be argued that the railway system may hold particular appeal because it offers both anonymity and mobility. Sadly, it seems that these individuals also frequently associate the railway with suicide. For those two reasons, British Transport Police encounters a disproportionate number of such individuals in comparison with other police forces.

At first, a pervasive theme of mobility may be difficult to interpret. Mobility can be understood as a desire to move away from problems or threats, or through a need to move towards whatever is desired. Analysis points towards a movement away as the primary motivation of most; individuals move in order to avoid detection, to avoid having to pay fees or to avoid getting constrained by officialdom be that criminal justice agencies, or health or social care agencies. Mobility, therefore, may be understood as serving the desire for anonymity. Interestingly, note that the behaviour of missing persons can also be characterised as ‘crisis mobility’ where individuals feel an imperative to leave and choose their travel plans such as to stay undetected (Stevenson et al., 2013) In addition, mobility can be understood in relation to an absence of factors that encourage these individuals to be rooted to a certain place through family, work or other social or emotional ties. That lack of ties can be better understood when examining the next theme, loss.

Loss
A sense of loss pervades the way in which the 15 individuals present themselves. April mentioned having had a child that died at birth. Michelle says that that she lost her daughter at six months old. On another occasion, Michelle has said that all her family are dead and that she wants to kill herself to join her family. The loss of children, loss of contact with children and failed pregnancies, in particular, dominate the emotional life of Kim as evidenced by the fact that she carries around pictures of children and foetal scans. Clearly troubled as a teenager, Kelly once took away her neighbour’s baby and was charged with abduction. Judy talks about visiting her children but is uncertain as to whether she can because they have been taken into care. When she worries that she cannot see her children, she talks about going abroad or about killing herself. Ben is estranged from his family and so is Clive. Helen seems estranged from her parents (she doesn’t know where they live)
and it is possible that she talks about an imaginary sister. Kristian says he has no family or friends and frequently is found in the arrival hall at airports waiting for a non-existent loved one.

Loss and loneliness typify the life of these individuals. There are exceptions where social bonds, such as with parents, do exist. One of the 15 is active on a social networking site, so displays virtual social bonds. In the main, however, it seems that most, if not all, have suffered severe loss and estrangement. This probably serves the function of not being able or willing to settle down in a place that feels like home. Although Brenda, for instance, says that she likes travelling and Kristian says that he travels for leisure since his retirement, their movements seem to lack pleasure or purpose.

Trauma
There appears to be little doubt that most individuals in the group have suffered severe trauma, often multiple traumas and continue to suffer the consequences. Several mention sexual victimisation often in the family sphere, something that may have happened when they were children. Others describe victimisation as causing an immediate crisis; Michelle, for example, says she was attacked and raped by four men, and Brenda says that she met a man who took her home and subsequently raped her. Nicky and Judy also said they had been raped. Many seem to be suffering from psychosomatic illnesses, which may well have childhood trauma comprising part of their causation. It is not unlikely that most would meet diagnostic criteria for one or more mental illnesses. However, because of their behaviour it is unlikely that diagnoses and treatment plans can be formalised and implemented. This clearly exemplifies a likely level of unmet need in this sample of individuals.

As was the case in the individuals interviewed for the ‘geographies of missing people’ project (Stevenson et al., 2013), trauma plays a dual role in the lives of these individuals. On the one hand, it may explain their lifestyle. It may help explain their estrangement from family and their difficulties in establishing meaningful relationships. On the other hand, the consequences of suffering trauma in the past may surface in the present, in the shape of a personal crisis, be it of a medical, social or emotional nature that subsequently brings the individual to ‘come to notice’

Illness
Illness is a theme that dominates interactions with services. The precise status of illness is often ambiguous. Although there is frequent mention of individuals feigning illness, such as epilepsy, and police officers frequently express doubt as to the veracity of health claims, there is little doubt that several do suffer from genuine somatic illnesses. Chloe suffers from asthma, April from angina and epilepsy, whereas Clive frequently checks in with real, but possibly self-inflicted injuries. Brenda has diabetes. Several have been prescribed medication for mental health problems. It is possible that Judy, Kim, Chloe and Michelle suffer from a personality disorder. Several engage in self-harm behaviour, suffer from depression and are, or have been at times, suicidal. Despite their emphatic and at times violent refusal to engage in treatment or accept other forms of help, there is little doubt that there is a great deal of somatic, physical, mental health and social care need among the 15 individuals. Severe trauma no doubt exacerbates these needs.

APPROACH, AVOIDANCE AND AUTONOMY
Having identified the manifest themes of crisis, anonymity, mobility, loss, trauma and illness, these can now be utilised to make sense of any deeper meaning. For that, these themes are placed in a dynamic perspective.
In order to achieve that, three more latent themes were identified through further interpretation of the six manifest themes and their interrelations (Braun & Clarke, 2006). They are approach, avoidance and autonomy. First, the factors that may contribute to a transient life are considered. These include trauma and loss. All 15 individuals seem to share a background that can be characterised as a constellation of these themes: many have suffered victimisation and traumatic loss. Many have lost touch with children and relatives. Many have issues with homelessness or travel from place to place without much plan or purpose. They have a multitude of mental health complaints including depression, possibly personality disorder and substance misuse. There have been numerous suicide attempts among the 15 individuals. These circumstances seemingly made these people unwilling or probably more likely, unable to deal with a regular life of work, family and local community.

Through a lack of social ties and a seeming inability to cope with regular life, the individuals seem to have adopted or drifted into a life on the move with fleeting social ties and temporary abodes, a lifestyle that places them at elevated risk of negative health outcomes, isolation and victimisation. Thus, anonymity and mobility are responses to loss, trauma and illness. Counter-intuitively perhaps, anonymity and mobility may be thought of as something resembling a degree of adaptation allowing for some sense of freedom until the next crisis, which could be a crime, a flare-up of an illness, an overdose or a suicide attempt. It is such crises that cause these individuals to come to notice. When the crisis is stabilised, the tendency for the individuals appears to be to return to the earlier state of mobility and anonymity.

In this conceptual framework, crises however frequent are not business as usual. The vast majority of our individuals do not seem to be habitually attention-seeking. Like the participants in the ‘geographies’ study, their inclination is more likely to evade detection; it is, however, acknowledged that one or two in the group are more habitual attention seekers, such as Hannah. In fact, for many of the individuals in a majority of instances, the drive to avoid attention is stronger than the need to seek it. Only a crisis can override that desire. In fact, it is suggested that their absconding, after the most immediate need is satisfied, is more typical than their coming to notice in the first place. It makes more sense, therefore, to understand this population through their efforts to regain a sense of autonomy through anonymity and mobility, rather than the circumstances that cause them (frequently reluctantly and often only very temporarily) to give it up.

This interpretation leads to a re-examination of the literature on absconding patients. It is clear that the come to notice sample does not match the profile of those most likely to abscond, both in gender, age and manifest mental illness. In addition, the thematic analysis has interpreted this behaviour in a somewhat different light: it considers their absconding not as a departure, but rather as a return. It is preferable to conceptualise their departure as a return to a previous state of affairs: a state of anonymity and mobility that an individual feels able to return to after a crisis has been dealt with.

A key barrier to engagements with services is that of feared loss of autonomy. This has led the project to examine the role of autonomy in the lives and discourses of individuals with a lifestyle characterised by mobility and anonymity, for example, the homeless population. Autonomy is certainly part of the ‘identity talk’ of homeless people. Thompson, McManus, Lantry, Windsor, and Flynn (2006) held focus groups with homeless youngsters. They found that many spoke of the importance of personal autonomy, and about survival techniques as well as the need to be safe. The freedom of the street, despite
the hardship, isolation and physical danger, is certainly a theme in the discourse of homeless youngsters. Interestingly, they also found that where a lot of thinking goes into making sure basic needs such as food and clothing are met, issues of health were not regularly attended to, with very few seeking medical treatment. They fear that seeking help would endanger their independence and control and worry that providers would not ‘respect their fundamental need for autonomy’ (Thompson et al., p. 41).

The American Psychiatric Association (APA, 1984) produced a report on the needs and circumstances of homeless people that also rather echoes the behaviour of our sample. When this group of homeless people in the USA come into contact with mental health services they argue that ‘a lack of trust and desire for autonomy cause them not to give their real name, to refuse our services, and to move because their fear of closeness, of losing their autonomy, or of acquiring a mentally ill identity’ (APA, p. 901). This is resonant of the behaviour of the 15 in the come to notice sample. In an extensive piece of ethnographic research, Snow and Anderson (1987) argue that homeless persons tend to be negative about services that threaten their autonomy in order to ‘secure a modicum of personal autonomy’.

By contrast, Melamed, Fromer, Kemelman, and Barak (2000) and Schimmel (2006) argue that the choices towards autonomy that homeless people seem to make should not be romanticised. Schimmel argues that homelessness can be a compelling alternative away from an abusive home. However, it is argued that it is a constrained choice, severely limited by the child’s abilities to make such decisions and the harsh environment to which they expose themselves. Although issues of autonomy are keenly felt by these homeless youngsters, Melamed et al. argue that talk of autonomy should not be used to excuse obligation towards these youngsters.

Thus, it would seem that the literature on homelessness seems to produce a closer fit towards understanding the behavioural dynamics of individuals who come to notice than the absconding literature. They are also more akin, or so it seems, to people who regularly go missing, as evidenced by Stevenson et al. (2013). This may offer further insights into how to engage with these people effectively while respecting their need for a degree of autonomy. At present, this dataset had a police source. It would be helpful if there were dedicated lines of communication between health and police organisations that specifically focused on this group.

The ‘come to notice’ population can safely be characterised as a group with unmet need and a strong reluctance to engage with services. However, they nevertheless take up resources of police and health and social care agencies. Future work could focus on the challenge of identifying this group through a multi-agency approach. Increased identification may assist in engaging effectively with these individuals, because at present the situation tends to be one of isolated episodes of contact that are fleeting, incomplete and haphazard. That offers insufficient basis for successful intervention. It is clear that better lines of communication between police and health agencies could yield benefits in order to secure better identification of these individuals and their needs.

Engagement needs to be wary of the sensitivities and vulnerabilities of this group. As is often the case with interventions involving reluctant or vulnerable groups, timing may be essential. Their approach and avoidance behaviour needs to be judged correctly and any interventions need to be undertaken whilst being mindful of the need for a degree of autonomy that this group displays. Local non-governmental organisations that specialise in homelessness and mental health provision may be well placed to play a role in this.

Future research in the short term should focus on further exploring the characteristics and needs of this group. Because the ‘Come to Notice’ database holds information about
well over 100 persons, there might be a basis to explore this statistically. In the longer term, efforts should be directed towards data collection to include both police and health information. This would allow for a fuller picture of the circumstances and needs of these individuals. At present, this is hampered by the fact that we rely on police summaries of how these individuals were seen to present themselves and for various reasons, the ‘come to notice’ individuals, in the middle of a personal crisis, will be unwilling or unable to provide a full account of their circumstances.

With a fuller account of these individuals and their needs and circumstances, a multi-agency approach could be considered to increase the chance that these individuals will engage with services as long as they are offered in a way that considers their specific issues and circumstances. Through that, it can be hoped, that what for many is a lifetime of chaos, illness and trauma can be positively influenced.

REFERENCES
American Psychiatric Association (APA). (1984). APA task force completes study on homelessness. *Psychiatric Services, 35,* 901.
Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane (1999a). Absconding: why patients leave. *Journal of Psychiatric and Mental Health Nursing, 6,* 199–205.
Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane (1999b). Absconding: outcome and risk. *Journal of Psychiatric and Mental Health Nursing, 6,* 213–218.
Bowers, L., Jarrett, M., Clark, N., Kiyimba, F., & McFarlane (2000). Determinants of absconding by patients on acute psychiatric wards. *Journal of Advanced Nursing, 32,* 644–649.
Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: Sage.
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 2,* 77–101.
Bryman, A. (2012). *Social research methods.* Oxford: Oxford University Press.

Clark, N., Kiyimba, F., Bowers, L., Jarrett, M., & McFarlane, L. (1999). Absconding: nurses views and reactions. *Journal of Psychiatric and Mental Health Nursing, 6,* 219–224.

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,* 543–550.

McIndoe, K. I. (1986). Elope: why psychiatric patients go AWOL. *Journal of Psychosocial Nursing, 26,* 16–20.

Meehan, T., Morrison, P., & McDougall, S. (1999). Absconding behaviour: an exploratory investigation in an acute inpatient unit. *Australian and New Zealand Journal of Psychiatry, 33,* 533–537.

Melamed, Y., Fromer, D., Kemelman, Z., & Barak, Y. (2000). Working with mentally ill homeless persons: should we respect their quest for autonomy? *Journal of Medical Ethics, 26,* 175–178.

Mosel, K. A., Gerace, A., & Muir-Cochrane, E. (2010). Retrospective analysis of absconding behaviour by acute care consumers in one psychiatric hospital campus in Australia. *International Journal of Mental Health Nursing, 19,* 177–185.

Muir-Cochrane, E., Mosel, K., Gerace, A., Esterman, A., & Bowers, L. (2010). The profile of absconding psychiatric inpatients in Australia. *Journal of Clinical Nursing, 20,* 706–713.

Schimmel, N. (2006). Freedom and autonomy of street children. *The International Journal of Children’s Rights, 14,* 211–233.

Snow, D. A., & Anderson, L. (1987). Identity work among the homeless: the verbal construction and avowal of personal identities. *American Journal of Sociology, 92,* 1336–1371.

Stevenson, O., Parr, H., Woolnough, P., & Fyfe, N. (2013). *Geographies of missing people: processes, experiences, responses.* Glasgow: University of Glasgow. Retrieved from eopldownloads/Stevenson-et-al.pdf

Thompson, S. J., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: perceptions of services and providers by homeless young adults. *Evaluation and Program Planning, 29,* 34–43.