Ideas of flight

C. Maher and D. Murray

As staff on the acute psychiatric unit at St Ita's Hospital had recently become aware of an increasing number of referrals from Dublin airport, a retrospective analysis of case notes of such patients admitted from 1987 to 1994 was undertaken. Twenty-three patients were admitted over this period, the majority arriving from the UK. Mania was the admission diagnosis in 11 patients, schizophrenia in eight, unipolar depression in two, and schizoaffective and personality disorder in one case each. All but two had a past psychiatric history. Seventeen had Irish friends or relations; five of these acting upon 'Ireland-related' delusions. Ten patients required temporary certification. The mean duration of hospitalisation was 19 days and the total 433 days. All patients were repatriated, nine being transferred directly to psychiatric hospitals, with the relatives eventually bearing the cost of transport in all but one.

The acute unit at St Ita's Hospital is responsible for all referrals from Dublin international airport. Staff on the unit have recently become aware that the numbers of such referrals are increasing and that they pose some unique management problems. This study was designed to quantify the increase noted, assess the difficulties in dealing with this group and to discuss how improvements may be made.

The study

A retrospective analysis of case notes was undertaken over the eight-year period from 1987 to 1994 of all patients referred from the airport. Patients were identified from admissions and discharges books. Before 1987 referral of patients from the airport was rare and data on them was incomplete. However, notes were available on all patients identified during the study period. The study group was made up of passengers who flew into the airport from other countries, except for one patient who was attempting to fly elsewhere. Referrals were made when the travellers' behaviour was noted to be unusual. For example, one lady had taken her clothes off and was wandering naked around the airport grounds. Referral sources were the airport general practitioner, the local police and, in some cases, the patients' own relatives. Material recorded for the study included patient demographics, previous psychiatric history and details of hospital stay. Diagnoses were based on ICD–9 criteria (World Health Organization, 1978).

Findings

A total of 23 patients were referred over the eight-year period, 14 males and nine females. There was one patient admitted in each of 1987 and 1989 with none in 1988. Four patients were referred in each of the following three years, three in 1993 and six in 1994. They ranged in age from 24 to 65 years, with a mean of 35. One patient was married, 16 were single, three separated, two divorced and one was a widower. Twelve of the referrals were unemployed, with six from socio-economic groups I and II, one from group III and four from groups V and VI (O'Hare *et al*, 1991). Fourteen patients arrived from England, four from Germany and one each from Scotland, Italy, Holland and Australia. The reasons for these people flying into Ireland were varied, but for 17 they were that they had friends or relatives there. Some patients were aware that they were unwell and were seeking help, whereas others seemed to be looking for comfort because of their distressing symptoms. Seven of this group of patients had 'Ireland-related' delusions. Examples of these included:

(a) a 37-year-old unemployed musician who believed that Bono, from the rock band U2, had stolen music from him and he had come to reclaim it;
(b) three patients had delusions regarding Northern Ireland, with two believing that they were responsible for the 'troubles' there, and one that he had special powers to end them;
(c) two patients believed that the Irish had superior healing abilities and came seeking cures;
(d) a 19-year-old Scottish student who had just completed examinations believed that Ireland was about to host a giant party and he had come to celebrate.

The remaining six patients appear to have chosen the destination at random. However, the lady from Holland had travelled several times before while psychotic, but she usually went to Paris. It appears that on this occasion she got on the wrong flight.

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The admission diagnoses were as follows: mania in 11 patients, schizophrenia in eight, unipolar depression in two and schizoaffective and personality disorder in one each. All but two had a previous psychiatric history. Three of the patients had travelled before while psychotic.

Clinically this group was rather disturbed, 10 patients requiring compulsory admission. At some time during their stay 11 patients needed constant observation and three others close observation, but the remainder needed no more than general ward supervision. The higher levels of supervision were needed for disturbed behaviour, such as aggression or over-activity to the extent that the patients were a risk to themselves or others.

The length of admission ranged from 2 to 53 days with a mean length of 19 days, and a total of 433 days. All of the patients were repatriated, nine being transferred directly to psychiatric hospitals, with relatives bearing the cost of transport in all but one of the cases, which was borne by the Eastern Health Board, which is responsible for health care in the greater Dublin area.

Comment

The number of psychiatric referrals from the airport in Dublin is increasing. The first reason being that there has been a significant increase in the number of passengers through Dublin airport over the past eight years, with 2.6 million travelling in 1987 as compared to 6.9 million in 1994. Second, although scheduled flights have become more expensive, there are many more special cheap flights. The annual incidence of airport referrals appears to have increased from approximately 0.4 to 1 patient per million travellers over the study period, but given the small numbers it is difficult to say whether this increase is real or coincidental.

The most frequent diagnosis among our group was mania (48%), with schizophrenia next (35%). This is not in keeping with literature studying airport referrals in other countries. Shapiro (1976) looked at referrals from John F. Kennedy airport in New York. He found that the majority of his group (74%) had schizophrenia, with only 2% having a diagnosis of bipolar affective disorder. He did not break this down into mania or depression. When Jauhar & Weller (1982) studied referrals from Heathrow airport in London, they found that 50% of those patients had schizophrenia, while 25% had affective disorder, with mania comprising the bulk of these. Although admittedly our numbers were small, it is surprising we did not see a similar trend. One possible explanation suggested by the Scottish student's reason for his visit is that Dublin has a reputation for being a rather lively and sociable city and therefore might be likely to attract people with mania. It is interesting to note that Dublin appears to have a higher incidence of mania than other cities such as London or Aarhus (Daly *et al*, 1996).

Compared with the remainder of patients admitted to the hospital over the same period, our patients were more likely to be diagnosed with mania (48% in our group compared with 9% in the remainder) and schizophrenia (35% compared with 19%) but less likely as depressed (9% compared to 29%) (Health Research Board, 1987–1993, further details available from the author upon request). This latter finding seems reasonable because it might be expected that depressed patients would feel less inclined to travel and would be less likely to draw attention to themselves. There was no particular difference noted between the airport patients and other patients with regard to personality disorders.

In none of the patients did alcohol or drug misuse appear to play any part in their presentation. Jauhar & Weller (1982) also noted a low incidence of substance misuse in their study. They did, however, observe that travel across several time zones increased the risk of affective illness. Such effects were not obvious in our study because, except for the patient from Australia, distances travelled were relatively short.

A number of problems were encountered while managing referrals from the airport. This group was quite disturbed and so required a high degree of nursing supervision. Five of the patients had communication difficulties due to a language barrier. Although all of them eventually spoke good English, most had reverted to their mother tongue while psychotic. This made initial management rather problematic but a return to fluent English became a good indicator of recovery. The language barrier also contributed to problems in obtaining notes from foreign institutions and collateral histories from relatives.

Another complication was that there was no allowance for them in the service budget because they came from outside the catchment area. With the high supervision requirements and necessity for lengthy overseas communications by telephone, to name but two items of expenditure, there was considerable strain on an already tight budget. Therefore current financial management of these airport referrals is unsatisfactory. A new policy of early repatriation might be preferable. This, however, would have some snags. First, the Eastern Health Board would have to shoulder the initial cost, and then try to recoup this from the patient or relatives. That may be difficult to enforce once a patient has returned home. If the patients had travel insurance, it would then be

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possible to reclaim expenses through this. However, none of the patients in our group had insurance, which is unsurprising as they were probably unwell at the time of booking their flights and were unlikely to think of it. Second, patients would have to be fit to travel, or sufficiently supervised to make this feasible. Given that a high proportion may be significantly disturbed, this could again be expensive.

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Implications of urban drift on health care resources in inner London

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All 34 patients admitted from a central area of London over a 10-week period were identified. The 25 (73%) who were subsequently interviewed were questioned about their whereabouts at various points in the past. Eleven (44%) of the interviewed patients had arrived in the area within one month prior to admission, nine (36%) within the last week. Seven (28%) of the total were identified as not being the responsibility of the local authority. Patients who have recently arrived provide a significant proportion of the clinical workload in this area.

London mental health services are in crisis (Marshall, 1997). The King's Fund (1997) has described the problems faced by London's services and identified a number of inadequacies in service provision. Current methods of assessing the degree of capitation weighting fail to fully reflect the extra challenges that such services face (Goldberg, 1997). The contribution that homelessness makes to service requirements has already been highlighted (Turner & Haskins, 1993). The extra burden of "geographical drift" (Gerard & Houston, 1953) of mentally ill people to city centres is not taken into account in the current method of capitation weighting.

Although work in Sweden (Lewis *et al*, 1992) has cast doubt on the validity of the theory of drift to explain the excess prevalence of schizophrenia in urban environments, analysis of census data in Hampstead (McNaught *et al*, 1997) suggests that some of the excess is due to increased movements of individuals with schizophrenia, in particular, young men with positive symptoms. Clinical experience indicates that a significant proportion of patients admitted from the South Marylebone (North-East Westminster South (NEWS)) catchment area have

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