

Psychiatric **emergencies**



Most people with mental illness can travel without incident. But cabin crew sometimes have to deal with passenger behaviour ranging from bizarre to downright dangerous.

A PASSENGER on a McDonnell Douglas MD-80 Super 80 was sitting quietly reading his Bible and listening to music. He was also naked. When the purser asked him his name, he sang it. The passenger refused to get up when the plane landed in Dallas, Texas. Police were called in to handle the situation.

In another incident, on a flight in an MD-80 from Dallas to Chicago, a passenger aged about 40 became hysterical. The man, who had not taken his prescribed lithium, demanded to land. He shouted that he was “the prince of darkness”.

Flight attendants notified the captain. They offered the passenger oxygen and water and resealed him towards the back of the plane. The aircraft made an emergency landing at Tulsa, Oklahoma, where it was met by the fire department and emergency medical service. The passenger was restrained and taken to hospital.

A Boeing 737 had to divert to Abilene, Texas when a passenger’s medication wore off, triggering a psychotic episode. The man scratched at the windows in a desperate attempt to get off. He shoved a flight attendant. The crew, helped by passengers, applied tie-wraps to the man. The man broke one of the wraps, and it took five men to restrain him for landing.

Psychiatric in-flight emergencies are rare. However, passengers with unstabilised psychiatric disorders sometimes threaten the safety of cabin crew and other passengers. In some cases, aircraft are forced to make emergency landings.

There can be tension in airline operations between the objective of not discriminating against passengers with psychiatric disorders, and the responsibility to make flying safe for all.

Recent studies, international medical guidelines and cabin safety guidelines show many people with psychiatric disorders can travel on scheduled airlines as safely and comfortably as other passengers.

However, some passengers can become upset by change to familiar routines, travel-related stress, crowding with strangers and confusion about how they are expected to behave.

Some passengers have undiagnosed and untreated psychiatric disorders. Some have been diagnosed but refuse to take their medication.

Aerospace Medical Association (AsMA) guidelines say that people with psychiatric disorders whose behaviour is “unpredictable, aggressive, disorganised, disruptive or unsafe” should not travel by air.

“Patients with psychotic disorders who are stabilised on medication and accompanied by a knowledgeable companion may be able to fly,” the guidelines say.

Similar guidelines in a 2002 medical textbook say that a prospective passenger with a psychosis can fly independently if the underlying disorder has been stabilised and the person is taking appropriate medication.



PHOTO: SAS/TED FAHM

International Civil Aviation Organization recommendations say that in principle, people with disabilities should be permitted to determine whether they need an escort and to travel without the requirement of a medical clearance. Airlines should be permitted to require passengers with disabilities to obtain medical clearance only in cases in which it is clear that the passenger’s safety or wellbeing or that of other passengers cannot be guaranteed.

The main psychiatric illnesses include schizophrenia, bipolar disorder, panic

disorder, clinical depression, dementia and obsessive compulsive disorder.

Psychoses (primarily schizophrenia and bipolar disorder in the manic state) are marked by bizarre behaviour beyond the patient’s control. They may involve loss of some or all contact with reality, hallucinations, delusions, incoherent speech, agitation, and, sometimes, violence.

The symptoms of acute anxiety may involve overwhelming apprehension, uneasiness and fear, often accompanied by physiological changes, such as sweating, trembling, increased pulse rate, a sensation of being smothered and a sense of hopelessness and doubt. These symptoms can become a cabin safety risk if people irrationally believe that their own lives are in danger. They might try to open doors or

break windows during flight in a bid to get out. People with panic disorder have recurrent unexpected panic attacks.

Dementia involves a deterioration in intellectual ability. The condition interferes with judgement and social functioning. It can become a cabin safety risk when a passenger is uncomprehending, confused, unable to remember crew member instructions or too disoriented to follow those instructions.

It is not known how many in-flight emergencies world-wide are caused by

psychiatric disorders. In a study of data on Qantas international flights in 1993, 23 (5 per cent) of 454 significant in-flight medical incidents were anxiety and panic reactions warranting medical interventions.

In Australia, cabin crew emergency training includes instructions on how to handle "deranged passengers and others whose conduct might jeopardise the safety of the aircraft". (CAO 20.11)

A MedAire emergency medicine expert says the aim of training is to teach crew members how to defuse the problem. Aggression in response to aggression could worsen the situation.

The first step is to talk to the passenger to gauge his or her grip on reality. Flight attendants should enlist the help of doctors if any are on board. However, some passengers might have to be isolated and restrained.

All psychiatric emergencies are different,

and there are no hard and fast rules on how to deal with them. Flight attendants must draw on their training and experience to decide what to do, the MedAire expert says.

Doctors who see agitated patients with un stabilised psychiatric disorders in hospital emergency departments consider the following:

Self-defence tactics: You should consider whether to:

- Relocate the person to a private area separate from others, if possible.
- Remove objects that could cause injury.
- Maintain a distance that does not crowd the person and enables a retreat if necessary.
- Monitor verbal cues and actions as indicators of the level of agitation and change in mood.
- Ensure that others are ready to follow protocols for the use of physical restraint if verbal interventions fail and safety is threatened.

Attitude: Begin the first interaction with respectful authority and emotional sensitivity. Respond calmly with a supportive and non-threatening attitude.

- Show respect and avoid being judgmental.
- Show empathy and develop trust, if possible.

Body language: Avoid extended periods of direct eye contact. Look calm.

Speech: Speak clearly in a non-confrontational tone. Be aware that the passenger's verbal communication might be impaired or ineffective.

Initial interview: Identify yourself and briefly remind the person of your role. Ask simple questions that require only short answers about why the person is upset and what can be done.

Adapted from Cabin Crew Safety, Vol 37 No 5, Flight Safety Foundation.



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