Psychiatric tourism is overloading London beds

EDITOR.—A recent conference on metropolitan health care highlighted the plight of mentally ill people in London. Of special note was the serious shortage of admission beds in all urban areas in the United Kingdom,1 with the bed occupancy rate for psychiatric beds in hospitals well above 100%, with some units actually running at over 120%.2 Pressure seems greatest in inner London, and it is a far cry from the therapeutic standard of a bed occupancy rate no greater than about 65%.3 Such occupancy would allow patients to be placed in their catchment area ward, with effective aftercare and an allocated key worker, as envisaged in the care programme approach.

This shortage is generating extraconventional referrals to both NHS and private, that are often far removed from the community from which the patient originates. The situation is exacerbated by the current shortfall in community care resources, and the increasing diversion of patients from the criminal justice system into the NHS. The lack of medium secure beds compounds the problem further. Such bed pressures have been identified as a key factor in the recent tragedy involving the homicide committed by Christopher Clunis.4

A factor not previously noted, in our view, is that inner London is acting as a magnet to people from all over the world. The need to seek anonymity in a metropolis has long been understood in relation to schizophrenia and schizophrenia. But with our increasing integration into Europe and the worldwide economic recession, a considerable number of patients now seem to be emanating from the European continent. Many others arrive from Third World countries that lack adequate resources for psychiatric care. If such patients have relatives in Britain they tend to come to London (often on a visitor’s visa) and have to be admitted to NHS facilities. Their access to a local address makes it difficult for administrators to establish true residency status.

A number of patients travel because of a “paranoid flight,” feeling they are being threatened in their home country. Once cared for in our NHS system they return every time their illness deteriorates, and their families cooperate in this. We estimate that at any one time at least a tenth of our inpatients are from abroad, but accurate figures are hard to obtain. Some even seek political asylum as a way of staying in Britain so as to obtain necessary treatment.

However, most of these patients do not figure on any census, and therefore no specific provision is made for their funding. It is often extremely difficult to arrange repatriation as most foreign embassies will not get involved, knowing that the British NHS and local social services will pick up the tab. Of course, once a visitor is detained under the Mental Health Act he (or she) is entitled to treatment under the NHS, and most acute psychiatric admissions in London (60-80%) are serious enough to require sectioning.

It has been suggested that bills should be sent to the Foreign Office, which may be able to make representations to foreign states. We suspect that the task is largely beyond central London but we would be interested to hear other people’s views. At least one London hospital (the Gordon) now refuses community care after discharge to non-resident foreign nationals. Given the current unacceptable rate of bed provision in London, can the NHS afford to treat mentally ill people not ordinarily resident in Britain?

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Advice to authors

We prefer short letters that relate to a recently published article and are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to do any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

Contraceptive failure may be a major factor in teenage pregnancy

EDITOR.—In their study of 147 teenagers with unplanned pregnancies V A H Pearson and colleagues found that 80% claimed to have been using contraception at conception.1 The authors argue that teenagers need to lower their threshold for use of emergency contraception when there is a risk of pregnancy. It should be a matter of concern that such a high proportion of unplanned pregnancies are due to contraceptive failure (which comprises technical failure and misuse of contraception). To gain an insight into the effectiveness of contraception in preventing teenage pregnancies at a population level I have examined the relation between trends in the use of condoms among teenagers and trends in teenage conception rates during 1975-91. I used data from the national survey of sexual behaviour2 to estimate the proportion of male teenagers who used condoms at first sexual intercourse during the period. The percentage who report having used condoms at first sexual intercourse is available for each year. Pregnancy rates in those aged under 16 and under 19 were obtained from routinely published data.3 I calculated a correlation coefficient for both age groups and found a highly significant positive correlation between teenage conceptions and male use of condoms (under 16: r=0.8553, P=0.001; under 19: r=0.7967, P=0.05). The figure shows a scatter graph with the regression line for the under 16 age group. These findings show a strong positive relation between use of a condom at first sexual intercourse and teenage pregnancy, with pregnancies increasing with increasing use of condoms.

Sex education and the national campaign to

Pregnant teenagers and contraception

Women know little about emergency contraception, and men know less

EDITOR.—V A H Pearson and colleagues report that 81% of the teenagers in their study had heard of emergency contraception.1 In the department of genitourinary medicine at St George’s Hospital we recently conducted a study of patients’ knowledge of emergency contraception. Of 100 consecutive women interviewed (age range 15-48), 85 had heard of emergency contraception. Eleven of those 85 had the misconception that the hormonal method of emergency contraception is effective only up to 12 hours—that is, a “morning after pill.” Only 35 of these patients were aware that it is effective up to 72 hours after unprotected sexual intercourse. Moreover, just five were aware of the alternative method of the intrauterine contraceptive device, which is effective up to five days after intercourse. Interestingly, of 100 men who were interviewed, only 36 had heard of emergency contraception.

This survey reinforces Pearson and colleagues’ conclusion that we need to improve sexual health education. Only a fifth of the women in our study who had heard of postcoital contraception had learnt about it at school; three fifths had learnt about it from a friend.

CONTRAINDICATIONS

Contraception rate among under 16 year olds by male use of condoms at first sexual intercourse (data are annual figures for 1975-91).

promote contraceptive through safer sex campaigns have undoubtedly been successful in increasing condom usage. Most people have assumed that increasing the use of contraception leads to a reduction in unplanned teenage pregnancies. Yet my analysis shows that this has not happened. A plausible explanation is that the marriage of teenagers with unplanned teenage conceptions is contraception failure, not the lack of contraceptive knowledge and availability. The findings of Pearson and colleagues support this view.

A further question is whether increasing the availability of contraception leads to an increase in sexual activity. If this is the case—and the national survey of sexual behaviour reports a large increase over the past two decades in the proportion of teenagers who are sexually active—then it is not surprising that the rate of teenage conceptions continues to increase. The answer is not more contraception or emergency contraception but a change in attitude towards sexual behaviour.

**The needs of older women are just as great**

**Editor,—**The contraceptive practices of, and reasons for contraceptive failure among 629 women attending an NHS unplanned pregnancy counselling clinic in Portsmouth were surveyed between September 1994 and February 1995. Our findings are similar to those of V A H Pearson and colleagues in Devon (table), although the mean age in our study was 25-2 years (range 14-40). Both these studies are in line with previous work showing a rising association between unplanned pregnancy and use of condoms.**1**

<table>
<thead>
<tr>
<th>Devon (n=167)</th>
<th>Portsmouth (n=629)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range (years)</td>
<td>13-19</td>
</tr>
<tr>
<td>No with unplanned pregnancies</td>
<td>147</td>
</tr>
<tr>
<td>Used condoms at time of unplanned pregnancy</td>
<td>67/147 (46)</td>
</tr>
<tr>
<td>Known why pill failed</td>
<td>39/67 (58)</td>
</tr>
<tr>
<td>Using contraceptive pill at time of unplanned pregnancy</td>
<td>45/147 (31)</td>
</tr>
<tr>
<td>Known why pill had failed</td>
<td>32/45 (71)</td>
</tr>
<tr>
<td>Patients for whom postcoital contraception was considered</td>
<td>135/167 (81)</td>
</tr>
<tr>
<td>Patients who had heard of postcoital contraception</td>
<td>15/135 (11)</td>
</tr>
</tbody>
</table>

**Combined oral contraceptive only.**

**Question not completed by all those who attended.**

In our study the main reasons given by the 266 patients who were not using postcoital contraception were ignorance of the method (20% (22%)), the woman not thinking about it at the time of conception (72% (27%)), and the woman under-estimating her fertility (86% (32%)). Our study included older women and showed that their needs are different from those of teenagers. We also concluded that much more education of patients and the public is needed to increase use of postcoital contraception.

**Scottish study does not replicate findings**

**Editor,—**Massimo Gallarini and colleagues found lower cholesterol concentrations in subjects after parasyuicide than in control subjects matched for age, sex, fasting state, hypercholesterolaemia, beta-methasone, drug dosage, and alcoholism.1 These results suggest an association between low cholesterol concentrations and suicide. The control population—331 non-suicidal subjects—was recruited from a population attending a general hospital outpatient therapy.

We have studied the proposed association between serum cholesterol concentration and parasyuicide in our catchment area of Scotland (Tayside) and found no such association. We studied 207 healthy patients who had committed parasyuicide (age 25-54) and 286 healthy volunteers matched for age and sex who were not attending hospital for any reason and were receiving no drug treatments. All patients who had committed parasyuicide who were receiving prescription drugs or had abnormal results of biochemical tests of liver or renal function were excluded. The patients who had committed parasyuicide had a higher serum total cholesterol concentration than the controls (mean (SD) 5-68 (0-41) mmol/l v 5-41 (0-80) mmol/l; P<0-001).

We suggest that a hospital outpatient population is not ideal for comparison with subjects who commit parasyuicide, who until the parasyuicide itself is not normally subject to biochemical testing, have no concurrent medical condition requiring treatment, and are not receiving any drug treatment. The findings of Gallarini and colleagues may be misleading and do not seem to apply to the Scottish population.

**No association between low cholesterol and violent death**

**Editor,—**The study by Massimo Gallarini and colleagues is the latest to investigate whether there is an association between low cholesterol concentration and violent events.2 However, no causality has been shown, and the associations in the six studies seem difficult to interpret. For example, in the Honolulu heart programme there was a direct relation: the higher the baseline serum cholesterol concentration the higher the risk of suicide during 23 years' follow up.2 Gallarini and colleagues incorrectly cite the Helsinki business- men study in the context of cholesterol and violence: the higher incidence of violent events in the group treated multifactorially was not due to low serum cholesterol concentration or lowering drugs. The results of the Scandinavian suicide survival study are a strong argument against a true association between cholesterol and violence: the study showed no difference in violent deaths or deaths due to suicide between the placebo and simvastatin groups despite a 35% reduction in serum low density lipoprotein cholesterol concentration for 5-5 years in the simvastatin group.1

**References**


