Controversy over psychiatric tourism

A real phenomenon . . .

EDITOR,—I run a community psychiatric service adjacent to that of Charles Tannock in the west end of London.¹ It is particularly closely integrated with social services and fully observes the principles of care management and the care programme approach.

I suspect that psychiatric tourism is well known. I have repeatedly presented audits showing that the phenomenon has an impact on our inpatient service. The data show that about half of the patients admitted are homeless (people staying in hostels are counted as having a home) and half (not a tenth, as Tannock and Turner state) are from overseas, with much overlap. Because of essential underprovision, the above factors, and clinically inappropriate admissions bed occupancy is extremely high. Patients are repeatedly transferred through multifarious overflow arrangements, which defies good practice.

Management and the local purchasers know the situation, but the forces and accountabilities of community psychiatry are equal but opposite to theirs. The greater the community commitment of a service and the nearer it is to an epicentre of "urban drift" the more acutely will this tension be felt. In our case, for some budgets the purchasers see the service as being cheap because (as an interim measure) extracontractual referrals to other areas are not paid for from the prime budget, the overflow of patients into colleagues' beds is "free," and the Home Office pays for some foreign nationals. There was no pressure to repatriate a South American who occupied a private bed for nine months (about eight months longer than clinically necessary) because the Home Office was paying (us) as if the patient was an extracontractual referral into our district. We do not find the Home Office and embassies uninterested but have learnt that committed liaison from the clinicians and social services is necessary to help such patients to go home reasonably promptly.

If a determined effort to sort out both demographic and clinical issues is not made from the time of admission then the situation becomes worse, as the community mental health team is overloaded with specious "obligations" for aftercare. We present all new inpatients at the team's weekly meeting as a first step in this. One of the many things that we do not provide is a full or even

partial package of community or outpatient care, with rights to prescriptions, priority housing, and supplementary benefits, to people (however mentally ill) who are in Britain illegally and do not have such entitlements. To do so would not only support the industry of psychiatric tourism but also issue psychiatric passports.

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¹ Tannock C, Turner T. Psychiatric tourism is overloading London beds. *BMJ* 1995;311:806. (23 September.)

. . . but short on evidence

EDITOR,—Charles Tannock and Trevor Turner's xenophobic outburst concerning psychiatric tourism is long on innuendo and short on evidence.¹ The authors say that "a considerable number of patients now seem to be emanating from the European continent." "Many others," they say, "arrive from Third World countries. . . . Once cared for in our NHS system they return every time their illness deteriorates."

I know that there are plenty of crazy people roaming the corridors of Heathrow airport, but I never realised that many of them were en route to London's psychiatric wards. Perhaps we could be told exactly how many make up this "considerable number." The authors estimate that "at least a tenth" of their inpatients are from abroad (does this include the Republic of Ireland?) but then go on to say that accurate figures are hard to obtain.

I have worked for eight years as a general practitioner in Kentish Town (about 1.5 km from University College Hospital, where Tannock works) and cannot remember one mentally ill patient who could remotely be described as a psychiatric tourist. There are many problems with our inner city psychiatric services, but I doubt whether blaming foreigners will help us to find the solutions.

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¹ Tannock C, Turner T. Psychiatric tourism is overloading London beds. *BMJ* 1995;311:806. (23 September.)

Absence of data fuels "foreign scroungers" mentality

EDITOR,—The obvious answer to the question posed by Charles Tannock and Trevor Turner at the end of their letter¹ is, "No, the NHS cannot afford to treat mentally ill people not ordinarily resident in Britain." When such issues are discussed, however, it is important that accurate figures are produced to back all claims. Anecdotal evidence and phrases like "a considerable number" or "many others" without accompanying statistics are not sufficient in a subject such as this, which has socioeconomic and political ramifications.

The mentally ill patients from the so called Third World who are seen by the authors may actually be British citizens or legal residents paying tax and National Insurance contributions. Visitors to Britain from the Third World go through extensive interviews at British embassies abroad before they are granted entry visas and subse-

quently undergo intensive scrutiny by immigration officers at the point of entry before being allowed into the country. This process is difficult enough for "normal" people wishing to come to Britain for legitimate purposes; a mentally ill person seeking treatment would be highly unlikely to get in.

In addition, the cost of an airline ticket and subsequent general care of the patient, which would be borne by his or her host in Britain, make it economically unwise to sponsor someone for "free NHS mental care." Indeed, there have been instances of people developing mental illnesses while in Britain and having to return home to be cared for by their relatives.

In the absence of definite statistics, the fears raised by the authors are simply echoes of the general belief held by some people and fostered by certain sections of the press that foreigners living in Britain are mostly scrounging off the welfare state. It has been suggested that doctors, teachers, and others working in the public sector should blow the whistle on people with whom they come into contact whom they suspect to be illegal immigrants. I await accurate figures on the number of Third World nationals who are freeloading off the NHS and, more importantly, on the cost.

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¹ Tannock C, Turner T. Psychiatric tourism is overloading London beds. *BMJ* 1995;311:806. (23 September.)

Authors' reply

EDITOR,—We acknowledge the fears of Fred Kavalier and Raymond K Akwayena concerning the accuracy of our statement that there are a "considerable number" of overseas patients in London's acute psychiatric wards. Reliable data cannot be obtained, since London is a cosmopolitan city and many patients have temporary addresses. Patients who are psychotic, frightened, or confused by language difficulties enhance the problem. Patients' non-residential status may emerge only weeks after their admission. The key issue is one of resources for London; this is exacerbated by ignorance about its true population and highlighted by the current dangerous shortage of beds for mentally ill patients.

Our view is that such admissions are inevitable and that funding should be available to adjust for the demand. We enjoy the challenge of multicultural presentations, which make for a stimulating and diagnostically varied practice; that is why we work in London. Immense benefits can accrue in terms of quality of training, research into transcultural issues, and improved nursing skills. Our letter was not a "xenophobic outburst" but, rather, an expression of "xenophilia."

The following gives a clinical flavour to the situation. Over the past two weeks one 17 bed ward in Hackney has admitted three non-Londoners: a psychotic patient from Sierra Leone, a Barbadian with learning difficulties, and a manic Australian. On a similar ward last month there were five non-Londoners: two manic patients (from New York and Argentina), a mute man from Guadeloupe, a Nigerian with persecutory delusions, and a Kurdish patient seeking asylum who had been in Britain for two months. Currently, on one ward five patients are of no fixed abode.

Advice to authors

We prefer short letters that relate to a recently published article and we 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 declare any conflict of interest. If you wish to know whether your letter has been accepted or rejected please enclose a stamped addressed envelope.