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,^{1,2} with the bed occupancy rate for mental health now well above 100%, with some units actually running at over 120%.³ 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 85%.⁴ 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 extracontractual referrals to hospitals, 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.⁵

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 schizophrenic illnesses. 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 this problem largely relates to central London but would be interested to hear other people's views. At least one London hospital (the Gordon) now refuses community care after discharge to non-

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resident foreign nationals. Given the current unacceptable state of bed provision in London, can the NHS afford to treat mentally ill people not ordinarily resident in Britain?

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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 38 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.

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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: $r=0.7967$, $P=0.001$). 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

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

promote contraception through safer sex campaigns have undoubtedly been successful in increasing the proportion of teenagers who use condoms. Most people have assumed that increasing the use of contraception leads to a reduction in unplanned teenage pregnancies.⁴ Yet my analysis shows that this has not happened. A plausible explanation is that the main factor in unplanned teenage conceptions is contraceptive 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.

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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.^{2,3}

	Devon ¹ (n=167)	Portsmouth (n=629)
Age range (years)	13-19	14-40
No with unplanned pregnancies	147	629
Used condoms at time of unplanned pregnancy	67/147 (46)	301/629 (48)
Knew why condom had failed	53/67 (79)	153/301 (51)
Using contraceptive pill at time of unplanned pregnancy	45/147 (31)	134/629 (21)
Knew why pill had failed	32/40* (80)	96/134 (72)
Patients for whom postcoital contraception was suitable		310/629 (49)
Patients who had heard of postcoital contraception	135/167 (81)	450/566† (80)
Patients who had used postcoital contraception	16/167 (10)	42/310 (14)

*Combined oral contraceptive only.
†Question not completed by all those who attended.

In our study the main reasons given by the 268 patients who were not using postcoital contraception were ignorance of the method (59 (22%)), the woman not thinking about it at the time of conception (72 (27%)), and the woman underestimating her fertility (86 (32%)). Our study included older women and shows that their needs are as great as those of teenagers. We also concluded that much more education of patients and the public is needed to increase use of postcoital contraception.

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Serum cholesterol concentrations in parasuicide

Depression may cause low cholesterol

EDITOR,—Massimo Gallerani and colleagues report low serum cholesterol concentrations in people who attempt suicide.¹ Their findings are consistent with those of our systematic review of the possible hazards of lowering serum cholesterol.² The question is whether the association arises because a low serum cholesterol concentration causes depression and so causes suicide or because a low serum cholesterol concentration is a consequence of depression since depressed people eat less on average and this will reduce their cholesterol concentration. The evidence indicates that the latter is the case.

Effective treatment of depression leads to an increase in serum cholesterol concentration.³ Recent large randomised trials of 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, which achieve large reductions (about 25%) in serum cholesterol, have established that lowering cholesterol does not lead to depression⁴ or increased mortality from accidents and suicide.^{4,5} Earlier trials, which lowered serum cholesterol by about 10%, are also reassuring.² Two trials gave rise to concern despite their results not being significant (11 v 4 and 9 v 5 deaths from accidents and suicide in the treated versus the control groups respectively), but the excess was concentrated in patients who did not take the cholesterol lowering drugs (so that cholesterol reduction cannot have caused it) and in patients with pre-existing psychiatric illness.⁶ In the remaining 25 trials in our review there was no excess mortality from accidents and suicide (78 deaths in treated patients v 77 in controls).²

Prospective observational studies support the conclusion that low cholesterol concentration does not cause suicide: there was no excess mortality in studies of working men, who, because they were in work, were less likely to have had serious psychiatric illness such as depression.² In studies of cohorts in the general community, which necessarily include people with illness on entry, the excess mortality was concentrated in the first six years of follow up, with no significant excess during years 7-20.²

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Scottish study does not replicate findings

EDITOR,—Massimo Gallerani and colleagues found lower cholesterol concentrations in subjects after parasuicide than in control subjects matched for age, sex, diabetes, hypertension, heterozygote β thalassaemia, drug misuse, 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 laboratory.

We have studied the proposed association between serum cholesterol concentration and parasuicide in our catchment area of Scotland (Tayside) and found no such association. We studied 216 healthy patients who had committed parasuicide (age range 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 parasuicide who were receiving prescription drugs or had abnormal results of biochemical tests of liver or renal function were excluded. The patients who had committed parasuicide 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 parasuicide, who until the parasuicide generally yield normal results on biochemical testing, have no concurrent medical condition requiring treatment, and are not receiving any drug treatment. The findings of Gallerani and colleagues may be misleading and do not seem to apply to the Scottish population.

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No association between low cholesterol and violent death

EDITOR,—The study by Massimo Gallerani and colleagues is the latest to investigate whether there is an association between low cholesterol concentration and violent events.¹ However, no causality has been shown, and the associations in different studies seem to be inconsistent. 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 Gallerani and colleagues incorrectly cite the Helsinki businessmen study in the context of cholesterol and violence³: the higher incidence of violent events in the group treated multifactorially was not due to low serum cholesterol concentration or cholesterol lowering drugs.⁴ The results of the Scandinavian simvastatin 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.⁵

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