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Current themes

Repatriation of mentally ill patients

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Of all the decisions taken by psychiatrists with or on behalf of their patients, few are as potentially far-reaching as the decision to repatriate a mentally ill person to his or her country of origin. Although many psychiatrists have anecdotal experience of individual cases, published research on repatriation is surprisingly sparse. Burke (1973) reported 66 persons repatriated from Britain to Jamaica over a four year period, and Asuni (1968) found 82 returning via Aro Hospital, Nigeria, over a similar period. Although it is difficult to extrapolate an estimate of the number leaving the UK each year, these figures suggest that the practice is not uncommon and that significant, possibly increasing, numbers of people are affected.

The desire to repatriate is commonly based on the belief that the individual's prognosis will be improved by being returned to his/her own culture and family, and in the case of developing or underdeveloped countries, re-immersion in a predominantly rural environment. Burke's original study and subsequent analysis (Burke, 1973, 1983), however, demonstrated that the return to Jamaica was associated with a high mortality and stigma, the latter also being applied to persons returning for reasons other than ill-health (Davison, 1968). Further, it appears unlikely that standards of care and access to appropriate means of treatment in such countries are equivalent to our own (Birch, 1983) and this consideration may outweigh any potential benefits.

Our attention was drawn to issues concerning repatriation by the management of two foreign patients. The first involved a 33-year-old West German tourist detained under Section 3 of the MHA 1983 who was known to have a history of schizophrenia. His family were keen that he should come home but the patient refused to consider voluntary repatriation. An application was made to the Home Office for his repatriation but while this was being considered the patient then agreed to return to a hospital in Nuremburg. His air fare and expenses and those of the two nurse escorts required by the airline's medical adviser were provided by the health authority.

The second case comprised a 24-year-old Chinese postgraduate student detained on Section 3 who had previously been admitted to Kowloon Hospital with a diagnosis of schizophrenia. The patient and his family were keen that he should return to Hong Kong. The airline agreed to carry him only if accompanied by two qualified escorts and in the absence of financial support from the health authority the total cost of repatriation was borne by the patient's family. Although the man remained paranoid and frightened, he agreed to continue on large doses of antipsychotic medication for the duration of the flight until his admission to Kowloon Hospital two days later.

These two cases have in common several features – both patients had a definite past psychiatric history and both suffered a relapse while legitimately staying in this country; they had supportive families who were prepared to assist in making the necessary arrangements for transfer to hospitals in their home countries; and both were detained under Section 3 at the time the decision was made to arrange repatriation, but eventually travelled home of their own free will.

The transfer of patients between hospitals within the United Kingdom is a well established practice. Removal to countries abroad is possible under Part VI of the MHA 1983, although no provision can be made for such patients once outside the jurisdiction of the United Kingdom. Section 86 empowers the Home Secretary to authorise the repatriation of mentally ill patients who are neither British nor Commonwealth citizens who are detained under Section 3, a hospital order or "an order or direction having the same effect as a hospital order". The Home Secretary must be satisfied on the advice of a Mental Health Review Tribunal that proper arrangements have been made for the patient's care or treatment in the country to which he/she is to be moved, and that it would be in the best interest of the individual.

Proposals for repatriation are made to C3 Division of the Home Office who decide whether authority under Part VI of the Act should be issued or whether the patient should be repatriated under other powers.

The Secretary of State may then issue a warrant authorising the removal of the patient from hospital to go to the pre-arranged destination abroad, and for the patient's detention during the journey.

Although it is not possible to generalise about the merits of repatriation, the practicalities involved raise a number of important clinical and medico-legal issues. Foreign patients detained under the MHA have the same rights of appeal as British residents, and when such appeals are considered the issue of repatriation may be raised. Although repatriation may be considered desirable, a Mental Health Review Tribunal considering the appeal is not formally empowered to make such a recommendation. Before compulsory repatriation can be pursued it remains necessary for a separate MHRT to be convened for this purpose by the Home Secretary. However, unlike an appeal hearing, there are no guidelines determining procedure or whether the requirements of Section 86 have been fulfilled.

The information required in considering repatriation is likely to be substantial and experience indicates that a failure to fulfil this requirement often hampers the Tribunal's ability to make a definitive recommendation about repatriation. It is unclear, however, where the responsibility rests for obtaining such information. In practice, this task is performed by the clinician, who must rely on the co-operation and assistance of a number of agencies including the Embassy of the country concerned. Such a process, at best, can be time-consuming but has the potential for considerable administrative impasse. If this is to be avoided it would seem appropriate that responsibility for ensuring the adequacy of information should rest with the Home Office.

In the event of a warrant being issued, the powers provided by Section 86 appear to give absolute authority for the patient's detention in transit to the agreed destination. It is assumed that staff escorting the patient will continue to have the authority and protection of the Act once outside British territory. This is particularly relevant if the journey involves travel by way of a third country, e.g. a change of plane. In cases where the patient is travelling voluntarily, the escorts appear to have no formal legal protection if they should be required to restrain the patient or enforce treatment. Their role should therefore be seen as predominantly supportive, and explicit agreement should be made with the authorities abroad as to the nature and extent of their responsibilities within that country.

Finally, there is the issue of who or what authority should bear the expense incurred by repatriation. As it is unlikely that an unaccompanied patient will be accepted as a passenger by an airline, the anticipated expenditure, including the fares and salaries of the escort(s), may be considerable. In practice, repatriation is often dependent upon the availability of financial support from the health authority or from the patient and his/her family. Although the latter may be appropriate in some instances, it would seem desirable that there should be clear guidelines as to who is responsible for this funding where repatriation has been formally recommended.

We live in an age of easy and inexpensive travel where there is an increasing likelihood of having to deal with patients who do not reside permanently in the United Kingdom. Repatriation raises a number of administrative and medico-legal issues which require clarification in the interests of a small but significant group of mentally ill individuals.

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