Psychiatric Bulletin (1990), **14**, 89–95

Correspondence

Treatment of the mentally ill on Leros and in Macao

DEAR SIRS

The College has in recent years made great endeavours to highlight the plight of those subject to political abuses (Reddaway, 1989; Finlayson, 1987). I surely cannot have been the only one to have found it ironic that the Soviet Union was readmitted to the World Psychiatric Association at its recent meeting in Athens (Smith, J., 1989), against the background of much media attention to the deprivation and degradation of the inmates of the Greek Island of Leros (Merrit, 1989).

Sadly it has been left to the media to highlight the deplorable and inhumane conditions of mentally ill and mentally handicapped people such as those on Leros (Merrit, 1989) and also in Macao (Smith, C., 1989) while the college has remained strangely silent.

Surely a body as world renowned and respected as the Royal College of Psychiatrists should be doing more to address the issues raised?

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DEAR SIRS

Dr Tyrie's point is well taken but there is a difference between the situation at Leros and that in the USSR. The College has been aware of the problems at Leros for some time but was also aware that a number of organisations have been taking active steps to do something about it. In particular, an EEC group, led by Professor Ivor Browne in Dublin, had visited Leros and made a number of recommendations. We had also received reports from various visitors subsequently. When the present situation was published I wrote in vigorous terms to the Minister of Health in Athens, the Greek Ambassador in England and the President of the Hellenic Psychiatric Association as well as to Professor Stevanis, the President of the World Psychiatric Association. The matter was of course extensively discussed at the WPA meeting itself. International pressure and particularly pressure from the EEC is still being exerted to improve the situation there.

Another difference, which has often been discussed, is that between the politics of neglect, whereby mentally ill or handicapped people are provided with poor or no treatment, and political abuse, whereby healthy people, who are seen as deviant are sent to psychiatric hospitals and even given 'treatment' against their will. The College should be alert to both, while recognising that they are different, and have different origins.

DR J. L. T. BIRLEY
President

Psychotherapy within general psychiatry

DEAR SIRS

I read with great interest Dr Thomas Freeman's paper (*Psychiatric Bulletin*, November 1989, **13**, 593–596) which so clearly outlined the changes of the last few decades that have led to analytically trained psychiatrists no longer being hospital based with involvement in the care of all kinds of in-patients, including organic and long-stay. I entirely agree that direct clinical contact and responsibility is essential to share fully common experiences with other general psychiatrists, and in helping trainees meaningfully to integrate psychoanalytic concepts into their everyday understanding and approach to psychotic patients.

The sad fact is that while British analysts continue to make seminal contributions to our understanding of different aspects of psychotic processes, there has been a relative failure to integrate them into general psychiatry at a clinical level.

I do not see an easy way to rectify this problem. It can come only from an encouragement of interested psychiatrists to undergo analytic training, with a view to applying this knowledge in a general psychiatric setting. Also there is a need to recreate suitable posts for this in the NHS. The only two in-patient specialist analytic posts in London at Shenley and the Maudsley Hospitals have now gone. The British Psychoanalytical Society has been concerned over the trend of the falling ratio of medics compared to

non-medics undergoing analytic training and they are giving much thought to this matter.

In the meantime, we need to be vigilant to ensure that analytic contributions are sought when an overall review occurs of a psychotic disorder. For example, in the recent, otherwise excellent, supplement on the symposium on Negative Symptoms in Schizophrenia, there was a conspicuous lack of a current psychoanalytic viewpoint.

I believe that I am now virtually in a minority of one in being a general psychiatrist with both acute and long-stay beds, as well as a practising psychoanalyst. It is from such a position that I fully endorse Dr Freeman's concern.

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Medical consultations in a therapeutic community

DEAR SIRS

I am writing to state that as part of my training in psychiatry I am currently working in a therapeutic community. The frequency of medical consultations, most of which have been trivial, by my patients (the majority of whom are in their 20s and 30s), has been remarkable.

Some explanation for this can be given, for example: patients 'testing-out' new doctors; patients seeking individual therapy (which otherwise is not encouraged); and hypochondriasis. These factors are combined with ready access to medical attention – in the therapeutic community there is no GP's receptionist to get past or any need for an appointment to be made.

The result is that, in an atmosphere of communalism, egalitarianism and democracy, the barriers a doctor normally has to protect against demands on his time and accessibility are lost. Is this merely because the doctor is a newcomer to the community and is it commonly experienced by other medical staff in similar situations which will subsequently resolve? Or will the frequency of medical consultations be maintained at a level significantly higher than would normally be expected? Other possibilities are that the patients who now form the community previously visited their GPs or attended casualty on a frequent basis. I am not aware if this experience is commonly encountered in other communities but it could be an area worthy of detailed study.

In this particular case measures have been taken in an attempt to reduce the burden of these consultations. These include requesting that any resident wishing to have a medical consultation should make his request at the community meeting, thereby informing the whole of the community. The result is that some matters can be dealt with at the community level rather than requiring the doctor's advice. However certain matters are particularly personal, for example a vaginal discharge, and in these cases the need for a consultation can be raised in the community meeting without specifying the nature of the illness. The idea of a special 'clinic' was considered but not instituted.

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Overseas doctors' training scheme

DEAR SIRS

It was with interest that I read the letter by Drs Moodley & Araya in the *Psychiatric Bulletin* (November 1989). Although the Dean has commented in his letter in the same issue, I would like to add a few further comments. The Collegiate Trainees' Committee has accorded priority to monitoring doctors on the overseas doctors' training scheme. A working party has been set up to monitor the training of doctors on the scheme from the view point of the individual doctors independent of the Overseas Desk. I have written to all doctors on the scheme and intend to communicate on a regular basis.

By the nature of the ODTS the trainees are in an isolated position, and they do have specific training needs. It is therefore valid for the CTC to ensure that their views are heard and that they are represented in the College.

OLA JUNAID

Honorary Secretary
Collegiate Trainees' Committee

Nafsiyat

DEAR SIRS

We would like to welcome the article by Penelope Campling entitled 'Race, Culture and Psychotherapy', (*Psychiatric Bulletin*, October 1989, **13**, 550–551) but as she has made reference to our organisation, we would like to clarify our position on two accounts.

Firstly, Nafsiyat does not believe in separate services for ethnic and cultural minorities, and furthermore we believe that all minorities should have their needs met by the statutory services within the NHS.

Secondly, Nafsiyat does not receive any Section 11 money whatsoever. It is a charity and is in constant need of funds.

We too believe that the answer is to look at the benign indifference of the majority community, especially professionals in the psychotherapy field