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

who continuously ignore racism and the needs of ethnic minorities.

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Mental Health Review Tribunals

DEAR SIRS

We were interested to read Dr Petrie's letter (*Psychiatric Bulletin*, October 1989, **13,** 571) and note that he appears to assume that discharge from a Restriction Order by a Tribunal means summary discharge from hospital.

This is not necessarily so; discharge from a Restriction Order only ceases liability to be detained by virtue of the relevant Hospital Order (Section 73(3) Mental Health Act 1983). This does not preclude patients from remaining in hospital (with the consent of the Managers) on an informal basis. This situation does and has occurred even in the English Special Hospitals.

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Self-referrals to the community psychiatric clinic

DEAR SIRS

The article by Boardman & Bouras concerning self-referrals to the Lewisham Mental Health Advice Centre (*Psychiatric Bulletin*, September 1989, **13,** 490–492) came at a time when we were examining the referral patterns and the number of self-referrals to Ashmore House, a jointly funded Community Mental Health Centre in Ashington.

Ashmore House has been in operation since March 1985; 299 clients were referred in the first nine months of operation (March–December 1985) and every year subsequently over 400 clients have been referred. Table I gives the numbers referred in each year and the source of referral. The clients in the 'others' group came by various sources but most were referred by local social services area teams.

Ashmore House is staffed by a multidisciplinary team and a duty officer is available each day between 9.00 am and 5.00 pm to see self-referrals or clients who are referred as an emergency by their general practitioner or from other sources. All referrals are discussed at a weekly allocation meeting and a plan of management is drawn usually involving one member of the staff becoming that client's 'key-worker'.

Self-referrals have always been encouraged. As can be seen in Table I, there have always been a considerable number of self-referrals. Although the number has risen in the years the centre has been in operation, there is no doubt that once clients have had contact with Ashmore House they will re-refer themselves on subsequent occasions if they require further help. For the year January to September 1989 there were 83 re-referrals; of these 35 were self-referral, 18 from general practitioners and 16 from psychiatrists. Of the remainder there were referrals from social workers (5) community psychiatric nurses (4) and the other sources (5). These figures are similar to those found in previous years. Most re-referrals are self-referrals with smaller numbers coming from general practitioners and psychiatrists.

In contrast to the findings reported in Lewisham and also in Lewes by Hutton (1985) Ashmore continues to have more women than men among both the new self-referrals and also the re-referrals. In both cases females out-number males in the approximate ratio of 3:2. This would suggest that the findings of an excess of males reported previously have been more due to a local rather than a general effect. The Lewisham study suggested that there was an excess of males in social class I and II in the self-referral group. We do not have specific figures for social class and it is possible that part of the explanation for our findings is that we do not have many patients in social classes I and II in our area.

Comparison of the self-referrals with the GP referrals was also undertaken. There were no statistical differences as regards age, sex, marital status, employment status or whether the client was allocated a key-worker. We are at present researching the appropriateness of the self-referrals. Our initial data would suggest that there were few inappropriate self-referrals.

For our client group the ability to refer themselves continues to be a major advantage. For those in acute distress it allows ready assessment by a skilled team of mental health workers and if necessary access to in-patient facilities. For clients who have already had contact with Ashmore House it allows them to return readily without having to go through their general practitioner.

Sayce (1987) has commented on the diverse nature of community mental health centres in the UK. Our findings clearly show some difference between the practice in Lewisham and that in Ashington. It is our hope that there will continue to be further reports from other centres so it can be established more clearly what are the general trends in terms of