who continuously ignore racism and the needs of ethnic minorities.

JAFAR KAREEM
ROLAND LITTLEWOOD
Nafsiyat Inter-Cultural Therapy Centre
278 Seven Sisters Road, Finsbury Park
London N4 2HY

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.

L. J. NAISMITH
J. B. COLDWELL
Park Lane Special Hospital
Maghull, Liverpool

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

TABLE I
All referrals to Ashmore House

Source of referral		Year: 1989 Jan–Sep		1988		1987		1986		1985 Mar–Dec	
GP	Male	30	99	44	149	41	154	43	112	17	60
	Female	69		105		113		69		43	
Self	Male	24	74	45	102	37	93	31	95	29	60
	Female	50		57		56		64		31	
Psychiatrists	Male	28	55	39	93	52	106	50	126	55	132
	Female	27		54		54		76		77	
CPN	Male	5	11	6	13	3	7				
	Female	6		7		4					
Other	Male	19	41	23	59	19	62	18	80	18	47
	Female	22		36		43		62		29	
Total		280		416		422		413		299	
Self-referrals (as percentage of total referrals)		26%		25%		22%		23%		20%	

referrals to community mental health centres and what effects are due to local practices.

W. GRANT
B. STEWART
D. HEBBLETHWAITE
M. GALLAGHER

Ashmore House
Ashington, Northumberland
NE63 0EY

References

HUTTON, H. (1985) Self-referral to a community mental health centre – a three year study. *British Journal of Psychiatry*, **147**, 540–544.

SAYCE, L. (1987) Revolution under review. *Health Service Journal*, **97**, 1378–1379.

Management of suicidal patients

DEAR SIRS

I would like to add one further point to R. Gardner's otherwise excellent guidelines on management of suicidal patients in psychiatric units (*Psychiatric Bulletin*, October 1989, **13**, 561–564).

On identifying suicidal patients another scenario is worth mentioning. The severely depressed patient, who for no apparent reason suddenly appears to achieve peace of mind, may be at risk. The calm exterior presented by a previously agitated and depressed patient may be a result of the patient's resolution to end his or her misery by committing suicide. The patient may also seek to convince staff that suicide is not being contemplated.

https://doi.org/10.1192/pb.14.2.91-a Published online by Cambridge University Press