

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 outnumber 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	44	41	43	17
	Female	69	105	113	69	43
		99	149	154	112	60
Self	Male	24	45	37	31	29
	Female	50	57	56	64	31
		74	102	93	95	60
Psychiatrists	Male	28	39	52	50	55
	Female	27	54	54		
		55	93	106	126	132
CPN	Male	5	6	3		
	Female	6	7	4		
		11	13	7	76	77
Other	Male	19	23	19		
	Female	22	36	43	62	29
		41	59	62		
Total		<u>280</u>	<u>416</u>	<u>422</u>	<u>413</u>	<u>299</u>
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.

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#### 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.