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

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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.

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In retrospect, I believe that this was indeed the course of events leading up to one in-patient suicide of which I had direct experience.

JOHN SIMPSON

Psychiatric Unit, Ards Hospital
Newtownards, Co Down

Assessment of suicide risk

DEAR SIRS

I feel impelled to respond to the letter of Drs N. D. Macaskill and S. Wood (*Psychiatric Bulletin*, September 1989, **13**, 507). I am not at all surprised that candidates for the membership examination should have difficulty in answering a question about how to assess suicide risk. However, the problem lies neither with the candidates, nor the training they have received. That suicide risk can be meaningfully assessed is a myth but a myth which has sunk deep into the psychiatric mind. In medicine the purpose of evaluating a risk is that the occurrence of a future outcome can be determined with reasonable specificity and sensitivity. Also, the 'at risk fact' should act as a powerful discriminator between the various managements which could be undertaken (i.e. the right course of action to prevent the unwanted outcome).

I am not aware of a single scientific publication which indicates that suicide can be predicted in an individual patient with any reliability. That which cannot be predicted cannot be prevented.

What the candidates for the examination are frequently required to do is to cite a list of features which have been determined *post facto* as being associated with a certain suicidal outcome. Even strong associations of this sort say next to nothing about the *prior* probabilities and the interested reader may like to familiarise himself with Bayes theorem if the reason for this is not immediately obvious.

In conclusion, therefore, how can the candidate be failed in an exam for failing to respond adequately to a question which has no correct answer?

C. HAWLEY

Charing Cross Hospital
Fulham Palace Road
London W6 8RF

Research methodology

DEAR SIRS

I would like to draw attention to an omission from the helpful article by C. Freeman and P. Tyrer (*Psychiatric Bulletin*, September 1989, **13**, 501–502) on research methodology. There was no mention of operational or action research as accredited methodologies with applications in psychiatry. They are used extensively within the social sciences to analyse organisations and evaluate how things work in the real world (Moore, 1987). The methodology lends itself to the evaluation of the service changes occurring within psychiatry, as these are often too large and complex to evaluate using controlled experimentation.

Indeed many of the articles published in the *Bulletin* are works of action research and I am sure that a full discussion of the methodology of such projects would be of benefit to psychiatrists in general.

G. HARBORNE

Clifton Hospital
Shipton Road, York

Reference

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Huntington's disease associations in Australia

DEAR SIRS

I refer to the paper 'Huntington's Disease – the Experiences of Voluntary Organisation' by Brian O'Shea published in the *Psychiatric Bulletin*, August 1989, **13**, 409–411.

It was most disappointing to read that Dr O'Shea contacted only the Huntington societies of Britain, Holland, Ireland, New Zealand and the USA. To the best of my knowledge as Chairman of the National HD Association in Australia he did not enquire of the Australian experience.

There are six HD associations in Australia, one in each state, and the achievements of each vary widely although they all provide ongoing services which include newsletters, family support, meetings and the distribution of information to families and health professionals.

Each state has an office, manned by paid staff and/or volunteers. For the diagnosis and management of HD sufferers there are either regular HD clinics or referral to neurologists and/or psychiatrists familiar with the illness.

Predictive testing has already commenced in South Australia and most other states are expected to follow in the near future. In both New South Wales and Victoria there is specialised nursing home accommodation for long-term and respite care of HD people. They are the Huntington's Unit at Lidcombe Hospital and the Arthur Preston Centre in Melbourne, respectively.

One of Australia's most notable achievements has been the introduction of holiday programmes for people with HD. Such programmes allow the carer to