McCLURE, G. M. G. (1987) Suicide in England and Wales, 1975-1984. *British Journal of Psychiatry*, **150**, 309–314.
ROWLANDS, R. P. (1995) Deal with self harm in prisons (correspondence). *British Medical Journal*, **310**, 127.

STEVEN F. REID and JOANNE TURNER, *Sutton Hospital, Cotswold Road, Sutton SM2 5NF*

Working with young offenders: a contribution to forensic training in child psychiatry

Sir: Specialist forensic training posts in child psychiatry are on the increase. However, in a survey of all child and adolescent psychiatry training schemes in the United Kingdom. Reder & Lucey (1990) found that training with regard to young offenders was virtually absent. The rise in juvenile crime rates, together with a contraction in services equipped to deal with antisocial young people, have led to increasing concern about the health of young offenders, particularly regarding suicides among young offenders and about a core group of recidivist offenders.

There is therefore a need for specialist training placements which include involvement with young offenders. One such placement exists in North West Thames. The post is equally divided between a children and families department and the regional forensic out-patient department and includes an attachment to Feltham Young Offenders Institution (YOI).

The placement offers unique opportunities. The modes of presentation of disorders and the difficulties faced in treating them can be seen. An insight into the lives of young offenders is gained which provides a valuable understanding of the routes they have followed into crime. The trainee can begin to comprehend the influence of a prison environment on prisoners and on therapeutic relationships through experience of the establishment and knowledge of the Home Office.

With the increasing role of child and adolescent psychiatrists in the assessment and management of young offenders, this area of training can no longer be ignored. Such a placement is time efficient and provides unique training opportunities. It is strongly recommended to senior registrars interested in forensic adolescent psychiatry and would provide an important adjunct to any broad-based training scheme for senior registrars in child and adolescent psychiatry.

REDER, P. & LUCEY, C. (1990) Child and adolescent psychiatry training schemes: recent developments. *Psychiatric Bulletin*, **14**, 615–617.

A. J. HILL-SMITH, *North West Thames Child Psychiatry Training Scheme, Adolescent Unit, Hill End Hospital, St Albans, Herts AL4 0RB*

Severe hypertension associated with risperidone withdrawal

Sir: We wish to report a case of severe hypertension associated with a rapid discontinuation of risperidone.

A 29-year-old man of mixed African and English origin with a nine year history of schizophrenia was admitted after he had been harassing residents at his hostel and expressing delusions. He had stopped his maintenance medication six months previously.

On arrival he was hostile and thought disordered. Blood pressure was 130/80. He was given oral chlorpromazine and a haloperidol decanoate depot of 200 mg 2-weekly. Continuing disturbed behaviour led to first clonazepam (day 12, increasing gradually to 4.5 mg per day) and then risperidone (day 21, 1 mg bd increasing to 4 mg bd) being started. Threats and an assault led to droperidol being added on day 23 of admission (increasing gradually to 30 mg tds).

On day 29 of admission he became still more aggressive and a decision was made to stop his clonazepam and risperidone. He was moved to a regional secure unit the following day after being given sodium amytal 500 mg intramuscularly.

On arrival he was surprisingly calm and cooperative. His blood pressure was 230/150 and pulse 100/minute. He had a frontal headache, but there were no clinical abnormalities that could explain the hypertension. Twenty-four hours later his blood pressure had fallen to 165/115 and at 72 hours normalised at 125/90. Investigations failed to provide an explanation for the hypertensive episode, indeed the only abnormality was a urine drug screen positive for cannabis.

Neither sodium amytal nor benzodiazepines have been reported to cause hypertension, and cannabis actually lowers standing blood pressure (Goodman & Gilman, 1985). Risperidone blocks D_2, alpha$_1$ and 5-HT$_2$ receptors and could have contributed to the hypertensive episode described in this patient,

rapid discontinuation elevating the blood pressure by withdrawal of the alpha$_1$ blocking effect. Although the manufacturers state that this effect was not observed in clinical trials and would be unlikely on theoretical grounds as risperidone has a relatively long half-life (24 hours), it is to the best of our knowledge the first report of a hypertensive crisis occurring on risperidone withdrawal.

We thank Professor Malcolm Lader of the Institute of Psychiatry and Dr Anthony S. David of the Maudsley Hospital for their advice and comments.

GOODMAN, L. S. & GILMAN, A. (1985) *The Pharmacological Basis of Therapeutics*. 7th edition. Collier Macmillan.

CHRISTOPHER G. KRASUCKI and JAMES A. C. MACKEITH, *Maudsley Hospital, Denmark Hill, London SE5 8AZ*

Problems with advocacy

Sir: I would like to raise some potential problems with advocacy for clients with mental illness and learning disability.

W is a patient with borderline intelligence and suffers from depression. He is physically fit although he has suffered from deep venous thrombosis and is treated with anticoagulants. He has been preoccupied with using a zimmer frame for about two years and which he has never needed. The staff strongly advised him and his family that he does not need it. His advocate was not happy about that and his premise was "it is his choice. What is wrong with having it". When the depression lifted the patient stopped requesting the zimmer frame.

M has a moderate degree of learning disability and a psychopathic personality. In recent months he has been involved in assaultative behaviour including against an elderly person and a female doctor. An urgent MDT meeting was arranged in the presence of the approved social worker (ASW) and a section 3 order agreed in order to protect him and others and all agreed that this was the right thing to do. His advocate disagreed and said he would not allow it to happen. The ASW said she would not be influenced by the advocate's attitude but a few days later she apparently found that it was not necessary to put him on a section. A few weeks later M told a senior staff member that he wanted to have sex with another person who could not give consent. When told he could not and should not he became aggressive and threatening. Days later he was approaching young teenagers. He also pretends to be a policeman and has been found directing traffic and asking for fines from drivers parking on yellow lines.

If I, as the responsible medical officer (RMO), fail to give appropriate, or give inappropriate, treatment I can be sued. What is the position if an untoward event happens to a patient or a third party as the result of obstruction or interference by a patient's advocate? I have also had experience of advocates acquiring confidential information about patients without permission from the RMO. It is worrying when one hears service managers insisting that everything done to a patient (client) should be discussed and preferably agreed by the advocate. Perhaps the College could advise on the best way forward. I would also like to hear about the experience and opinion of other colleagues.

EMAD YOUSIF, *New Possibilities NHS Trust, New Possibilities House, Turner Village, Turner Road, Colchester, Essex CO4 5JP*

Offensive or stigmatising labelling

Sir: Our group has met to discuss ways of dealing with the problem of offensive or stigmatising labelling. The candidate for the most distressing and unacceptable term was, not surprisingly, 'schizophrenia' (even more so to be referred to as a 'schizophrenic' although people are becoming more educated about its mis-use).

We would like to ask for comments and suggestions from psychiatrists and others who read the *Psychiatric Bulletin* if they would be kind enough to write to:

SUE STEVENS, *Unit 5, Coopers Yard, Curran Street, Cardiff, South Glamorgan*

Improving initial attendance to a child and family psychiatric clinic: Australian experience

Sir: I thought it would be useful to look at the Australian scene and therefore surveyed the referrals made to my team over one year. I work as a team leader of the South West Outpatient Team at the Royal Children's Hospital, Melbourne offering a service to a