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

resident population of about 250,000. We provide child and adolescent services (for ages 0-18) to the western half of Victoria which has a resident population of approximately two million.

Referrals have been generally by telephone although the trend is changing with more referrals being by letter. Traditionally the service has encouraged parents to contact the centre by phone. Cases are allocated at a weekly allocations meeting. The clinician then contacts the family by phone to arrange an appointment.

The survey includes patients referred who were offered an initial appointment. Of the 420 referrals, 68 (16.2%) were either redirected to other agencies (30), did not require an appointment (32) or were not contactable on the phone (6) to arrange an appointment. We offered the remaining 352 an appointment and of this group 335 attended while 17 failed to keep the appointment. This gives a nonattendance rate of 4.8% and an attendance rate of 95.2%. Eight out of the 17 patients who failed to attend were parent referrals.

Our attendance rate (95.2%) is higher than the rate reported in comparable studies (64% and 87.1%) (Jaffa & Griffins, 1990; Mathai & Markantonakis, 1990).

The good attendance rate of first appointments in Melbourne appears to be due to the large number of parent referrals, i.e. 50% being made by parents directly to the service as opposed to 90% by general practitioners in the UK. It is recommended that parents be encouraged to contact the service directly along with the written referral being made by the GP or primary agency to the specialist service. Early parental contact not only facilitates information sharing about the clinic and its work but also ensures that the first appointment is kept by dealing with any apprehensions of the parent who has to attend the first appointment with the referred child. This is a cost-effective measure leading to saving of resources that could be easily wasted through failure to keep appointments.

JAFFA, T. & GRIFFIN, S. (1990) Does a shorter wait for a first appointment improve the attendance rate in child psychiatry? *Newsletter of the Association for Child Psychology & Psychiatry*, **12**, 9–11.

MATHAI, J. & MARKANTONAKIS, A. (1990) Improving initial attendance to a child psychiatric clinic. *Psychiatric Bulletin*, **14**, 151–152.

JOHN MATHAI, *Royal Children's Hospital, Parkville, Victoria 3052, Australia*

Kuf's disease: request for patients and families

Sir: The neuronal ceroid lipofuscinoses (NCLs) are a group of inherited disorders characterised by the abnormal storage of lipopigments. They can be classified according to the clinical features and age of onset into four main subtypes: infantile, late infantile, juvenile and adult NCL. Adult onset NCL is also known as Kuf's disease, and presents around the age of 30 years with dementia, myoclonic epilepsy and motor deterioration. Both autosomal recessive and dominant inheritance patterns have been described. Despite intensive biochemical investigation the underlying metabolic defect is unknown and treatment is symptomatic only.

The genes for infantile, one form of variant late infantile and juvenile NCL have now been mapped using family studies and linkage analysis. It is anticipated that these genes will be cloned within the near future and disease causing mutations characterised. The Department of Paediatrics at University College London has a long-standing interest in this group of disorders.

We plan to investigate families and individuals with Kuf's disease using linkage analysis and mutation detection on a candidate gene basis. Ultimately the characterisation of this group of disorders at the molecular level will enable an understanding of the metabolic pathways involved, improved disease classification and genetic counselling, and may provide new therapeutic strategies.

Please contact for further information:

RUTH WILLIAMS (telephone: 0171-209-618, email rwilliam@hgmp.mrc.ac.uk) or SARA MOLE, (telephone: 0171-209-6104, email s.mole@ucl.ac.uk) *Department of Paediatrics, UCLMS, The Rayne Institute, 5 University Street, London WC1E 6JJ* (fax 0171-209-6103)