Serious incident inquiries have a role

Sir: the irrationalities identified by Szmukler (Psychiatric Bulletin, January 2000, 24, 6–10) suggest that serious incident inquiries serve a role well beyond the need to explain how – or even why – something ‘untoward’ happens. Inquiries are, in fact, attempting to answer questions about fear, stigma, morality and personal responsibility, areas where rational inquiry has a poor record of satisfactory results. The folly of applying rational tools to irrational material becomes clearer when one considers the different perspectives and expectations of the agencies involved. To psychiatrists, inquiries are a quasi-legal form of local service audit, with powers to drive change far in excess of what may rationally be expected from a single case study. For the bereaved they serve a proprietorial role, the inquiry process helping families to make sense of the powerful emotions that accompany homicide. To the public at large, they provide a superficial way to soothe a fear that has troubled us since antiquity, and even more so in our individualistic, comfort-driven culture: ‘It could happen to me for no reason!’ The idea of a ‘methodical’ investigation of the causes of such a natural but irrational fear renders it more manageable. To the Government, inquiries into the minutiae of local service provision provide welcome distraction from the simple fact that the psychiatric services generally have always been neglected.

The common theme of these irrationalities is the fear of mental illness. Many have suggested solutions to the problems of inquiries themselves (Eastman, 1996; Buchanan, 1999), but until we address the stigma-driven emotional responses that propel the current serious incident culture, or at least attempt to identify them, it seems that all shall lose and none shall have prizes.

References


Mark Salter. Consultant Psychiatrist, Homerton Hospital, Homerton Row, London E9 6SR

Children’s consent to medical treatment

Sir: Moli Paul, in his letter (Psychiatric Bulletin, January 2000, 24, 31), refers to Section 133 of the Mental Health Act 1993 (he in fact refers to Section 10(2) of the Act which we assume to be a typographical error) which deals with the informal admission of patients, including children, under the Act. He then analyses the guidance in the 1999 Mental Health Act Code of Practice.

The 1999 Mental Health Act Code of Practice has a number of functions, which include providing essential reference guidance on practice and giving guidance on how the law, whether contained in statute or case law, should be applied. The Code correctly summarises the law in relation to treating a child, that is any person under the age of 18, without their consent (code para. 31.12). The Code refers to the leading case in this area, Re: W. (1992) which states that the refusal of a child to be treated cannot override a consent to treatment by either the court or someone with parental responsibility.

The court in Re: W went on to emphasise that the child’s refusal: ‘... is a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.’

Be that as it may the court, or person with parental responsibility, can and will continue to ‘trump’ the child’s refusal in certain circumstances, even if the child has capacity. The most striking recent example of this was in July 1999 when a judge overrode the wishes of a 15-year-old girl who refused to consent to a heart transplant (Re: M, 1999). The judge’s decision was based on the objective of seeking what was best for the child.

Dr Parkin suggests that there are inconsistencies between good clinical practice and the guidance in the Code. It would be more accurate to say that there are inconsistencies between the current law and good clinical practices. The foreword to the Code acknowledges that the Mental Health Act is increasingly out of date. Unfortunately, the Government, in the proposed reform of the Mental Health Act (1999) has not adopted the recommendations of the expert committee in this area. The Committee recommended that there should be a “threshold of 16 years for the presumption of capacity to make treatment decisions i.e. to both accept and refuse treatment” and in the case of children from 10–16 years old there be a rebuttable presumption of capacity.

Dr Paul refers to the Code’s guiding principles which provides that a patient should be treated in such a way as to promote the greatest practicable degree the patient’s self-determination and personal responsibility, consistent with their own need and wishes (Code para. 1.1). In practise this means that, insofar as is practicable, the patient’s treatment wishes will be respected, but when not practicable their own treatment decisions will be overridden, by using the Mental Health Act.

The difficulty with this discussion is the inter-relationship between the provision of non-consensual medical treatment for mental disorder and the provision of medical treatment without consent. The former can be provided without consent and subject to certain safeguards under the Mental Health Act. The latter in the case of adults depends on an assessment of capacity. If capable an adult cannot be given medical treatment without their consent. If incapable the doctrine of necessity applies and treatment can be given if the treatment is in the patient’s best interests (Re: F, 1980). In the case of a child even if the child has capacity their refusal to be treated can be overridden. This is the position as stated in Re: W.

The Mental Health Act abridges a patient’s autonomy. As the Act is not age specific this will encompass children. Children do not have complete autonomy in the field of medical treatment, as is reflected in the common law. Code guidance has to incorporate guidance on statute and the common law. The general
guidance in the Code reflects the qualification of autonomy for detained patients. It can also be applied to the additional reduction of autonomy, which may be experienced by the child patient, even if the child’s legal status is informal. The Code reflects reality, tacitly acknowledging an abrogement of autonomy, which in certain circumstances will result in detention.

As the Code correctly summarises the law it is incorrect to state that it ‘creates’ inconsistencies (Parkin, Psychiatric Bulletin, October 1999, 23, 887–889) or undermines the child’s rights. All the Code does is highlight what may be regarded as the conflicts between the current law, current clinical practice and the child’s human rights. This is the area where the debate needs to be focused. In particular whether the competent child’s human rights have been infringed where a decision to override their treatment decisions has been made.

References

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William Bingley, Chief Executive, Mental Health Act Commission

Serotonin syndrome

Sir: Mir & Taylor (Psychiatric Bulletin, December 1999, 23, 742–747) in their review of serotonin syndrome reminded us of the diagnostic criteria (Sternbach’s criteria) for the diagnosis of this syndrome at a time when we had recently championed the drug therapy of a patient from trazadone to paroxetine. In this patient we saw the emergence of five symptoms listed in Sternbach’s criteria (agitation, myoclonus, shivering, tremor and incoordination). We have two points to make: we noted that the most severe symptoms in this patient were nausea and vomiting. Although, it is accepted that nausea and vomiting may occur as part of the serotonin syndrome (Lane & Baldwin, 1997) they are not diagnostic criteria. Gastrointestinal symptoms are well-recognised effects of increased serotoninergic activity and it is surprising that there is little emphasis on them in the literature relating to this subject. Where serotonin syndrome is a result of changing drug therapy the possibility of a discontiniuation syndrome should be considered as an alternative diagnosis because of the overlap in symptomatology between the two syndromes.

References

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Sir: It may be helpful for clinicians to appreciate that the great weight of recent evidence indicates that a spectrum model best explains serotonin syndrome phenomena. Serotonergic side-effects merge imperceptibly into ‘toxic’ effects or serotonin syndrome. Much confusion exists in the literature because in many reports an insufficiently precise distinction is being made between side-effects and toxicity.

At present the evidence is that life-threatening morbidity or mortality, only arises from combinations of monoamine oxidase inhibitors (this definitely does include so-called ‘RIMAs’ (reversible inhibitors of monoamine oxidase A) such as moclobemide) and drugs able to act as serotonin reuptake inhibitors (which includes some nortriptyline analgesics). The risk remains unclear for catechol-O-methyltransferase inhibitors.

I also wish to draw attention to some valuable prospectively gathered and systematically documented data specifically addressing the issues of what symptoms and signs characterise toxicity from various drugs when taken in overdose. These data come from Iain Whyte’s group. In a series of over 5000 cases of self-poisoning 10% were with a single, primarily serotonergic, drug. Of these, 16% met the Sternbach criteria for serotonin syndrome.

The only serotonin reuptake inhibitor that was significantly different from the reference drug (sertraline) in its frequency of association with the serotonin syndrome was clomipramine, with which serotonin syndrome was only one-tenth as frequent (odds ratio 0.1 and 95% CI was 0.0–0.9). This may be because clomipramine is a potent 5-\textit{HT}_{2A} antagonist.

Our extensive database of references about serotonin syndrome is available to researchers at www.psychotropical.com.

Ken Gillman, Honorary Senior Lecturer, James Cook University, Tropical Psychopharmacology Research Unit, Suite 3, 40 Carlyle Street, MacKay, Queensland 4740, Australia

Sir: Mir & Taylor (Psychiatric Bulletin, 23, 742–747) make an error in their article on serotonin syndrome. They start their article by stating that serotonin syndrome appears to be a new phenomenon; this is untrue. Serotonin syndrome is well-known to be an element of the carcinoid syndrome, a medical disorder characterised by high levels of circulating catecholamines due to inappropriate secretion by a tumour, for example, of the gut or adrenal medulla. This is not a drug side-effect.

The implications of this are potentially serious; a patient could present with the symptoms described without having a drug-induced serotonin syndrome, and the differential diagnosis is not discussed in this paper. The sections on ‘Causes of serotonin syndrome’ and ‘Biochemical mechanism of serotonin syndrome’ are, therefore, dangerously misleading. This could result in missed diagnoses of carcinoid syndrome, or misattribution of systemic serotonergic effects because other causes have not been considered.

Mark Ruddell, Clinical Research Fellow, Division of Psychiatry, University of Nottingham, Duncan MacMillan House, Porchester Road, Nottingham NG3 6AA

College comments on the Fallon Inquiry

Sir: I refer to Dr Veasey’s letter (Psychiatric Bulletin, November 1999, 13, 690) asking who at the College was responsible for the College’s comments on the Fallon Inquiry Report on Ashworth Hospital. I thought it appropriate to reply to Dr Veasey. I am now well briefed and informed about the controversy which gave him particular concern.

In this regard my information is that the College’s response to the report on the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (chaired by Judge Fallon) was first drafted by my predecessor Dr Robert Kendell and then finalised, following extensive discussion at the Executive and Finance Committee and then subsequently at Council on the 3 February 1999. I am sure that the intent was not to act in an unjust and unfair way against any individual psychiatrist. Let us hope, however, that structures are now in place which will make this fraught situation less likely to occur in the future.

John L. Cox, President, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Martial arts for psychiatrists

Sir: Once a peer-reviewed article appears in a reputable journal it carries a certain cachet of validity, any editorial disclaimers
to the contrary not-withstanding. The November 1999 issue of the Psychiatric Bulletin (23, 641–701) is a good example of this. The first three or four articles include stimulating discussions on evidence-based medicine in psychiatry (Laughare) and a balanced and critical article on community treatment orders (Moncrieff & Smyth) with an equally penetrating commentary (Burns). Articles by Davies & Oyebode analyse the application of modern methods of risk management to psychiatric care. Then, quite suddenly, an extraordinary paper appears from Pereira et al giving (literally) blow-by-blow instructions on how to restrain and overcome protesting patients and force them to take clozapine therapy. Ethical considerations are dismissed in one sentence at the end. The commentary paper by Barnes also deliberately excludes any discussion of ethical aspects, but briefly sets out some practical reasons why it would not, in any case, work. Ironically, other papers in the same issue express concern at excessive dosages of antipsychotic medication being given to patients by some psychiatrists (Tyson et al) and another by Lawrie bemoans the stigmatising attitudes of the general public to psychiatric patients. The mental arts manual by Pereira et al is provocatively entitled ‘When all else fails’. This letter is written in the same spirit. I am concerned that this article was published at all, since it could be interpreted as incitement to violence — by psychiatrists — and be endorsed as such. Any such endorsement, however inaccurate and misleading it might be, could conceivably bring psychiatry into disrepute. I sincerely hope my fears in this respect are unnecessary and in any case I cannot think what can now be done to remedy the situation. I shall have to content myself with writing to doctors Moncrieff & Smyth to ask for further details of the campaign mentioned by them to oppose the introduction of community treatment orders which, thankfully, are not included in new mental health legislation now being introduced in Ireland.

T. J. Fahy, Department of Psychiatry, Clinical Science Institute, National University of Ireland, Galway, Ireland

Estimating bed occupancy
Sir: Peter Greengross’ recent article on the pressure on acute adult psychiatric beds was a useful attempt to quantify an important problem (Psychiatric Bulletin, February 2000, 24, 54–56). There has been little published about the experience of clinicians outside of London and this paper would appear to confirm that similar problems occur, particularly in southern regions. Such findings have implications for future resource allocation and should inform local strategic planning. Unfortunately, the approach used, although producing a rapid overview, has disadvantages. Any survey that is reliant on postal response to questionnaires is open to response bias. The chief executive of an NHS trust when invited to comment whether beds are, ‘over-occupied’, ‘rarely, sometimes, or frequently’, is being asked to define what he or she considers is the ideal rate of bed occupancy and then give an estimate of what is occurring locally. This arbitrary estimate will, at best, follow consultation with medical records and clinicians. It may simply be a subjective estimate based on anecdote.

At a time of change in emphasis towards community-based resources, planning can only be based on reliable information. Quantification of a perceived problem can only occur with ‘real’, data and this is best produced by a census approach as suggested by the authors. Kennedy (2000) has recommended a systemic approach to the needs assessment involving an initial mapping of the services available to psychiatric patients, including specialist services. This would be more informative, as the pressure on acute adult psychiatric beds is likely to be related to the availability of longer stay beds, thus better informing strategic planning.

Reference

Anand Sharma, Clinical Research Fellow, North London Forensic Service, Cramton Lodge RSU, Chase Farm Hospital, Ridgeway, Enfield EN2 812

Nominees elected to the Fellowship and Membership under Bye-Law III 2(ii)

At the meeting of the Court of Electors held on 15 February 1999, the following nominations were approved.

Fellows – UK
Dr Patricia Mary Abbott, Dr Helen M. Anderson, Dr Gary Bell, Dr Anthony P. Boardman, Dr Sikander Abbas Bokhari, Dr Michael P. Bourke, Dr Daniel M. Brennan, Dr Martin H. Briscoe, Dr David P. K. Brown, Dr Aggrey Burke, Dr Sheila A. Calder, Dr Lachlan B. Campbell, Dr Maria T. Campbell, Dr Peter K. Carpenter, Dr John F. Connolly, Dr Sarah Anne Davenport, Dr Shamim Dinani, Dr Stephen Edwards, Dr Morad El-Shazly, Dr Kim Fraser, Dr Nilani P. Gajawira, Dr Richard A. Gater, Dr John R. Geddes, Dr Raymond Goddard, Dr Stephen Hunter, Dr Chuda Kariki, Professor Michael B. King, Professor James Lindesay, Dr Hilary Lloyd, Dr Hameen R. Markar, Dr Caroline Marriott, Dr Brian V. Martindale, Dr Maria G. A. McGinnity, Dr Kenneth Merrill, Dr Niall Moore, Dr John R. Morgan, Dr Andrew W. Procter, Dr Mohammed Abdur Razzaque, Dr Stephen P. Reilly, Dr Drew Ridley-Siegert, Dr Philip J. Robson, Dr Mangayatarkasya Sabaratnam, Dr Kamran Saedi, Dr Lester Sireling, Professor Graham J. Thorncroft, Dr Ariyadisa Ubyekeyorka, Dr Nicholas Wagner, Professor Simon Wessely, Dr Peter Wood.

Fellows – overseas
Professor Cliff Allwood, Dr Zeinab Bishry, Dr David R. Dossetor, Dr Kandath V. Girjashanker, Dr Yan Ming Ip, Dr Jacob K. John, Dr Sia Wah Li, Dr Norman Moore, Dr Kenneth Nunn, Professor Helmut Remschmidt, Dr James Rodney.

Membership under Bye-Law III 2(ii) — UK
Professor Anthony R. Kendrick, Dr Gabriel Kirtchuk, Dr Kolappa Sundarajan.

Membership under Bye-Law III 2(ii) — Overseas
Dr Chwen C. Chen, Professor Afaf H. Khalil, Dr Nicolaio Paolletti.

Elective at President
Notice to Fellows and Members
Fellows and Members are reminded of their rights under the Bye-Laws and Regulations, as follows:

 Bye-Law XI
The President shall be elected annually from among the Fellows.

Regulation XI
(1) As soon as may be practicable after the first day of June in any year the Council shall hold a nomination meeting and shall . . . nominate not less than one candidate and not more than three candidates . . .
(2) Between the first day of June in any year and the date which is four clear weeks after the nomination meeting of the Council, written nominations, accompanied in each case by the nominees' written consent to stand for election, may be lodged with the Registrar, provided that each such nomination is supported in writing by not less than 12 Members of the College who are not members of the Council.

(3) An election by ballot shall be held in accordance with the provisions of the Regulations. The nominating meeting of the Council will be held on 28 April 2000 and the last date for receiving nominations under (2) above will therefore be 25 May 2000. Professor John Cox is in his first year of office as President and is therefore eligible for re-election.

The Royal College of Psychiatrists Winter Business Meeting 2000

The Winter Business Meeting of Council was held at the Royal College of Psychiatrists on 31 January 2000.

Minutes

The Minutes of the Winter Business Meeting held at the Royal College of Psychiatrists on 3 February 1999 were approved as a correct record.

Election of Honorary Fellows

The following were elected to the Honorary Fellowship:

The Right Honourable Sir Stephen Brown, PC; Dr Robert Kendell, CBE; Professor Israel Kolvin; Professor Juan Lopez-Ibor Alino; Professor Toma Tomov.

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CAMDEX-R: The Cambridge Examination for Mental Disorders of the Elderly


This pack consists of a book including the questions in the Cambridge Examination for Mental Disorders of the Elderly; a computer disk onto which answers can be entered and from which questionnaires can be printed; and a smaller book with pictorial materials for cognitive examination. Within the main book there is a structured clinical interview, a brief neuropsychological battery; a structured interview with a relative; the diagnostic criteria from DSM—IV and ICD—10 for dementia and other categories including differential with depression. The CAMDEX—R also gives operational criteria which it suggests are used for clinical diagnosis and guidelines for classifying dementia according to clinical severity.

The first aim is to enable a differential diagnosis of dementia to be made according to the most recent criteria with the materials needed (apart from for physical examination and biochemical examination) included. The book gives the range of information required for differential diagnosis of the varying forms of dementia available in a single standardised interview and examination pack. However, I found it surprising that the criteria for Alzheimer's disease and vascular dementia are not given, although I agree they are fairly well known, but you could argue that about the rest of the material as well. Most mental health professionals know how to elicit the history or mental state.

The pack is designed so that different mental health professionals can use it. However, a physical examination and blood tests are needed to fill in the checklists. As a result only medically trained professionals can use the pack to make a differential diagnosis.

The computer pack has no installation instructions in the handbook. Once installed I was pleased to see that it was year 2000 compliant, but it would accept ridiculous dates for the year the interview was done, for example, 1957. The package is not as professionally laid out as the handbook and is DOS based. I was disappointed that the diagnosis had to be entered into the computer package by the interviewer, as I was hoping that the diagnostic criteria would be matched up with the answers to give an indication as to how they were fulfilled even if the programme did not come to a diagnosis. The GMS—AGECAT (a similar package designed by Professor Copeland and his team in Liverpool) comes to a standardised diagnosis from the information given with which the interviewers are free to disagree clinically. It would be helpful if CAMDEX—R did this as well. The authors state that they are currently developing a computer programme for examining individual scores observed versus expected scores on both the total and the sub-scales based on demographic characteristics.

In summary, the CAMDEX—R is a well organised and generally comprehensive research instrument for the differential diagnosis of dementia. The materials are beautifully laid out and a pleasure to handle. It would be a helpful research tool in providing standardised assessments. The computer package is, however, disappointing.

Gill Livingston. Senior Lecturer in Psychiatry, Department of Psychiatry & Behavioural Science, University College London, Wolfson Building, 48 Ridgeway House Street, London W1N 8AA

Differential Diagnosis in Psychiatry

By S. Peters. Sheffield: Sheffield University Television. 1998. £35.00 (1 video), £180.00 (all 7 videos)

The introduction included on each video stated that they provided “an overview of mental illness based on the ICD—10 classification”. The diagnoses selected covered the main p categories in the ICD—10 (organic disorders, psychoactive substance use, schizophrenic disorders, mood disorders, neurotic, stress-related and somatiform disorders and personality disorders). The last video was called ‘Challenging Cases’.

All but the last video consisted of the same format. First, text is displayed against a monochrome sagittal section of a brain with a voice over to introduce the clinical features of each diagnosis. This was followed by a brief clinical interview with the psychopathological features outlines at the beginning and captioned as the interview proceeded. Last, the differential diagnosis for the disorder was again outlined in text according to the ICD—10 diagnostic hierarchy. The seventh video ‘Challenging Cases’ presented four interviews of difficult presentations for group discussion.

The videos have been professionally produced, financed by pharmaceutical companies, and provide a clear introduction to the basis of differential diagnosis in psychiatry. In my opinion they are probably best suited to undergraduates rather than a postgraduate audience and should be shown separately. The patients included in the interviews seemed somewhat unreal, and I assumed that they were actors following a script. Also the credits indicated that the tapes were “written by Dr Steve Peters” whom I assumed had also ‘acted’ as the interviewer.
I thought it unfortunate that the differential diagnoses followed the hierarchical ordering of ICD–10 with organic causes being listed first. While in some respects this is logical in other ways it is not so. The reason relates to the old adage that “if I see a bird flying past my window it is more likely to be a sparrow than a canary”. Clearly in terms of organic disorders, hypothalamic tumour is a possible differential diagnosis for mania. However, substance misuse is much more common as a cause of manic symptomatology. There was also one “holler” – pheochromocytomatosis is given as the first differential diagnosis of panic symptoms, even before thyrotoxicosis! Examiners would not be impressed by such ordering.

In spite of these reservations, used in conjunction with other teaching methods and in short segments, the videos provide a good adjunct to the teaching of basic psychiatry.

Anne Farmer, Professor of Psychiatric Nosology, Social, Genetic & Developmental Psychiatric Research Centre, Institute of Psychiatry, Denmark Hill, London SE5 8AF


When I was introduced to the first edition of this book I was enthralled. Here was a bestseller of the addictions world which combined good readable English with evidence-based medicine and sound clinical judgement. When I came to read this third edition I assumed it would be as good, so I took it on holiday, some clinicians are warned against, but the risk was worth it and I was not disappointed.

For this new edition the first author has been joined by two others. This enhances the book by giving it a broader creative base from two well-respected figures. The volume is divided into two parts, the first of which covers basic areas which give a background understanding of alcohol problems, while the second part gives a thoroughly practical account of clinical relevance to screening, assessment and treatment. This is an introductory guide which sets forth the aims of the authors and would allow easy access by a reader to those areas of immediate interest at any time when dipping into the book.

As might be expected, where statements are made, references are quoted to back up the opinions expressed. This means it can function as a very useful starting point for pursuing an area of interest. Appropriate references are quoted from the past (with Trotter, 1804, being the oldest I could see) while incorporating up to date literature as well.

FOCUS, the child and adolescent mental health project at the Royal College of Psychiatrists’ Research Unit, has produced an internet guide for child and adolescent mental health service (CAMHS) professionals. This resource contains two sections: the first is a comprehensive ‘how to’ guide to the internet and the second lists sites of interest to people working in CAMHS. The resource is available free of charge to members of the FOCUS network. Further information: Catherine Ayres, The Royal College of Psychiatrists’ Research Unit (tel: 020 7235 2351 ext. 256; e-mail: catherine.ayres@virgin.net).

Professor Hugh Freeman has been awarded the 650th Anniversary Medal of Merit of the Charles University of Prague.
to pathways, with some ‘live’ examples, while enabling users and clinicians to begin to discuss the care which they deliver and receive. King’s College London Community Care Development Centre (CCDC) are also the organisers of The 2000 CCDC Annual Learning Disabilities Congress, which takes place in Birmingham on 14–15 June 2000. The main themes of the congress will be: social inclusion; partnerships with self-advocates and families; organisational change and development; and service change and development. Further information on both events: Geoff Hodgson, Director of Events, King’s College London, Second Fields, Friars House, 157–168 Blackfriars Road, London SE1 8EZ (tel: 020 7928 4994; fax: 020 7928 4101).

The British Society of Medical and Dental Hypnosis (Metropolitan and South) is organising a two-day course/workshop on The Uses of Hypnosis in General Practice and Hypnosis in Children. The course will be held at The Royal Society of Medicine on 3–4 June 2000. Further information: Mrs Anne Valentine, 23 Broadfields Heights, 53–59 Broadfields Avenue, Edgware, Middlesex HA8 8PF (tel: 020 8965 4342; fax: 020 8998 8069).

Mole Conferences are the organisers of Munchausen’s Syndrome by Proxy: Fact or Fiction? A one-day seminar being held in central London on 12 June 2000. The seminar is part of a series of multidisciplinary seminars for all mental health professionals and those in allied professions, especially accident and emergency departments, general practitioners, paediatricians, child psychiatrists and family lawyers. This particular seminar aims to raise awareness of current issues in the assessment and treatment of Munchausen’s syndrome by proxy and related diagnoses. Further information: Mole Conferences, 26 Church Road, Portscliffe, Brighton BN41 1LA (tel: 01273 242634; fax: 01273 235095; e-mail: enquiries@mole-conferences.com).

The North London Centre for Group Therapy would like to announce: Inside and Outside your Group, a group analytic weekend workshop taking place at the North London Centre for Group Therapy on 30 June–2 July 2000. Further information: Lesley Holmes, North London Centre for Group Therapy, 138 Bramley Road, Oakwood, London N14 4HU (tel: 020 8440 1451; fax: 020 8449 3847; e-mail: NLCent@aol.com).


The Professional Education & Training Unit (PET), University of Southampton are the organisers of the following events: Psychosis and Spirituality, to be held on 7–8 September 2000 at Regent’s College, London; Section 12(2) Mental Health Act 1983 Refresher Day, to take place in Portsmouth on 1–2 November 2000; and Sex Offenders, scheduled for 10 November 2000. Details of the programmes and further information about the events: Mr David K. Beck, PET Unit Director, Mental Health Group, University of Southampton, Royal South Hants Hospital, Southampton SO14 0YG (web site: http://groups.medschool.soton.ac.uk/mentalhealth/).

The Tavistock and Portman NHS Trust Training Programme commences in October 2000. The following courses are available: Foundation Course in Psychoanalytic Psychotherapy: an introduction to the theory and practice of psychoanalytic psychotherapy, providing a new way of thinking about clinical work. Seminars on Working with People in Later Life: A Psychoanalytic Perspective: this series of seminars aims to provide a forum in which individual, group or organisational work in the area of later life can be thought about from a psychoanalytic point of view. Further information: Academic Services, Tavistock Centre, 120 Belize Lane, London NW3 5BA (tel: 020 7447 3722).