Finally, anxiety about the future funding of regional units was expressed, since districts may consider alternative treatment interventions that are cheaper but of less certain clinical benefit. This again emphasised the importance of in-patient units clearly defining their work and demonstrating its effectiveness.

Discussion concluded with a proposal that interest groups be formed, perhaps on a regional basis, and an acknowledgement of the importance of a shared professional approach to defining the scope of in-patient treatment in child and adolescent psychiatry, and its systematic description. It was suggested that the implications of the NHS White Paper made this a matter of urgency. A group proposed to cover units in SE England was then formed, and another group was formed, convened by Jonathon Green (Booth Hall, Manchester), for those further afield to carry on the task of systematising descriptions of in-patient treatment.

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Liaison psychiatry for senior registrars*

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The two striking features of this conference were, firstly, the high standard of presentations from the trainees, and, secondly, the participation of physicians in some of the sessions.

Detailed and meticulous prevalence studies of psychiatric disorder in multiple sclerosis, haemophiliac children and chronic fatigue syndrome were presented, respectively, by Drs Gilchrist, Logan and Wood. The problems in developing and monitoring liaison services were addressed by Drs Middleton and Lynch, and Dr Zirinsky in her account of the excellent child psychiatry liaison service at the Royal Free Hospital demonstrated the benefits of liaison psychiatry when there is collaboration between psychiatrists and physicians. Of particular interest were two intervention studies; Pauline Cowmeadow is conducting a randomised controlled trial of Cognitive-Analytic Therapy in patients who self harm, and Michael Murphy graphically described his work involving psychological intervention with chronic somatisers.

The collaborative sessions involving physicians and psychiatrists were stimulating and provocative. Mike Cheshire, a consultant geriatrician, gave an account of how to, and, how not to, forge links between the geriatric department and the psychiatry of old age department. He pointed out that good liaison invariably depends upon good social and working relationships between colleagues, and suggested inviting each other to parties was a good way of establishing *bonhomie*! Dr Rosenbloom, consultant paediatric neurologist, enlivened the meeting by suggesting that all child psychiatrists should spend some time doing paediatrics, and vice versa. He called for much closer liaison between paediatricians and child psychiatrists and readily acknowledged the ignorance of most paediatricians in regard of the therapeutic work carried out by child psychiatrists. In the same session, David Foreman, senior research fellow at Keele University, presented a stylish and thought-provoking account of the application of the principles of social anthropology to the development of liaison child psychiatry.

The final day was spent in a workshop format. The task was to establish a new liaison psychiatry service in a district general hospital. We were divided into three groups; one supervised by a health service manager, one supervised by a manager/former clinician and the final group supervised by a clinician. Needless to say, one group came up with a mission statement and a plan to carefully assess need before implementing a service, one group came up with a full liaison service, complete with nurse therapists and psychologists, ready to swing into action on the day of appointment, and the third group devised an approach midway between these two extremes. No prizes for guessing the advisers to each group!

**Report of the second liaison psychiatry training conference held in Manchester from 5–7 October 1990.*

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