P M Report

After the introductory talks and for the early part of the afternoon participants split into five speciality groups. All groups had one or two psychologists and psychiatrists acting as facilitators. Facilitators were given detailed briefs to encourage a structured and constructive response to certain themes across the groups. This brief is available from the College or the BPS. I was allowed a roving observer's role between the groups and was asked to report back on the final plenary session. The account which follows is a personal view intended to give the flavour of the proceedings.

My first impression was that different specialties were at different stages of professional and political development. The discussions in the Old Age and Mental Handicap Specialties seemed to be more realistic, trusting, constructive and task oriented. The Forensic and the Child/Adolescent groups seemed more bogged down with long-standing responsibility and control issues. The Social/Community group were somewhere in between with more emphasis on treatment models than responsibility issues *per se*. These different concerns were reflected in the feedback to the plenary session.

The old age group (5 psychologists, 14 psychiatrists) wanted to build on existing collaboration to improve services. They recommended that a joint working party be set up by Psychologists Special Interest Group in the Elderly (PSIGE) and the Old Age Section of the Royal College to plan more specific projects, e.g. to press for better recruitment of both professions into their specialty and for integrated unit management structures for elderly services (including geriatricians).

The child/adolescent group (17 psychologists, 7 psychiatrists) emphasised a number of issues, e.g. the problem of defining let alone meeting population needs; the fact that Korner data sets will not reflect their consultative and indirect work; the lack of national guidelines on interprofessional collaboration; and the need to promote innovation and supportive collaboration between the professions at district level as the Association of Child Psychology and Psychiatry does at national level. It was clear that some child psychiatrists believed they were responsible for providing a *comprehensive* child service including access to other professions but this merely recapitulated the territorial and political confusions identified in the morning. As far as analogies were concerned, this group suggested that our interprofessional relationships were more characteristic of adolescent separation than marital disputes and that the former analogy better reflected the historical background and present 'dynamics'.

The social/community group (20 psychologists, 12 psychiatrists) was large and diverse. They felt they needed more information about each other's training to avoid the biological versus psychological split. (The introduction of these polarised models was referred to as bringing on the dinosaurs.) The group expressed concern that clinical innovation was being constrained by tighter planning, budgetary and management controls. Some preferred the previous era of organisational vagueness, others did not. Several participants urged that mental health teams should become more democratic. Some thought that psychiatrists and psychologists (in mental health) should be part of the same management unit which is not always the case. Many were concerned that psychiatric rehabilitation was losing out in terms of funding to acute psychiatric services.

The forensic group (7 psychologists, 5 psychiatrists), like the child group, seemed to be struggling with interprofessional power and control issues but with the additional legal and procedural complications of special hospitals and secure units. The group identified three problems of concern to both professionals viz (a) effective team functioning is often difficult in the face of clients with poor prognosis, staff with low morale and related problems; (b) clarification was required concerning the degrees of *clinical* freedom of other professions in the context of specific legal and medical (*not* ultimate) responsibilities of forensic psychiatrists; (c) recruitment into the specialty was problematic for both professions.

The mental handicap group (15 psychiatrists, 4 psychologists) stole the show in the feedback session with some amusing visual aids on the misperceptions and stereotypes underlying disputes between psychiatrists and psychologists. They reported amongst themselves some agreement on the desirable respective roles of the professions, i.e. psychiatrists concentrating on neuropsychiatric care and psychologists on behavioural learning strategies. It was also agreed that clinical psychologists played a key role in social skills training and development of community services, much of which may not directly involve psychiatrists.

Two points emerged in the general discussion. First, there was a trend towards more specific and detailed collaboration between the specialties proposed by the elderly group but also supported by others. Second, there was general interest in the availability of team building training events looking at interpersonal and organisational problems and options in team functioning. The Joint Standing Committee undertook to research details of such events.

Finally, I would like to thank the group facilitators for their valuable preparation and assistance in the workshop.

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