'alcoholism' rather than hazardous drinking patterns. These barriers are both attitudinal and practical and are found among primary health care physicians themselves, their patients, and the structure of the health care system. The Alcohol Action Plan will need to address vigorously all of these areas throughout Europe in the next few years.

The group has identified 12 competencies that general practitioners and their teams should acquire for the successful management of patients. For example, it would be a great and simple step forward if nurses and doctors in primary care would regularly take a systematic drinking history.

The report rightly emphasises the importance of undergraduate and postgraduate training in these relatively straightforward skills which should become part of the core curriculum which is being revised for medicine and nursing in many European countries. This report should now lead to action at national and local level and encourage training for both GPs and practice nurses. Alcohol-related problems are a major cost to the over-burdened health care systems of Europe and this model provides a simple low cost means of reducing this load and preventing more severe health consequences.

The report needs to recognise that it is not only doctors but nurses and other health professionals who should be drawn into this strategy. Models of primary care vary widely but this approach can be adapted to different settings. Psychiatrists with a responsibility for substance misuse services should obtain copies of this report and its recently published successor concerned with 'community and municipal action on alcohol'. This extends the response beyond health workers towards developing an integrated approach toward reducing the harm attributable to alcohol at a local level.

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The Mental Health Needs of People with Learning Disability. SE Thames Regional Health Authority. 1993. £7.50

The United Kingdom is rather envied for its provision of services for mentally ill people with learning disability. This report reveals that current trends in South East Thames Regional Health Authority (SETRHA) are not favourable to a comprehensive service for the learning disabled population. The working party which produced the report consisted of three consultants in psychiatry and one in public health medicine. The report was intended to stimulate debate and encourage commissioning agencies to reassess the mental health needs and services for people with learning disabilities in their areas. The report therefore has a wider interested readership than simply the South East Thames Regional Health Authority. In SETRHA, the working party's starting point was an awareness that medical manpower planning had not kept up with the changes, that there were large communities within the region which had no in-post consultant in the psychiatry of learning disability (LD) and other areas where the consultant has no medical staffing support or training grades, and that the previous geographical sector medical teams based in the long-stay hospitals have not been redeployed in all the district health authorities within the region.

The report properly starts with a needs assessment and indicates that all the current commissioning in the region is geared to residential day care and support needs and mental health needs have been ignored or included under unspecified professional input required for 'the development of skills and/or therapy needs'. This is unsatisfactory as one of the basic maxims one teaches students is that of 'diagnostic overshadowing' (i.e. the diagnosis of mental handicap overshadows and obscures the presence of a mental health problem). One has to tell this to commissioners, too.

The working party's analysis includes primary health care. They note the high incidence of added sensory, communication and physical ill health with key references, and advise that each FHSA should monitor the primary health care of this group and identify centres of good practice. To the time-worn fallacy that institutions were the cause of behaviour disturbance in people with LD must now be added the fallacy that there will be *de facto* 'health gain' in people with learning disabilities by being looked after by general practitioners. Much planning has to go into the primary health care of this group and, as the working party indicates, adequate training opportunities, and help by a clinical medical officer or a senior clinical medical officer with a special interest in health surveillance and health education of people with LD. Such professionals exist and work well within child services but establishing such professionals for adults is debatable.

In the consideration of mental health care for adults with learning disabilities, the working party describes three models:

(a) a separate specialist comprehensive LD service provision with specialised psychiatric units to meet the needs of those with mental illness, who offend, who have behaviour problems, the elderly, etc. – describing the advantages and disadvantages.

(b) a community-based specialist LD psychiatric service integrated with a LD service.
(c) a community-based specialist LD psychiatric service integrated with a mainstream psychiatric service.

The report also briefly (and superficially) addresses the concept of challenging behaviour services, residential and non-residential services.

Particularly valuable in the report is the clear thinking on services for children.

The report emphasises that the patterns of the past for the psychiatry of LD are no longer sustainable: "it is essentially a speciality of community care forming a bridge of knowledge between and across the frontiers of primary and social care and mainstream mental health services" – a memorable phrase. It includes a job description for a consultant of LD which is helpful and should be sent to all clinical directors of mental health services, particularly highlighting that the consultant should be an integral member of the mainstream mental health service and community LD service. One point that seems dated is that the consultant should be appointed to a specific district not to a hospital or a group of hospitals. As trusts are now being configured, this will require further clarification.

The report should be read by all consultants and senior registrars in LD and by everyone who negotiates with purchasers, and offered to purchasers as the first instalment of a blueprint for service contracts. The next instalment ought to be a description of the increasing diversity of contracts and service agreements for delivering psychological services to this population.

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Mental Health Programme in Poland. Published by the Institute of Psychiatry and Neurology, Warsaw, 1992

This fascinating brief document provides a succinct summary for the status of Polish psychiatric services, and their aspirations, in the midst of a tumultuous social transformation from a communist to a capitalist orientated political economy. The programme sets out a 'sociomedical analysis' of the political situation, and then structures the planned service developments under the heading of Primary, Secondary, and Tertiary Preventions.

Many other components of the model proposed for development throughout Poland are familiar to the British reader, sectorised, multidisciplinary teams, community orientated services, continuity of care across in, out, day and community settings, and local alliances of professional, civil, and patient groups. It is striking that the current question consensus of these matters has translated so directly into an unfamiliar social content.

There are also elements of the mental health service programme which introduced a startling perspective to Western practitioners. The authors explicitly link unemployment to mental ill health, and comment that unemployment in Poland rose from 50,000 to 2.5 million between 1990 and 1992. They also deliberately link the political framework with prevalence rates of mental disorder, citing new and higher levels of uncertainty within the increasingly capitalist economy being directly responsible for rising rates of alcohol dependency, drug dependency, and suicide. Strikingly absent from virtually the whole document is any reference to the costs of services. The equitable distribution of services is, however, given a high emphasis, and particularly the creation of smaller in-patient units within one hour's travel time to all citizens. Major service deficits are itemised: very poor living standards in in-patient units, virtually no sheltered housing, extremely limited day care and community team provision, and an inadequate legal framework, and little progress so far in evaluating mental health services, or establishing medical statistics systems. But this programme sets out an impressive framework for action, and may be a useful starting point for a further, more detailed, action plan that specifies priorities, responsibilities and timescales.

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Working Together for Better Health. Department of Health. 1993. Pp 63

This handbook is produced by one of the working groups of *The Health of the Nation* which itself sets out 25 targets likely to improve health in England over the next two decades. One of the key themes is that by working together in 'healthy alliances' we can achieve more than by working separately, and no-one would deny this principle.

The handbook sets out, in three short chapters, to provide guidance on how we can best work together. The first chapter explores the concept that to achieve health gain it will be necessary to alter behaviours, change environments and provide high quality local services. The second describes how to set up 'healthy alliances' to achieve these aims, and the third lists the sorts of organisations – health and local authorities, education, industry, trades union and voluntary bodies – likely to be involved in the process. Some examples of current co-operative