development and operation and of the experiences of clients and staff.

A range of broader issues is also discussed and illustrated by quotations from the 'users' – a designation which the authors have chosen 'for want of a better term' despite its unsuitability as a label for the supportive interaction between professionals and clients, which it is made clear is essential to the continuing success of the projects. The stress that may be imposed on patients by responsibilities as workers, and in one of the projects as managers, and the stress on staff required to be helpful without being intrusive or taking over, are not disguised. This is important as the difficult task of combining support with the maximum empowerment is likely to be facilitated by open recognition of the paradox involved, as in the original clubhouse.

Despite the difficulties, the projects have clearly contributed a great deal to the users' sense of purpose, accomplishment and self-respect, enlarged their social networks, and provided at least some of the cash without which talk of deinstitutionalisation bringing autonomy and freedom to choose risks becoming patronising cant.

I intend to circulate the study among local purchasers and have some hope they will be persuaded of the need for similar developments by its clearly expressed findings.

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Music Therapy in Health and Education. Edited by Margaret Heal and Tony Wigram. London: Jessica Kingsley. 1993. Pp 292. £19.95

Derived from 22 conference papers reflecting the broad spectrum of clinical practice and research of music therapy internationally, the editors of this book are to be congratulated on producing an extremely readable text making it accessible to a wide audience of health professionals. A major strength is the continuous use of practical clinical examples (illustrating and enriching the description of the therapeutic processes involved).

As a psychiatrist not involved in music therapy it does, however, tend to come over as 'all things to all people', there being no specificity as to diagnosis or treatment approaches. Where its particular strength seems to lie is in providing a channel for non-verbal communication as described with adolescents in secure care (CH4) and with families (CH5) where verbal communication is impaired or impossible. The point is made that communication can take place on several levels ranging from psychoanalytical to simply a pleasant experience as illustrated in the Croft Children's Unit, Cambridge.

What effect does music have on the mind and body? CH12 proposes a model relating music to the limbic system and CH15 lists a variety of therapeutic uses of music ranging from reducing stress, inducing relaxation and enhancing immune functioning, to more specific interventionist techniques of altering heart rate (entrainment). Whether such events merely influence health as a result of an enjoyable event rather than a specific therapy appears debatable.

Research on the components of music, the therapist's use of the medium and outcome are given wide coverage.

The title of the book is somewhat misleading since it focuses predominantly on mental health, and education only as it relates to learning disability. Some of the claims to 'therapy' are over-ambitious in view of the methodological problems in the outcome studies. Although overpriced for the personal pocket, the book has encouraged me to see a role for music therapy within the traditional composition of the multidisciplinary team in the mental health field, but whether this is simply as a pleasant and relaxing experience rather than having a deeper therapeutic significance is something of which I am still unsure.

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The Role of General Practice Settings in the Prevention and Management of the Harm done by Alcohol Use. WHO, Copenhagen, 1992

Europe is the continent with the highest alcohol consumption and in some countries the economic burden resulting from alcohol misuse has been estimated as 5–6% of gross national product. The European Alcohol Action Plan was adopted by the regional committee of the World Health Organisation in Europe in September 1992 and aims to stimulate a widespread commitment to reducing alcohol-related harm. One facet of the plan aims to strengthen the contribution of primary health care to the prevention and management of harmful drinking. This brief report from a working group sets the scene for the advancement of this particularly crucial component of the strategy.

Regarding alcohol as a health risk factor fits well within strategies of health promotion and community-based interventions. The feasibility of recognising hazardous and harmful drinking in primary care and the effectiveness of focused interventions is now clear but has yet to be widely accepted.

The case for these developments is thus soundly based but the authors recognise that there are many barriers to effective action including pessimism, lack of skill and a continuing tendency to lapse back into a preoccupation with

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'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.

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