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the college

Advice to Commissioners and Purchasers of Modern Substance Misuse Services

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This document provides advice and guidance to health and social care commissioners, drug action teams and other agencies involved in the planning and commissioning of modern substance misuse services. There is increasing recognition of the impact of substance misuse on individuals and society and the emergence of national strategies and standards for service and commissioning. Services should be able to respond to a spectrum of need and should work closely with, and in support of, primary care, other secondary care services and non-statutory agencies.

Young people's services

The special needs of young people are addressed in detail in a specific section in this document, with key elements drawn from the Health Advisory Service 2000 guidance document (Christian *et al*, 2001).

Interface with general psychiatry

The contribution of general psychiatry and other psychiatric specialities is acknowledged. The exact nature of the interface with substance misuse services will be clarified at the College level in the light of the Department of Health good practice guidance on dual diagnosis (Department of Health, 2002) and the substantial work by the College Research Unit.

Alcohol services

Alcohol consumption in the UK continues to increase, with consequent adverse effects on physical, psychological and social (including community) well-being. When supported by specialists, effective interventions can occur in a variety of settings, including primary care, general hospitals, general psychiatry, social services and probation.

Multi-disciplinary, specialist treatment is effective and is needed to tackle complex alcohol problems, especially where there is psychiatric comorbidity. Non-statutory agencies provide invaluable facilities in both community and residential venues.

Specialist services must include a range of effective interventions and have close links with other agencies, to provide 'stepped care'. The needs of special groups of patients must be taken into account also.

Alcohol services have a clear contribution to make in tackling the key health improvement areas: cancer, coronary heart disease and stroke, accidents, and mental illness.

Drug services

Drug misuse in the UK also continues to rise. Prevention of communicable diseases, especially hepatitis C, is being prioritised. There is increasing evidence of the need for provision of a range of services for drug users, and that these services are effective in reducing harm to individuals and society. Community care is the norm, with a greater emphasis on proper support for treatments based in primary care. It is more important to retain patients in services and there are more demands for treatment from the criminal justice system.

Tobacco

Substance misuse services have a significant contribution to make to the planning and provision of smoking cessation services.

Levels of treatment

Three main levels are evolving:

(1) Shared care with primary health care:
  (a) community treatment for more complex patients
  (b) liaison with general hospitals
  (c) liaison with, and response to, the criminal justice system
  (d) liaison with mental health and learning disability services for patients with substance misuse comorbidity.

(2) High intensity treatment as in-patients, out-patients or day patients for people with high levels of complex needs.

(3) Extensive contact with social services and non-statutory organisations to provide appropriate treatment packages.

Services for young people also warrant a tiered approach, with a specific model to reflect the special issues surrounding this group.

Roles and responsibilities of psychiatrists

Because of the development of extended roles for other disciplines, psychiatrists have key roles in: diagnosis; medical and other treatments; training doctors and other professionals; management; and service planning. The rising demands within varying contexts indicate the need to increase provision to 0.9 whole time equivalent (WTE) consultant psychiatrists per 100 000 population, with a further increase to 1.5 WTEs in more deprived, urban settings. There are significant workforce issues to address for psychiatrists to meet such increasing needs.

References

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obituaries

Israel Kolvin

Previously Emeritus Professor, The Tavistock Clinic, London

Israel Kolvin was one of a small group of medical practitioners who, in the late 1950s, decided to specialise in child and adolescent psychiatry. Over the next 4 decades 'Issy' Kolvin was to become one of the great pioneers of academic child mental health and a leading figure in clinical child and adolescent psychiatry.

Issy was born in Johannesburg in 1929, the youngest of five children of Jewish immigrants from Poland and Germany. After completing a degree in philosophy and psychology at the University of Witwatersrand, he later graduated in medicine. His interests in both psychology and medicine, together with his exposure to child poverty and deprivation in his home country, led him to seek a career in psychiatry. He undertook his postgraduate education and clinical training in the UK and, in 1958, went to Edinburgh where he gained valuable experience in general psychiatry and psychodynamic child psychiatry. At that time, there were no formal training schemes in child and adolescent psychiatry, so Issy obtained a senior registrar post in Oxford under Christopher Ounsted, Medical Director of

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the Park Hospital for Children, which was then one of the few places in the UK with an academic child psychiatry unit. It was here that Issy conducted his first two research projects: a description of aggression in adolescent delinquent boys and one of the first major studies of childhood autism. He demonstrated that patients with this condition had high rates of concurrent neurodevelopment difficulties but these did not inevitably develop into schizophrenia. His work laid the foundations for considering classical Kanner autism as a biological disorder, in sympathy with a growing body of British research dispelling the myth that autism was a childhood functional psychosis with no organic origins. In 1964, he was appointed Physician-in-Charge of the Nuffield Psychology and Psychiatry Unit in Newcastle-upon-Tyne, and Lecturer in Child Psychiatry at the Department of Psychological Medicine, headed by Sir Martin Roth. He remained in this consultant post for the next 27 years, turning the Nuffield into one of the foremost university departments of child and adolescent psychiatry in the world. His work was recognised with one appointment in 1977 to a personal chair. Three of his many research and clinical successes over this time stand out. First, and perhaps the most remarkable, was the unique study of psychological interventions in the maladjusted child in schools, published as a book in 1981, *Help Starts Here*. This, the first controlled trial of psychological treatment in primary schools, proved that skilled conversational treatment was effective in ameliorating emotional and behavioural difficulties. The second was the longitudinal epidemiological investigations of the intergenerational transmission of psychological disadvantage, carried out through the 1000 families first identified and recruited in 1947 by Sir James Spence at the Department of Child Health, Newcastle-upon-Tyne. Kolvin and colleagues traced a sub-sample of 300 families, then in their early 30s, and identified continuities in the risk for deprivation in the offspring of the original cohort, as well as protective factors against such a negative outcome. These positive characteristics included a flexible behavioural style in the face of adversity, social competence, parents who planned ahead and provided physical and emotional care in spite of privations this may have meant for themselves. These broad categories of psychosocial resilience have subsequently been replicated with remarkable robustness in many other similar studies worldwide. The third important success was in the clinical and political challenge of chairing the Cleveland Inquiry into child abuse. This most difficult task was carried out with a fairness and thoroughness that brought him the respect of many in the community and led to significant recommendations to central government regarding the roles and practice of professionals and parents concerned in child protection.

In 1991, at the age of 60, he was appointed to the newly created John Bowlby Chair in Child and Family Mental Health at the University of London, based at the Royal Free Hospital and Tavistock Clinic. He was Chair of the Association for Child Psychology and Psychiatry, 1994–1996. The photograph was taken in 1996 at the Association's 3rd European Conference in Glasgow. Over the 4 years, before his retirement, he engaged a clinically oriented group of clinicians of international repute for psychodynamic practise in quantitative methods of evaluation in therapy. On his retirement, he left a clinical workforce engaged with modern scientific methods of examining clinical practice and a thriving academic department that few thought possible in such a brief period. He continued to engage in research and to publish through his last illness. When asked what, looking back, he saw as his greatest achievement, he said, without hesitation, his own family. He is survived by his wife, Rona, whom he married 50 years ago, and his two children.

Ian Goodyer

As an addendum to Professor Goodyer's obituary of Professor Israel Kolvin, allow me to emphasise his invaluable services to the College. He was, *inter alia*, a man of business: under his stewardship the finances of the College (he was Treasurer from 1993–1999) prospered. Further, his annual financial reports were so presented that the simplest mind could understand them.

Henry Rollin

Max Meir Glatt

An internationally renowned pioneer of the treatment of alcohol and drug misuse

Max Glatt, by the narrowest of margins, succeeded in escaping the Holocaust. His parents, as he discovered much later, were less fortunate: they were slaughtered in an Estonian concentration camp leaving him and a sister, who had been smuggled out of Germany into Holland, as the sole survivors of his entire family.

Max was born in Berlin on 26 January 1912 into a prosperous, middle-class Orthodox Jewish family. His Judaism was then, and remained, central to his life despite all the difficulties involved in keeping the complex beliefs and practices of orthodoxy, particularly in the Diaspora.

Max's career as an undergraduate in the 1930s was blighted by the rise of Nazism, particularly the malignant persecution of the Jews. Nevertheless, in 1937, he was awarded his MD at the University of Leipzig. By that time, the poison of anti-semitism had seeped into every layer of the German medical establishment so that further academic progress was blocked, practice in any general hospital was forbidden by diktat, and the only work available for Max, as a Jew, was in a small hospital in Berlin which served exclusively Jews. Even so, his innate optimism coupled with, apparently, a degree of political naivety, caused him to hang on. And hang on he did until the momentous events of Kristallnacht shattered the last vestiges of optimism: the message on the wall was clearly written, not in chalk, but in blood.

Max put his escape plan into effect. The plan in the event was shot through with failures, and it is a near-miracle that he finally succeeded in arriving safely in England (for the second time). And it was in England that, in 1942, Max resumed, or was permitted to resume, medical practice, fortunately, as it happened, in mental hospitals controlled

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