

Addressing alcohol through the new GP contract. A briefing for primary care organisations

Summary:

This briefing paper aims to help Primary Care Organisations exploit the flexibility of the nGMS / GP contract to develop a coherent strategy for the management of alcohol problems in the communities they serve; a strategy designed to improve public health, reduce health inequalities, provide basic preventive services and improve access to specialist provision.

Target Audience

Commissioners within Primary Care Organisations, General Practitioners and Practice Managers, alcohol treatment providers working in primary care settings.

KEY POINTS

- Alcohol-related accidents, acts of violence, and chronic disease contribute substantially to the cost of NHS care.
- The Alcohol Harm Reduction Strategy for England, published in March 2004, identifies Primary Care as the main “capture point” for people with alcohol-related problems.
- Primary Care Organisations are identified as responsible bodies within Crime and Disorder Reduction Partnerships.
- The new GP contract provides a timely vehicle for delivering flexible solutions to local problems, and may be adapted to address alcohol issues.
- An Alcohol Local Enhanced Service could be used in preference to the flawed Alcohol National Enhanced Service.
- Care pathways should be modelled in accordance with Models of Care, with interventions tiered to match patient need and clinical pathways.
- An alcohol in primary care strategy has significant implications for staff training
- A template for a Local Enhanced Service (LES) for alcohol is provided.

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The Primary Care Information Service is a project run by Alcohol Concern. provides factsheets, briefings, newsletters and web pages aimed at sharing good practice between clinicians and professionals working in the primary health and alcohol fields. PCAIS promotes the inclusion of alcohol in strategies developed for the enhancement of primary care interventions, and updates the primary care and alcohol fields.

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Introduction

The World Health Organisation describes alcohol as the second biggest cause of preventable deaths in the developed world. Despite this, there has been no strategic approach to tackling alcohol in this country until the publication in March of the Alcohol Harm Reduction Strategy for England. The strategy represents a step change in government thinking about alcohol.

The strategy makes a strong case to identify 'capture points' at which to identify and intervene with hazardous drinkers and refer those in greatest need for specialist treatment. The strategy points to Primary Care as the single most important capture point in the entire health and social care system; 98% of the population is registered with a GP, and no other health or social care organisation has comparable access to so many people. Those people who misuse alcohol are also more likely to attend their GP than normal range drinkers and simple, evidence-based and cost-effective interventions can achieve impressive clinical results.

There is a pressing need for Primary Care Organisations to develop a strategic approach to tackle alcohol-related harm, both to enable them to meet wider health goals¹, and also to fulfil their responsibilities under the strategy. The new GMS contract provides a timely opportunity to improve the care of people with alcohol misuse problems.

The nGMS

The new GMS contract aims to provide general practitioners with greater flexibility in determining the range of services they provide. It creates the possibility of opting out of some provision, such as out-of-hours care, and providing others at a more enhanced or special interest level. The GMS contract is inspired by the Government's NHS modernisation agenda, which has also informed the NHS plan, the National Service Frameworks and the Priorities and Planning Frameworks.

The new contract will be between Primary Care Organisations (PCOs) and practices, rather than GPs and Health Authorities; and compartmentalises clinical work into three service categories:

- *Essential Services* - all practices must provide a full range of essential services, covering the day-to-day work of general practice (for example, chronic disease management).
- *Additional Services* - most practices will offer a range of additional services like contraceptive services, maternity services, cervical screening and some minor surgery.
- *Enhanced Services* – these are optional (other than *Direct Enhanced Services* which must be provided in every locality), and involve either the provision of essential or additional services to a higher standard, or more specialist interventions not provided by most GPs. Enhanced services can be negotiated at a local level (see next section), though for a small number of treatment areas there are national specifications and benchmark pricing. There is a National Enhanced Specification for Alcohol.

¹ As described in 'Why Alcohol is good for health – Guidance for Primary Care Trusts, NHS trusts and Local Authorities on how tackling alcohol can help meet health priorities and targets'

A Missed Opportunity?

In its present form the nGMS misses a key opportunity to reduce alcohol misuse; the greatest problem being one of omission. The specification of *Essential services* contains no mention of alcohol, so the contract does nothing to encourage the appropriate clinical management of alcohol across the vast majority of GPs and thus the vast majority of patients.

The *Alcohol National Enhanced Service* (NES) section of the contract aims to create a small number of more specialist GPs, who undertake basic screening and more specialist interventions. In principle, Alcohol Concern welcomes the introduction of an enhanced service for alcohol, and if there were an alcohol NES GP in every area of the country it would raise the quality of care for many people.

However, even the limited aspirations of the NES (limited in that it seeks to influence the practice of only a small number of GPs) are greatly undermined by difficulties in the wording of the contract itself.

The contract lacks a clear definition of 'alcohol misuse'. There is a risk that the current wording would be assumed to refer only to dependent drinkers and not the much larger group of hazardous drinkers. This latter group are unlikely to seek treatment for their drinking, yet are a prime target group for alcohol intervention in primary care.

The contract has a number of other problems.

- It is unclear whether the payment system will be based on remuneration for patients screened positively (with the danger of a perverse incentive to over-identify), or those with whom intervention is made.
- The contract proposes that practices have a register of those 'admitting they are alcohol misusers', rather than a 'disease register' based on clear diagnostic criteria. The proposed register would offer little useful data to service planners or epidemiologists (an extremely useful side effect of a disease register). The contract also fails to make clear how an individual might come to discuss with the GP that they have a problem with alcohol; many of the target population do not know they are misusing alcohol, so self-disclosure is inadequate.
- The drafting of the NES does not adequately define terms such as brief interventions, and could include useful reference to the use of standardised protocols of best practice, such as on the provision of detoxification. Some terminology is extremely ambiguous, with it being unclear, for example whether 'routine use of assessment tools' describes screening tools such as AUDIT or simply tracking of clinical progress.
- Many PCOs have already identified their priorities for investment in enhanced services and are not in a position to commit additional funds. GPs will be naturally reluctant to take on more specialised work in the absence of a commitment of payment.

Combined with the other areas of ambiguity, many PCOs have found the NES difficult or impossible to implement. It is also arguably 'not the tool for the job' as it fails to provide a

mechanism to change practice across a wide number of GP surgeries. The conclusion must be that baseline practice across all GPs needs to be improved, and that a minimum standard of screening and brief interventions is required *as well as* increased availability of more specialist support and interventions from a smaller number of GPs.

Possible revision of the nGMS

If the nGMS contract were to be reviewed, some simple revisions would enable it to encourage a more effective response to alcohol. Possible approaches would include:

- Alcohol should be included in the Quality in Outcomes Framework (QOF) in the essential services contract, to provide all GPs with incentives for undertaking brief interventions with harmful and hazardous drinkers (as per the interventions described later in this document as 'Part One LES' activity). This approach would work along similar lines to the smoking cessation work currently covered in the QOF. This would then apply to all GPs, rather than to a small minority and avoid the need for a separate alcohol contract for every GP, as is required by the LES approach described in the next section.
- Requiring some Additional Services, such as contraceptive services and maternity, to include requirements to provide the basic screening and minimal intervention interventions.
- Rewriting the NES and re-designating this as a Direct Enhanced Services, which must be provided to every area rather than be a local option as is the NES.

An Alcohol LES: a way forward through local negotiation

The Alcohol Harm Reduction Strategy has elevated alcohol up the list of public health priorities, driven in part by public interest in the effect the new licensing laws will have on drinking behaviour and a government emphasis on reducing binge drinking.

Many local Crime and Disorder partnerships are seeking to make Alcohol a priority, which is resulting in opportunities to lobby successfully for investment in alcohol initiatives

The 'Local Enhanced Service' provides a contracting mechanism within the nGMS that offers PCOs an opportunity to promote screening and brief interventions within primary care settings and incentivise practices to participate. Given the difficulties with the NES, and the long timescale in achieving reform of the contract, it is recommended that PCOs implement an alcohol LES at the earliest opportunity.

Later in this document is an outline LES for PCOs to adapt to local need. The proposed LES aims to:

- Provide an evidence-based and cost-effective way for PCOs to commission services in such a way as to make screening and minimal Interventions widely available and thus prevent alcohol misuse, enhance the quality of chronic disease management, and improve access to services for dependent drinkers.
- Create clinical pathways that make sense and are accessible to patients and can be linked to specialist treatment services where needed.

- Be coherent with the *Models of Care* framework (the proxy national service framework for drugs), and thus hopefully in line with the Models of Care for Alcohol (MoCA) when it is produced.
- Align activity and payments for screening and minimal interventions with those for similar QOF indicators, in order to enable dovetailing or convergence in future.

The LES template is based loosely on the format of the NES minimum specification, but is separated into two parts:

Part one is for practices that wish to improve their overall management of alcohol misuse by offering minimal interventions and brief-interventions which can usefully be delivered with non-dependent drinkers, but which do not wish to develop substantial specialist expertise or greatly increased time commitment.

Part two is for those practices willing to take on a more specialist role. This would cover part one services plus services to people with alcohol dependencies and more complex needs whose problems can, nonetheless, be managed in the community with the assistance of Primary Care.

The proposed LES does not constitute clinical guidance or guidelines. Such guidance should be available by early 2005, though in the mean time commissioners can refer to the UK Alcohol Forum Guidelines or the Scottish Intercollegiate Guideline Network to compliment the specification of activity proposed.

Using Models of Care to design coherent clinical pathways

It is vital that activity commissioned from GPs creates clinical pathways that are coherent with the planning of specialist alcohol treatment services. The proposed LES is not prescriptive, and allows considerable flexibility in how it is adapted for local need.

In order to understand the network of services that should be available in an area, primary care commissioners are advised to refer to the National Treatment Agency's *Models of Care* (MoC) document. This includes a commissioning framework, which is expected to remain largely unchanged when the *Models of Care for Alcohol* (MoCA) is published in 2005. The document describes the four tiers of intervention, which map interventions from non-specialist (tier one) through structured specialist treatment to high care services such as in-patient detoxification (at tier four).

Practices offering Part One of the LES model template for alcohol in this briefing would be described as providing a Tier 1 service, in that the services they offer fall within the context of a wider range of services whose sole purpose is not drug or alcohol treatment. The screening, minimal and brief interventions and referral services they provide will arise from information gathering carried out routinely or in relation to other health-related issues. The delivery of these services does not require specialist substance misuse workers, but can be provided by appropriately trained primary care staff. The services contained within Part Two of the LES model, sit within Tier 2. These services are directed specifically at excess drinkers who require specialist intervention.

Care should be taken to avoid patients identified at Part One surgeries coming to Part Two surgeries solely for triage assessments and then being referred on to specialist services for comprehensive assessments (creating waiting times and drop out at each stage).

Commissioners should be particularly mindful of the need for very fast referral mechanisms for the most at risk patients (and commissioners more familiar with drug services should take note of the higher morbidity and urgent medical needs of many drinkers).

The organising function of the Models of Care system can be useful in tracing the pathways through services, though might need adjustment to work effectively for alcohol (until the Models of Care for Alcohol is published early 2005) so pragmatism and patient need should be the watch words.

Linking LES activity to Existing Provider units.

The Alcohol LES opens the way to a variety of commissioning arrangements, with PCOs being able to mix and match to achieve comprehensive coverage. The Part One contract is designed to be implemented in as large a number of practices as possible, and does not overlap with or complicate the planning of specialist services. The rest of this section is therefore concerned with implementing the Part Two LES, which is more complex.

GPs on the LES Part One contract need to be able to refer on patients who require more specialist support. In the tier model this would generally mean referral to a Tier 2 service. The defining requirements of a Tier 2 service are “specialist screening and assessment, care planning and management” as well as “advice, information and referral services for misusers and their families”.

- If there is pre-existing Tier 2 provision, (usually voluntary sector run street agencies or ‘shop fronts’), some PCOs might decide to commission only Part One GPs. These would then refer patients who needed more specialist support into the Tier 2 services; thought would need to be given how to cover the functions described in the Part Two LES. There may also be a need to expand capacity of the Tier 2 services, as demand will increase.
- If there is pre-existing Tier 2 provision, there is a strong case to commission one or more Part Two GPs. These GPs would then provide valuable support to patients managed jointly with the Tier 2 specialist services; for example by prescribing community detoxification and shared care with complex needs patients. There may be a need to expand capacity of the Tier 2 services, as demand will increase.
- If there is no pre-existing Tier 2 provision, a stand-alone alcohol project and one or more Part Two GPs might be commissioned (though funding for stand alone treatment may come from budgets other than those used to support the nGMS). Stand-alone projects have some advantages over primary care, in that they can usually provide a walk in service and some patients do not like medicalised settings. On the flip side, GP surgeries are more dispersed and in many areas closer to the patients.
- If there is no existing (or insufficient capacity in) Tier 2 provision, commissioners could identify several Part Two GPs and additionally arrange the other Tier 2 functions to be located at the GP surgery. This might be achieved by contracting with a specialist alcohol treatment provider to locate specialist workers at the surgery. This approach

might be particularly useful in a rural area as a means of creating 'points of access' across a wide geographical area. It could be seen as a hub and spoke model, with Part One Practice "spokes" feeding their more severe cases into the Part Two "hub" Practice for assessment, triage, and home detox and / or referral on as necessary. This model would also be an excellent combination with the new NHS Primary Care Walk in Centres.

It is important to note that the enclosed Part Two specification does not cover the entire range of Tier 2 functions. Care is needed to ensure that these functions are commissioned. Other Tier 2 work that may require further attention from commissioners, include:

- Comprehensive Substance Misuse Assessment
- Advice and Information
- Ad hoc support and walk in services
- Outreach services to hard to reach and continuing drinkers
- Low threshold 'wet' provision, such as day centres for continuing drinkers
- Support for the families and affected others of problem drinkers

Training and workforce planning

Many of the activities recommended by this document are not currently included in the professional training of either GPs or Nurses.

Work is underway at a national level (driven by targets in the Alcohol Harm Reduction Strategy) to address this longer-term problem, though short and medium-term solutions are needed if alcohol in primary care is to be implemented widely. One part of the jigsaw is the recent development of an occupational standard setting out the competencies required to conduct screening and brief intervention work. This standard will appear in the 'Skills for Health' portfolio, and eventually drive changes to the curricula of nurse training (medical schools are not currently working to Skills for Health standards, so present another hurdle).

PCOs looking to implement an LES for Alcohol must consider the training needs of staff, and cover the range of interventions needed. At the heart of this must be training on screening and brief interventions to the competencies described in the new Drug and Alcohol National Occupational Standards unit "AH10 - Carry out brief interventions with alcohol users"

Alcohol Concern is working with the Royal College of GPs on a training package which links well to the two-part contract described in this document. We are seeking funding for a wider roll out of this package, though individual PCOs could contract directly with Alcohol Concern and RCGP to deliver this package locally. It is likely that the package will be made freely available, so PCOs could contract with another training provider who is able to deliver the package. This might include local alcohol treatment services who will also be able to provide local expertise on linkage to local services as part of the training.

Training for Part One GPs may be as short as a single session, training for practice nurses to carry out Brief interventions is likely to be a full day.

LOCAL ENHANCED SERVICES FOR ALCOHOL A TEMPLATE FOR USE WITH THE CURRENT CONTRACT

Introduction

The specification is designed to cover the enhanced aspects of clinical care of alcohol misuse that are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services. The specification does not constitute clinical guidance or guidelines, and should be complemented by national or local protocols. Much of the preamble of the Alcohol NES remains relevant, and PCO commissioners would need to work up a more complete and formal service specification and contract, adding or deleting from this draft as they see fit.

PART ONE SPECIFICATION

The key tasks to be undertaken under part one of the contract are:

Screening and referral assessment

The practice must implement procedures to conduct screening and referral assessment in line with Models of Care:

- Identification of alcohol misuse problem
- Identification of related or co-existent problems
- Identification of immediate risks
- Assessment of urgency for referral

Screening will take place at capture points, such as new patient bookings, well-person check-ups, maternity bookings and contraception advice sessions. They may usefully be introduced at “rites of passage” such as on the death of a life partner. Opportunistic screening, where alcohol-related harm may already have occurred, will take place in the course of basic care in dealing with *essential* and *additional* services.

Identification may be made by appropriately trained staff members using written or oral questioning, and validated screening tools. While there are many different tools available, the AUDIT (3) measure is recommended, as it is fairly quick to administer and can support triage of patients into “hazardous”, “harmful” or “likelihood of dependence”. A quicker version, FAST (4), takes only one minute to administer and is preferred by some practitioners. T-ACE (5) may be preferred in maternity and pre-conception settings. CAGE should not be considered appropriate.

Production of an Up-to-Date Register

Practices will produce an up-to-date register of patients who are identified to be hazardous drinkers, harmful drinkers and those who have been referred on. Units and pattern of consumption will also be recorded, according to a locally agreed protocol.

Undertaking minimal / brief interventions

Drinkers in the “hazardous” category should be offered a single-session of advice, information and education, and provided with appropriate written advice. These are “minimal interventions”, and can be delivered by GPs or practice nurses at the surgery where the problem is identified. If the patient remains ambivalent about change, the evidence base suggests the use of a “Brief Intervention” if they are willing to accept it.

Excess drinkers in the “harmful” category should be offered a more intense intervention of a number (2-6) of interventions of up to twenty minutes per session, which will include structured and personalised health information and feedback. This may be provided by an appropriately trained practice nurse or by an alcohol counsellor based sessionally at the surgery or within a ‘Part Two LES’ practice. The care is more patient centred if this activity can be commissioned to take place at the surgery where the patient is identified.

Onward referral

Where the “likelihood of dependence”, or any complication such as organic damage or psychiatric co-morbidity is detected, or where there are concomitant life problems, the patient should be referred on for assessment at the Tier 2 alcohol specialist services (or Part Two GP surgery if this model is adopted, see commissioning notes).

Patients who are found to be dependent, but who resist referral or appropriate intervention should be treated non-judgementally, given one brief session of clear advice about risks and consequences, and offered the opportunity to reconsider and return at any time. Where child protection issues are involved, local protocols must be followed.

Appropriate Training

This must be available to all primary care team members to enable them to understand the problems experienced by people who misuse alcohol and their families, to deal sensitively with issues of confidentiality, and to communicate effectively with them. Clinical training should include identification, screening, triage and goal setting, carrying out minimal and brief interventions and monitoring, appropriate education, advice, motivation and information skills work, and relevant cognitive-behavioural techniques. In order to enhance the cohesiveness of the interventions, it is recommended that Midwives, District and School Nurses and Health Visitors receive complementary training.

Competences should be aligned with those in the Drug and Alcohol National Occupational Standards, note that a new DANOS module will shortly be available to describe screening and brief interventions.

Proposed Costing Structure

- An initial set-up cost could be offered, to encourage as many practices as possible to participate.
- A modest one off payment paid on production of the register and evidence of implementation of the locally agreed screening protocol.
- A low level “per patient” fee could be offered for every Minimal Intervention (MI) delivered, coded at a practice level and audited by the PCO.
- A significant “per patient” fee could be offered for every Brief Intervention (BI) delivered. (While the guideline outlines appropriate opportunities for offering MI or BI, it is not prescriptive, so that Practices unable to deliver BI can still tender to offer Part One services.)
- Consideration could be given to aligning remuneration levels with those offered in the QOF clinical, records and patient communication indicators for smoking, where there is a range of 2-7 depending on its salience to the condition and the level of intervention entailed.

PART TWO SPECIFICATION

Introduction

The purpose of the Part Two LES is to increase the availability of more specialised interventions for people experiencing harm as a result of their alcohol misuse. Although not an alternative to specialist treatment services, they compliment these through provision of specific medical interventions for alcohol dependency, medically competent supervision of complex patients and by increasing overall capacity.

The key tasks to be undertaken under Part Two of the contract are all the items listed in the Part One specification, plus:-

Triage Alcohol Misuse Assessment

The Triage assessment is described in Models of Care, and is a filtering process that “aims to establish which intervention or tier of service would best suit an individual alcohol misuser”. This assessment is less detailed than the comprehensive substance misuse assessment that will take place when the patient arrives at a specialist treatment service. The GP should be competent to refer the patient on to other support services such as bereavement services and mental health services.

Care should be taken to avoid multiple step referral procedures (especially for high risk patients), see the notes in ‘Linking LES to existing provider units’.

Brief Intervention

All Part One GPs will provide minimal interventions to hazardous drinkers. It was optionally suggested that they might be contracted to provide multiple session ‘Brief Interventions’. It is recommended that all Part Two practices have the ability to deliver these more intensive interventions.

Detoxification

Home / Community detoxification programmes will be provided to the GPs own patients, and appropriate patients referred from specialist services (or Part One GPs if that is the local arrangement). All community / home detoxification should be to agreed local protocols, covering indications, contra-indications, role of relatives, support that is to be provided alongside the detox, relapse policy and prescribing regime.

Referral into specialist services

Most harmful drinking patients will require support from specialist treatment services. After the Triage assessment, the GP will make appropriate referral to Tier 2 or Three provision for comprehensive assessment and structured treatment. Assessment information will be supplied to the specialist providers according to locally agreed protocol.

Shared care with specialist services

In many cases, the patient referred on to specialist treatment services will benefit from ongoing support from the Part Two GP in close co-ordination with the specialist service. This might range from provision of general medical care for challenging patients to formal care programme approach for patients with complex needs. Local protocols will need to be agreed on shared care arrangements to be implemented under the contract.

Training

Staff will need training in all areas covered in Part One above, as well as: triage assessment, detoxification, relapse management, management of co-morbid conditions, relevant drug interactions, referral procedures, the nature and philosophy of local specialist services and agreed shared-care working protocols.

Review Procedures

Commissioners should agree criteria against which the performance of the contract can be measured. This might include (but is not limited to):

- Numbers identified and recorded as hazardous, harmful and 'likelihood of dependence'.
- Number and type of intervention offered to excess alcohol patients
- Time interval from first contact to first intervention
- Number of patients who have reduced their consumption, reduced their consumption to within sensible limits, and / or become abstinent
- Actual unit consumption before and after intervention and / or at 12 months
- Numbers having sustained improvement from intervention in previous year

Costing suggestions

The following could be considered, in addition to the fees offered for Part One work, above.

- A "priming" set-up cost could be offered, instead of the "retainer" suggested in the NES.
- A fee per assessment, per detoxification and per referral could be offered.

Payment levels need to take account of the evidence that in a Practice with the average list size of 1820 patients, there would be approximately 364 excess drinkers.

Acknowledgements

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Glossary, acronyms and definitions

Sensible limits – males < 21 units per week, with no more than 4 units on any one day, females < 14 units per week, with no more than 3 units on any one day.

Hazardous drinking – drinking which is likely to jeopardise a person's health (rough guide : males 22 - 50 upw, females 15 – 35 upw)

Harmful drinking – drinking which has already given rise to physical or psychological harm (rough guide: males > 50 upw, females > 35 upw)

Dependency – according to ICD 10 / DSM IV criteria

Binge – > Half the weekly DoH recommended maximum intake in one session

Home detoxification – a detox managed in the patient's home with medication prescribed by the GP, and a responsible adult relative or carer

Community detoxification – a detox managed in the patient's home, with medication prescribed and monitored by a Community Psychiatric Nurse specialist attached to a specialist NHS team.

The *Frames* model is an approach to Brief intervention

MI – *Minimal Intervention*

BI – *Brief Intervention*

QOF – *Quality in outcome framework*

References

- (1) Alcohol Harm Reduction Strategy for England. 2004. DoH.
- (2) Why Alcohol is good for health – Guidance for Primary Care Trusts, NHS trusts and Local Authorities on how tackling alcohol can help meet health priorities and targets’: 2003, Alcohol Concern. Available in hard copy, or free download:
<http://www.alcoholconcern.org.uk/doc/823>
- (3) & (4) *Screening tools for healthcare settings* – Alcohol Concern factsheet
<http://www.alcoholconcern.org.uk/doc/568>
- (5) T-ACE see www.niaa.nih.gov/publications/t_ace-text.htm
- (6) Engaging General Practitioners in the management of hazardous and harmful alcohol consumption; results of a meta-analysis. 2004. Anderson, P., Laurant, M., Kaner, E., Wensing, M. and R. Grol, *Journal of studies on alcohol*, 65 (2).
- (7) Models of Care for Drug Misuse Treatment Commissioning, 2002, National Treatment Agency. (see www.nta.nhs.uk)

Useful resources

- (Also see references for Alcohol Concern Downloads)
- *The management of harmful drinking and alcohol dependence in primary care; a national clinical guideline*. 2003. Scottish Intercollegiate Guidelines Network
www.sign.ac.uk
- *UK Alcohol Forum guidelines* –
www.ukalcoholforum.org/pages/alcoholguidelineset.
- *Drug and Alcohol National Occupational Standards* –
www.danos.info/standards
- *Modernising the Care Programme Approach: a policy booklet*, 2003. MHSIG.
www.basw.co.uk/mhsig/national3.htm

Feedback, and future development of nGMS

Alcohol Concern no longer receives specific funds from the Department of Health to run the Primary Care and Alcohol Information Service, so may not have the capacity to respond to all questions about this briefing. We do however have an ongoing interest in the issue, and would like to keep in touch with how the nGMS rolls out.

We are particularly keen to hear about:

- Intelligence of how you have implemented the LES locally, especially on how you have meshed this with existing specialist provision.
- Copies of actual contracts if possible, indicating if we can circulate these as examples to others.
- Comments on this briefing, or suggestions for future revision.
- Send correspondence and comments to pcais@alcoholconcern.org.uk

Help From Alcohol Concern

Alcohol Concern runs a Consultancy service, and may be able to help you develop an nGMS implementation plan for your area. We also carry out alcohol impact studies, needs assessments, service reviews and support the development of local alcohol strategies contact consultancy@alcoholconcern.org.uk for more details.

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