SCALE-UP OF PREVENTION AND MANAGEMENT OF ALCOHOL USE DISORDERS AND COMORBID DEPRESSION IN LATIN AMERICA

SCALA TRAINING MANUAL

Acknowledgements

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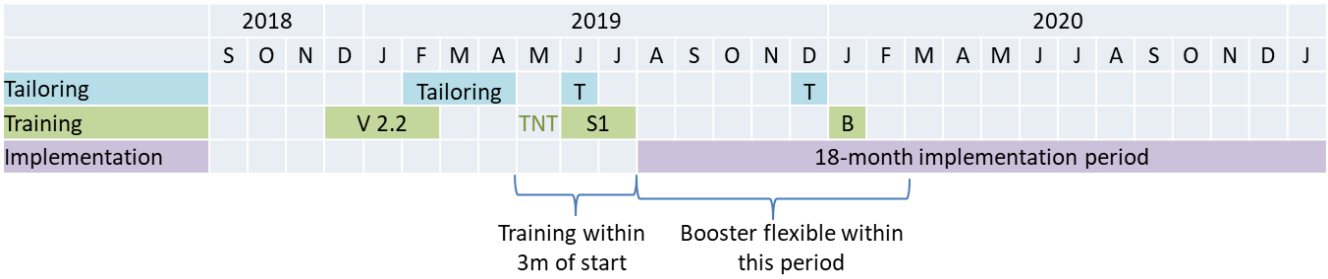
Executive Summary

The aim of the SCALA training package is to prepare and support the PHC teams in scale up municipal districts to implement the SCALA SBI programme during the study implementation period and beyond.

The primary training methodology adopted is a modelling strategy, based on model videos, with the training package (session and materials) tailored to the PHC settings and system in the SCALA Latin American scale-up municipalities.

The SCALA training comprises:

- 2 x 2hour training sessions (S1+S2 - 4h total) immediately prior to the 18-month study implementation period. These can be in the same day, or on different days, up to a month apart, depending on the availability of trainers, participants and training space etc.
- 2 x 1hour tailored booster sessions (B1+B2 – based on tailoring (T) through an online questionnaire in previous months, and peer-led trouble-shooting in first twelve months of scale-up phase



How to use this manual:

This SCALA training manual gives suggestions for the preparation and planning of your training course, session plans and details on how to run the SCALA training sessions. Hand-outs and other course material can be found in the Annexes at the end of this document, and are indicated in the session plans.

Use the 3 PowerPoint presentations (Session 1, Session 2 & Booster Session) to present the material and as a guide through the SCALA training and booster sessions.

Use the 3 videos to model the conversations involved in clinical processes of screening (Videos 1a & 2a), brief intervention/advice (Videos 1b & 2b) and referral (Video 3), as indicated below for Sessions 1 and 2.

Session 1

- **Before session 1**

Training space and group sizes:

- The training space for each 2 hour session should be booked for 3 hours to allow for networking and internal PHCC planning of next steps after the training.
- The optimal size for training groups would be 15-25 professionals (ideal ratio: 1 trainer per 10 professionals).
- Training space should be set up in a U-shape without fixed tables (to allow for splitting/joining for small- and whole-group activities).

Certificates

As a motivation to complete the training, it is recommended that the Latin American partners arrange for the SCALA sessions to be accredited by a known and valid institution (e.g. a public body, professional association or university). You will need a means to verify attendance (e.g. a signature list or whatever means you commonly use). Issuing personalised certificates will also require some administrative time after the course. We have found that the certificates can also sometimes be used to encourage return on the evaluation/feedback.

Local tailored aspects:

- Choosing trainers – Latin American partners to make this decision. Our recommendation: A mixed team of 2 trainers (general clinical professional and specialist in alcohol) or Second option (if only one trainer): clinical professional with experience in SBI. Also see the spirit of the training sessions below.
- Group composition - Latin American partners should make the decision of whether groups should be mixed health PHC professionals (GPs and nurses), or have sessions/units tailored to different professionals. Our preference would be for mixed groups of the whole PHCC.
- Timetable of sessions – Latin American partners to find most convenient 3 hour slot for PHC professionals (e.g. lunch time slots? After work? In turns?), and how many breaks needed (if any in a 2-3 hour session)

Spirit of the SCALA training (must be clear and acceptable to the trainer(s)):

- Active role of professionals – the professionals must come prepared to participate actively, not passive recipients of knowledge.
- Practical approach – the training aims to give professionals tools and techniques to use in their practice.
- Real life consolidation of techniques – the trainer(s) must transmit and reassure participants that the SBI methods become more natural and more agile with practise and that they should start using the techniques immediately following the sessions.
- Participation is voluntary – no professionals will be forced to participate or respond if they don't feel comfortable (to avoid generating resistance)
- Respectful attitude – for different professional profiles and differences of opinion

- Shared and agreed values – as shown in WHO Hand-out 1.2: agreement suggestions – (see Annex 1)

Reminders (and baseline measures – WP4)

We suggest sending reminders via e-mail or memo (mechanism to be decided by the centres according to normal communication channels) 1 month, 2 weeks (with all background material) and 1 week before the training sessions. The reminders should be synchronised with any info sent out re SCALA (e.g. evaluation).

Advance material:

The following material (Annex 1 – advance material pack) will be **sent 1 week in advance** of the session to the trainees to save time in the training course:

Material	Format	Local tailoring by trainer
- SCALA Project flyer	- 2 page	
- Introduction to the SCALA training: Information on the trainer (with photo, short bio etc.) and the training course (aim, intended training outcomes, agenda + participation agreement – based on WHO Hand-out 1.2: agreement suggestions)	- 2 page	- Photo and bio of trainer
- SCALA protocol slides + SCALA Provider Booklet (Guide for healthcare professionals – definitions, SDU, screening, brief advice, referrals)	- 5 pages - 36 pages (26 without pages in patient booklet)	
- Patient Leaflet (explanation/guide to brief advice)	- 10 pages	
- Clinical pathway (diagram)	- 1 page	
- E-mail/memo reminder and session info (logistical info and aims/agenda of session 1)	- 1 page (e-mail)	- Channel of reminder and wording to be added by SCALA partners or trainer

- **Session 1 plan (2 hours)**

Unit 1 - Generic concepts + Attitudes to alcohol (30 mins)

Activity	Group format	Method	Time	Materials	Local tailoring by trainers
Welcome and warm-up	Whole group	Ice-breaker (to be defined in tailoring stage)	5’	(To be defined in tailoring stage)	- Choose acceptable ice-breaker activity (or use the quiz teams)
Impact and costs of alcohol use	Whole group or 2 teams	Quiz: Quick revision of local impact/costs, patterns of use, SDU & risky levels	10’	Slides or app of quiz based on the SCALA patient booklet (Annex 2) or introduction to the topic (see material sent before session 1) - as a live multiple choice quiz (either on an app or hands up exercise)	- Decide if you do the quiz with ‘Hands up’ or app - Quiz questions 7 and 8: Use local statistics.
Attitudes towards alcohol	5-6 small groups (of 3-5 people each)	Each group discusses 1-2 statement(s) from WHO attitude worksheets for 5 mins Feeds back to whole group overall opinion and points of discussion (1 min per group) – highlight key attitudes.	15’	Slides 5-10 selected statements from WHO worksheet 2.1 (Annex 3) on cards (2 per sheet).	

Unit 2 - Screening for alcohol problems and comorbid depression (50 mins)

Activity	Group format	Method	Time	Materials	Local tailoring by trainers
Beginning the conversation	Whole group	Elicit experiences of talking about alcohol with patients – how did it come up. Present 3 different ways: opportunistic, patient-led, planned Elicit phrases that could be used for each type & suggest	10’	Slides with example phrases adapted from WHO beginning the conversation hand-out 5.1 (Annex 4)	
Screening tools and skills	Whole group	Explain SCALA screening criteria. Present AUDIT (and AUDIT-C) and PHQ-2/9 and where to find them in material Highlight the key skills for screening (which they will see in the video)	5’	Slides with screening flow diagram and scales and key skills Screening scales: AUDIT (-C), PHQ-2 and PHQ-9 as hand-outs	
Modelling and practicing screening	Whole group → role play in pairs → whole group	- Watch video 1a (Screening Alc+ / Dep-) and video 2a (Screening Alc+ / Dep+) - Put in groups of 2 (doctor, patient) and explain they have 5 minutes to role-play the screening part of consultation, using the skills and scales seen in the videos and hand-outs - Role-play screening situation with predefined patient roles (hand out cards assigning those in patient role to be either alcohol only or alcohol and depression) - Swap roles, new cards and repeat role-play	25’	See video plan + scripts (Annex 5) video 1a (Screening patient Alc+ / Dep-) video 2a (Screening patient Alc+ / Dep+) Role play cards giving details on patient condition and severity (half alcohol only, half alcohol + depression) – (See Annex 6) Screening scales and key Role-play instructions slide/ sheet	
De-briefing	Whole group	Verbal feedback on role-playing exercise and short discussion	10’		

Unit 3 - Brief intervention on alcohol (45 mins)

Activity	Group format	Method	Time	Materials	Tailoring
Brief intervention	Whole group	- Present steps of brief intervention for alcohol, refer to provider booklet. - Introduction of core skills + change talk - Highlight 5 key messages	10’	Slides based on SCALA provider booklet + Key messages decided in collaboration with WP2 (5 “what you do” + 4 “How you do it” Slides based on WHO Unit 7 Hand-outs (Annex 7) and 5 key messages as agreed in SCALA meetings	
Modelling and practicing brief advice	Whole group → role play in pairs → whole group	- Watch video 1b (BI for alcohol) - Put in groups of 2 (doctor, patient) and explain they have 5 minutes to role-play the BI part of consultation, using the skills and scales seen in the video. - Role-play brief intervention situation in groups of 2 - Swap roles and repeat role-play	20’	See video plan + scripts (Annex 5) Video 1b (BI for alcohol) Role-play instructions slide/ sheet	-
De-briefing	Whole group	Verbal feedback on role-playing exercise and short discussion	10’		
Wrap up	Whole group	Recap and close session	5’		

Session 2

- **Before session 2**

The following material will be sent 1 week in advance of the session to the trainees:

Material	Format	Tailoring
- Reminder and session info (logistical info and aims/agenda of session 2)	- 1 page	- Local language
- Schedule of booster sessions (dates and process of gathering input prior to session)	- Doodle? - 1 page	- Adapt to local availability

- **Session 2 plan (2 hours)**

Unit 4 - Recap + Advice/information for co-morbid depressive symptoms (40 mins)

Activity	Group format	Method	Time	Materials	Local tailoring by trainers
Opening	Whole group	- Recap (elicit + feedback) on screening for alcohol and depression and brief intervention for alcohol - Present strategy for co-morbid depressive symptoms	5’	Slides as visual cues	- Recap any especially difficult areas
Modelling and practicing BI	Whole group → pairs → whole group	- Watch video 2b (BI for alcohol + depression) - Put in pairs (doctor, patient) and explain they have 5 minutes to role-play the BI part of consultation, using the skills and scales seen in the videos - Role-play brief intervention situation in groups of 2	25’	See video plan + scripts (Annex 5) Video 2b (BI for alcohol + depression)	-
De-briefing	Whole group	Verbal feedback on role-playing exercise and short discussion	10’		

Unit 5 - Referrals for alcohol and depression (40 mins)

Activity	Group format	Method	Time	Materials	Tailoring
Services for referral	Whole group	- Summary presentation of services for alcohol and depression/depressive symptoms (tailored to local context) - Brief discussion of services, barriers and solutions	10’	Slides based on SCALA Provider booklet sections 5 and 6	Referral options to specialist support services in each country for: - Alcohol - Depression
Modelling and practicing referral	Whole group → Groups of 2 → whole group	- Watch video 3 (referral for alcohol problems and co-morbid depression) - Role-play in groups of 2 - Swap roles and repeat role-play - De-briefing and feedback on role-playing	25’	See video plan (Annex 5) Role-play instructions slide/ sheet	Videos tailored to L.A. context and language: - Consultation room layout - Attire etc. of professionals - Language used
Suicide prevention	Whole group	- Discussion on detecting suicide risk and suicide prevention (elicit existing knowledge) - Reinforce key messages (referral for suicide risk must be urgent, if available)	5’	Slides based on SCALA Provider booklet section 7	Referral options to specialist services for suicide prevention in each country

Unit 6 - Treatment when referral is not possible + wrap up (30 mins)

Activity	Group format	Method	Time	Materials	Tailoring
When referral is not an option	Whole group	- Elicit situations that referral is not possible (patient and system reasons)	5’	Slides showing drug treatment options for alcohol and depression in PHC (detox, relapse prevention antidepressants) Psychoeducation	Referral options in each country Availability of PHC drug treatments in each country
Coaching	Whole group	- Presentation on options for professionals when referral services are not available or patients are not willing. - short discussion	10’	Slides of key process to follow based on MHGap (ES) indication of further resources	
Wrap up		- Clearing up doubts – round of Q&A - Take home messages – presentation	15’		

Booster sessions

Two booster sessions of 1 hour each will be delivered in the in first twelve months of scale-up phase (for example, 4 and 8 months after the start of the implementation phase), and based partly on responses to the tailoring questionnaire, collected in the month before each booster session.

Spirit of the booster sessions

The booster sessions serve two functions: to refresh key aspects of the SCALA intervention and trouble-shooting of common and specific barriers or obstacles in SBI for alcohol. Each booster session will follow the same format, as described below, whilst the specific content may vary considerably, according to the needs of the participants.

We propose that the main part of the booster sessions will adopt a *peer-led problem-solving* approach, with several implications for methodology and attitude:

- The difficulties or barriers to implementation will be identified by the professionals in the run up to the booster session (elicited through the tailoring questionnaire);
- Difficulties and barriers will be raised and selected for discussion by the participants in the session;
- Solutions will be offered by peers in small and whole group formats;
- Although the trainers will be expert in SBI in PHC, it is not expected that the trainers should have the answers to all possible questions or problems that participants might raise, and the trainers should be comfortable to open the questions to the group and mediate discussion (e.g. summarising suggestions)

Before the Booster sessions

The following material will be sent 2 weeks in advance of the session to the trainees:

Material	Format	Tailoring
- Reminder and Schedule of booster sessions (dates and aims)	- 1 page (e-mail)	- Local language + availability
- Tailoring survey (to identify barriers and facilitators to screening and brief advice – in synergy with the process evaluation work task 5.2 - see draft questionnaire in Annex 8)	- Online questionnaire	- Latin American Spanish

- **Booster sessions, activities and on-site material**

Activity	Group format	Method	Time	Materials	Tailoring
Refresh	Whole group	- Welcome and 1-2 free comments on progress - Present summary of key concepts + SBIRT process	5’	Summary slides of key concepts based on training session slides	- Highlight areas identified in booster tailoring questionnaire.
Trouble shooting	Individual → Small groups (5 - 6 people) → whole group	- Elicit / raise specific problem areas or barriers - small-group guided discussions - Identify practical solutions – interactive whole group method (for a suggestion of how this can be done, please see step-by-step peer-led trouble-shooting in Annex 9).	45’	Flip charts and post-its to record solutions	- Problems raised are specific to the PHCC (identified both through the tailoring questionnaire and in the session)
Wrap-up	Whole group	- Summarise take home points from the session’s discussions	10’	Slide of take home points + board/flip charts	

- **After the Booster sessions**

A tailored summary mail should be sent round after each booster session with the barriers and solutions identified (and contact info for further support).

Annexes

- **Annex 1 – Advance material**

Instructions:

1. Download or print the SCALA flyer and project brochure (protocol slides, provider and patient booklet, care pathway) to send or give to the participants before the training.
2. Complete the information about the trainers and save / print to send or give to the participants before the training.

SCALA Project flyer

SCALA

SCALE-UP OF PREVENTION AND MANAGEMENT OF ALCOHOL USE DISORDERS AND COMORBID DEPRESSION IN LATIN AMERICA

La magnitud del problema

El alcohol y su uso excesivo son la causa de una amplia variedad de enfermedades y daños. El abordaje de la gran cantidad de daños individuales y sociales debidos al trastorno por uso de alcohol (TUA) y al uso excesivo de alcohol es una prioridad de salud pública. Esto es especialmente relevante en América Latina donde el alcohol se sitúa en la cuarta posición de los principales factores de riesgo de morbilidad y muerte prematura. El TUA presenta una elevada comorbilidad con otros trastornos mentales, y más del 40% de los pacientes diagnosticados con TUA en Atención Primaria padecen depresión que, a su vez, es el trastorno mental más frecuente.

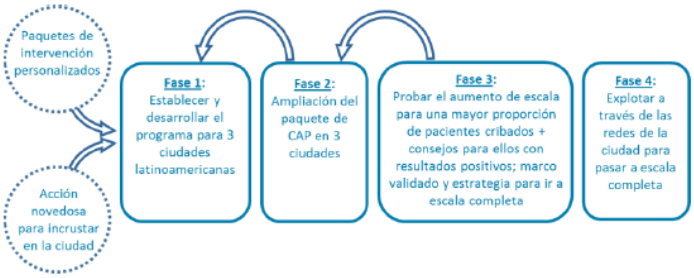
Implementación escalonada de la solución

Aunque los programas de prevención y manejo del uso excesivo de alcohol en el contexto de Atención Primaria (AP) han demostrado ser clínicamente eficaces y coste-efectivos, el nivel de adopción e implementación de estos programas en la práctica clínica habitual sigue siendo bajo, por lo que los beneficios de salud pública son modestos y a corto plazo. Algunos estudios de la OMS han sugerido que esta situación se podría mejorar si las actividades de la AP estuvieran integradas en un apoyo comunitario y municipal más amplio, así como mediante la formación de los proveedores de salud individuales

SCALA tiene la intención de evaluar y basarse en esta hipótesis en América Latina, mediante un estudio cuasi-experimental que compara la implementación escalonada de un programa de cribado e intervención breve personalizado en el contexto de AP, integrado en un plan de acción municipal de apoyo continuo, con la práctica clínica habitual.

Objetivos del proyecto SCALA

- Paquetes de intervención personalizados para mejorar la prevención, detección precoz y consejo para el uso excesivo de alcohol y depresión co-mórbida en Colombia, México y Perú.
- Evaluar si la implementación escalonada integrada de los paquetes personalizados mejora el cribado y de la intervención breve en municipios urbanos de países de ingresos medios.
- Identificar barreras y facilitadores a la implementación escalonada y documentar los requisitos de recursos para un análisis económico.
- Producir un marco y una estrategia de implementación escalonada validados, teniendo en cuenta el estigma y la igualdad, con el fin de mejorar la reproducción de los paquetes SCALA personalizados alrededor del mundo.



El proceso de SCALA está basado en el marco de 4 fases para implementar de forma escalonada del *Institute of Health Improvement* (IHI) de los Estados Unidos. Los pasos de este marco han sido adaptados para adecuarlos al área de prevención de problemas por uso de alcohol y depresión co-mórbida y al contexto de atención primaria en América Latina.

El estudio de SCALA

El estudio de SCALA evaluará la hipótesis según la cual la implementación escalonada de un paquete de intervención breve personalizado, integrado en una estrategia más amplia de apoyo comunitario y municipal en ciudades de América Latina, incrementará los niveles de cribado y consejo para el uso excesivo de alcohol y depresión co-mórbida en mayor medida que sólo la práctica habitual de los proveedores de atención sanitaria. SCALA utilizará un estudio cuasi-experimental que compara la prevención y manejo del uso excesivo de alcohol y depresión co-mórbida en el contexto de AP en tres distritos de intervención (áreas municipales) en tres ciudades latinoamericanas con la práctica habitual en tres distritos de comparación situados en las mismas ciudades.

Las ciudades que participan en el estudio son Bogotá (Colombia), Ciudad de México (México) y Lima (Perú). En estas ciudades se identificarán distritos o barrios (áreas municipales con gobierno local) emparejados y se les asignará o bien a la condición de implementación escalonada, o bien a la de control. En los distritos de implementación, las Unidades de Atención Primaria (UAP) recibirán una formación integrada en el plan de acción de apoyo continuo a nivel municipal (gobierno, trabajadores e infraestructura locales) durante un período de implementación de 18 meses. En los distritos de comparación se continuará con la práctica habitual tanto a nivel municipal como a nivel de UAPs.

Sigue el código QR para leer la publicación sobre el Protocolo de Estudio de SCALA :

Entidades Participantes

Maastricht University

ESADE Business School

Technische Universität Dresden

Nuevos Rumbos

Universidad Peruana Cayetano Heredia

Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz

Newcastle University

Fundació Clínic Barcelona

Universitätsklinikum Hamburg-Eppendorf

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SCALA

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Introduction to SCALA Training (2 pages)

Photo	Trainer's names and affiliation(s): *Trainers: Please complete the first section with your professional information.* Trainers' short bios: *(150 words approx.. – mention your own training background and any experience in the alcohol/brief intervention fields)* Trainers contact (optional):

SCALA Training Course aim and learning outcomes

The aim of the SCALA training is to increase health professionals' confidence and ability to screen, offer brief advice and referral to patients with risky or problematic alcohol use and (where identified) co-morbid depression in primary care centres.

Participant Learning Outcomes:

After the SCALA sessions, the participants should be able to:

- Screen and identify patients with different degrees of alcohol problems and co-morbid depression
- Provide brief advice to patients with high-risk alcohol use
- Provide further information to patients with co-morbid depressive symptoms
- Offer referral or other appropriate responses to patients with more severe symptoms of problematic alcohol use / depressive symptoms.
- Employ basic motivational techniques in screening, intervention and patient visits in general, and identify counter-productive practice.

SCALA Training Course outline

Trainers: Please complete the outline with the correct logistic information (date, time, location of training sessions).

Day/Session 1 (2 hours) - *date & time*

- Unit 1 - Generic concepts + Attitudes to alcohol (30 mins)
- Unit 2 - Screening for alcohol problems and comorbid depression (45 mins)
- Unit 3 - Brief intervention on alcohol (45 mins)

Day/Session 2 (2 hours) - *date & time*

- Unit 4 - Advice for co-morbid depression (50mins)
- Unit 5 - Referrals for alcohol and depression (40 mins)
- Unit 6 - Treatment when referral is not possible + wrap up (30 mins)

Participation agreement (based on WHO Handout 1.2. Group agreement suggestions)

To maximise the effectiveness of the course, it is useful to lay some simple and intuitive ground rules in the form of an agreement for participation. By coming along to the training sessions, you agree to the following statements and conditions.

√ *Respect each other, even when we disagree.* We need to recognize diversity and our differences. Discussing alcohol use and alcohol problems can sometimes be sensitive and raise strong feelings and emotions. It is important to acknowledge and accept these differences and each other's right to express views and feelings, even if we do not always agree with them.

√ *There should be no "put-downs" (snubbing or humiliating people).* If we do not agree with a view or an opinion we all have a right to challenge that view. We also have to respect people's right to express that view or opinion, even though we may not agree with them. We should, therefore, challenge the view or behaviour and not the person. We are also responsible for considering and managing the effect of our views and behaviour on others and on their feelings.

√ *Listen to what other people say without interrupting them.* Everyone should be afforded the same opportunity to participate and to be listened to. People should be given the opportunity to speak and express their views and opinions without interruption. This course has been designed to ensure that people can participate equally.

√ *Be on time.* As trainers we commit ourselves to finishing the sessions on time, and we expect that participants will also arrive and return from breaks on time.

√ *Participate actively and constructively.* The more we put into training, the more we will get out of it. The training course is designed to be interactive with lots of opportunities for active participation and for sharing information and knowledge and learning from each other. We commit ourselves to giving our best to each unit and practice session to maximize our own learning and to give active and constructive feedback to others when it is called for.

√ *Ask questions as needed.* We come to training from different starting points. It is the responsibility of each participant to make sure they understand by asking when things are not clear or if they want additional information.

√ *Respect confidentiality.* It is important that people feel comfortable expressing their views and opinions in the knowledge that whatever is said is not repeated outside the course. Participants are not expected to share any personal information that they do not feel comfortable about, whether about their own behaviour or that of family or colleagues. Anything that is shared should remain confidential, including information or opinions about organizations or patients.

√ *Enjoy the course.* We learn best when we are relaxed and enjoying ourselves. It is up to all the participants to ensure that the session is enjoyable by getting involved with the activities, giving their opinion and providing feedback where they can.

SCALA Protocol slides (pending final and translated versions)

Scale-Up of Prevention and Management of Alcohol Use Disorders and Comorbid Depression

A Protocol

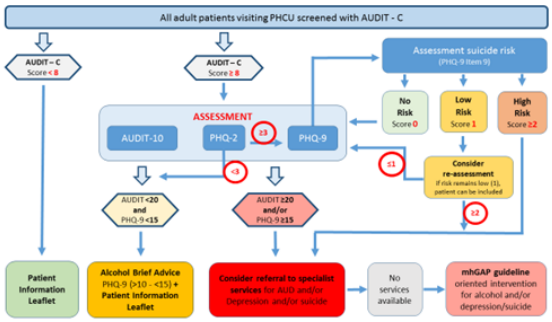
OTHER LOGOS

SCALA

SCALE-UP OF PREVENTION AND MANAGEMENT OF ALCOHOL USE DISORDERS AND COMORBID DEPRESSION IN LATIN AMERICA

OTHER LOGOS

Care Pathway



Alcohol Screening

It is recommended you complete alcohol screening with all adult patients. If you see a patient who has already completed the alcohol screening there is no need to repeat this unless yourself or a colleague has recommended ongoing monitoring of alcohol consumption.

AUDIT C

This three item tool should be used with all adult patients.

Patients who score 0-7 should be given positive feedback on their lower risk drinking status and a copy of the patient alcohol leaflet 'Drinking and Me'.

Patients who score 8 or more should go on to complete the seven additional questions that make up the full AUDIT 10 questionnaire and should also be screened for depression using the PHQ 2.

AUDIT 10

Patients who score 8-19 on the AUDIT 10 should be provided with a few minutes of verbal brief advice and should be given the patient brief advice booklet to take away with them. These patients should also be screened for depression. For patients who score close to the cut off point of 20, use your clinical judgement to consider if there are any indications the patient would benefit from referral to specialist services.

Patients who score 20 or more on the AUDIT 10 could be dependent on alcohol. Use your clinical judgement to consider if referral to specialist alcohol treatment services is appropriate and screen for depression with the PHQ2. Patients who you consider do not require referral should be provided with a few minutes of verbal brief advice and a copy of the brief advice booklet.

Depression Screening

Aim to conduct depression screening with all patients who score 8 or more on the AUDIT C questionnaire.

PHQ-2

Complete the two PHQ – 2 questions with the patient. Patients who score 3 or more should complete the seven additional questions that make up the PHQ-9. Patients who score 0-2 need no further screening or action.

PHQ-9

Patients who score 15 or more on thePHQ-9 could be clinically depressed. Use your clinical judgement to decide if referral to specialist services for treatment of depression is required and remember to screen for suicide risk. If you decide referral is not required, provide the patient with a copy of the Self management for Low Mood and Depression' leaflet.

Patients who score 10-14 should be provided with a copy of the 'Self management for Low Mood and Depression' leaflet and be screened for suicide risk. For patients who score close to the cut off point of 14, use your clinical judgement to consider if there are any indications the patient would benefit more from referral to specialist services.

Patients who score 3-9 should receive positive feedback and be screened for suicide risk.

Suicide Risk Screening

Question 9 of the PHQ-9 can be used as a quick screen for suicide risk.

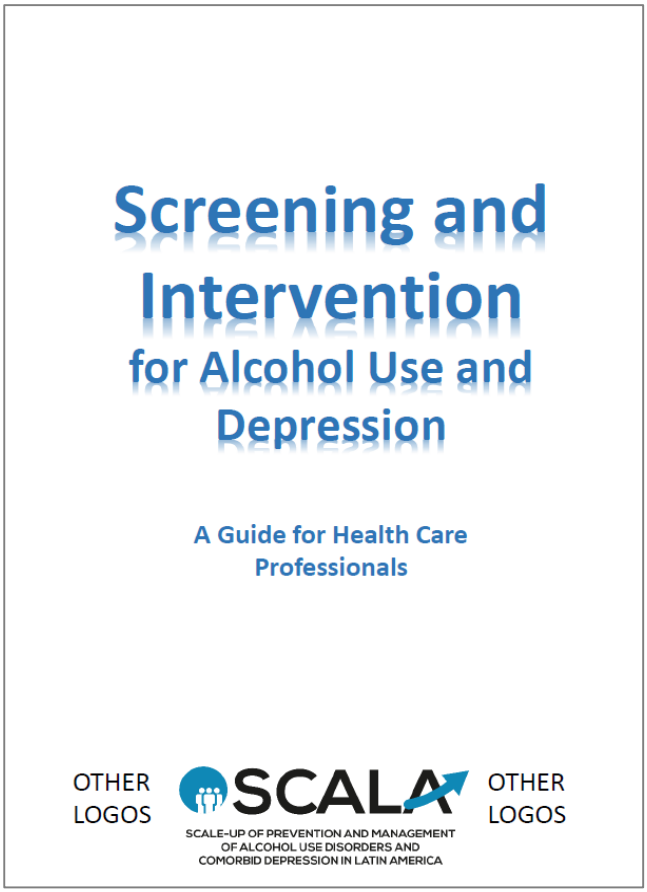
Assess PHQ – 9 Question 9 score

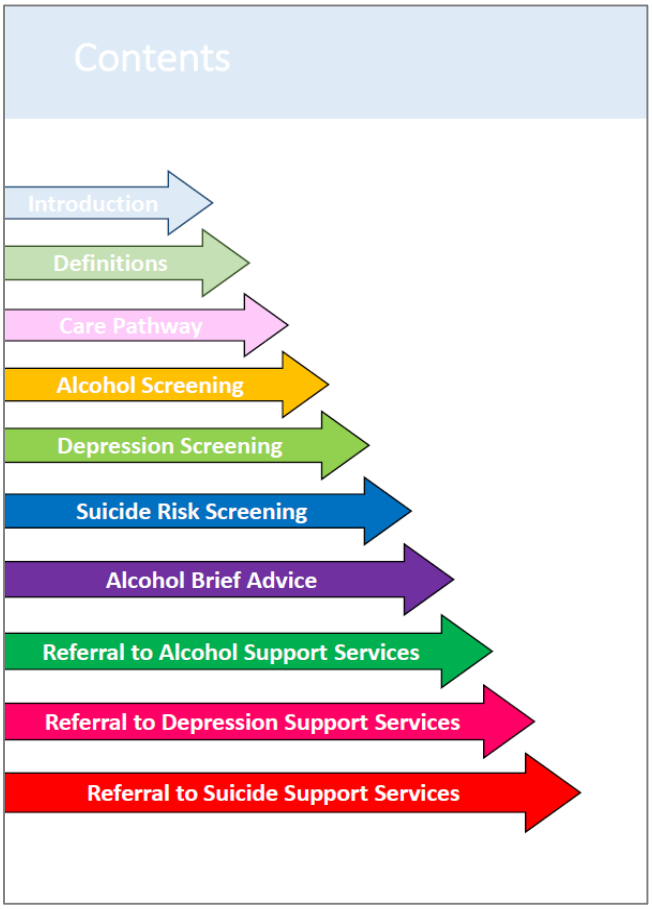
Patients who score 0 on this question are not likely to present a risk of suicide. No further action is required for suicide risk.

Patients who score 1 on this question could present a low risk of suicide. As such, monitoring is indicated. Use your clinical judgement but arranging a two week follow up visit to reassess suicide risk is recommended. Patients who remain stable at score of 1 on this question can be included and receive the appropriate SCALA materials (as judged by their screening scores)

Patients who score 2-3 on this question may present a risk for suicide. Referral to specialist services is indicated. Use your clinical judgement to assess whether referral to additional treatment and support is required or if monitoring is appropriate.

SCALA Provider Booklet (pending final and translated versions)





Patient Leaflet (pending final and translated versions)

Drinking & Me

A Guide to Alcohol and Health

OTHER LOGOS

SCALA

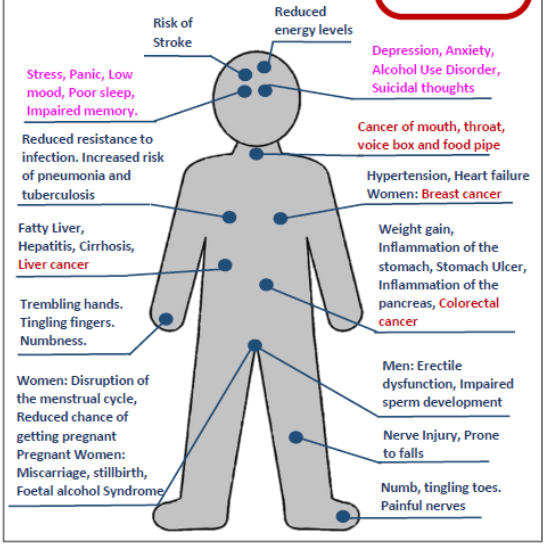
SCALE-UP OF PREVENTION AND MANAGEMENT OF ALCOHOL USE DISORDERS AND COMORBID DEPRESSION IN LATIN AMERICA

OTHER LOGOS

Alcohol and Your Health

In addition to the acute harms (such as alcohol related injuries) alcohol is also associated with a range of **physical** and **mental** health harms. The diagram below shows the key effects risky drinking has on your health.

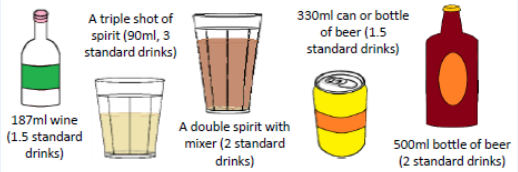
All types of alcohol can cause cancer



A Standard Drink:

Contains 10 grams of pure alcohol. Each of these contains 1 standard drink:

These all contain more than 1 standard drink:



Lower Risk Drinking is:

Limiting alcohol use to amounts and patterns that are unlikely to cause harm to yourself or others around you.

- To lower the lifetime risk of harm, drink no more than 2 two drinks on any day
- To lower the risk of injury, drink no more than 4 drinks on any one occasion

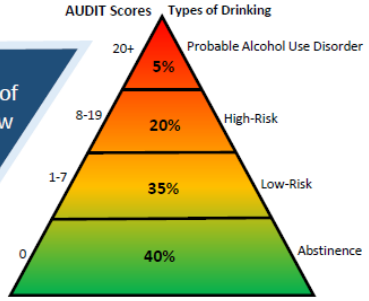
Higher Risk Times

There is no completely safe level of drinking. Even small amounts of alcohol present risks. You should not drink alcohol at all when you:

- Engage in strenuous exercise
- Drive – drinking before driving increases the risk of being involved in a collision, pedestrians and passengers are also at risk.
- Are pregnant or breast feeding
- Are taking medications that react with alcohol

The Drinkers' Pyramid

The Majority of people are low risk drinkers or abstain from alcohol.

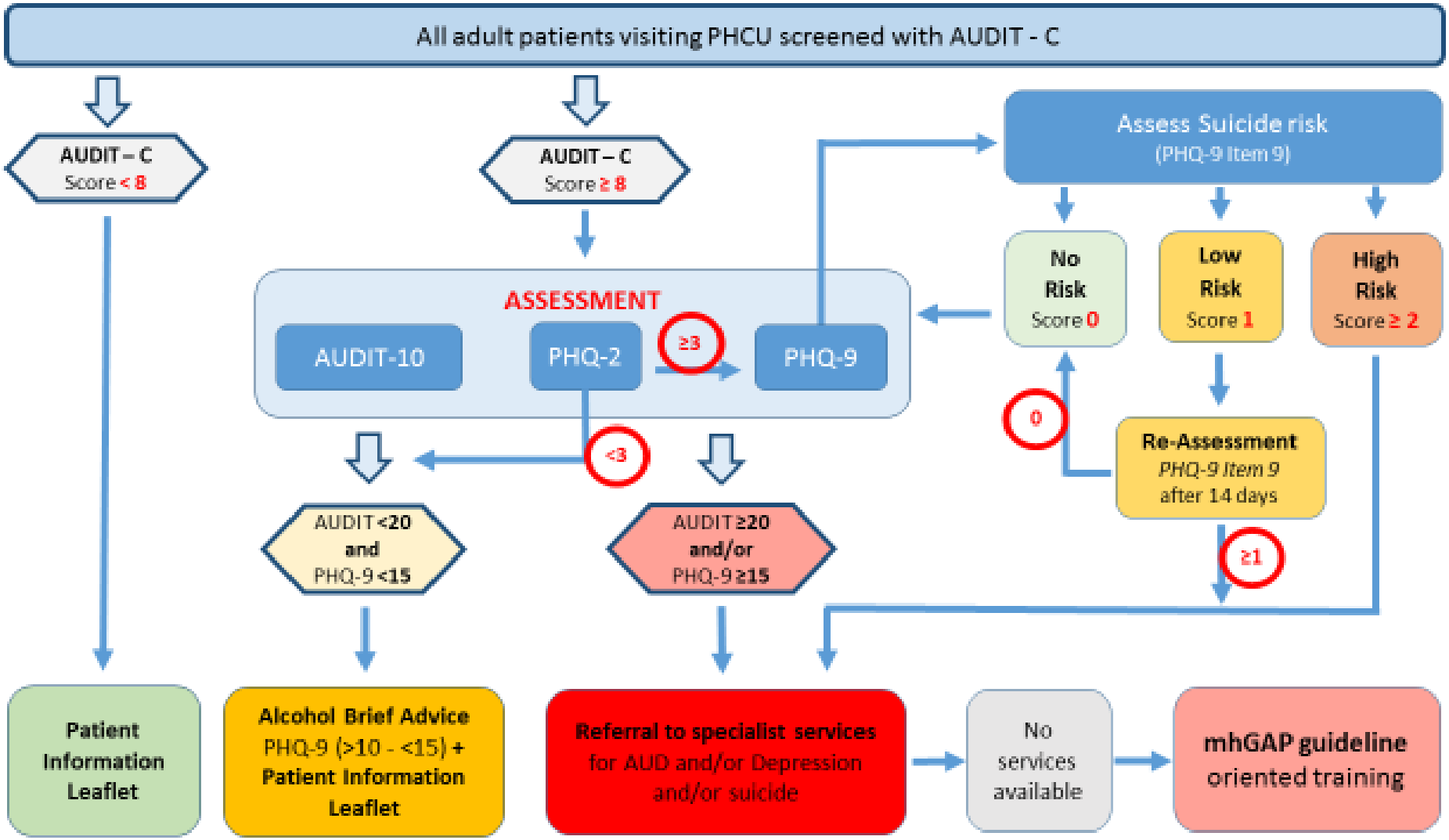


Where Can I get more Information?

Go online: www.website.co.uk
www.website2.co.uk

Call: 000000000000

Clinical pathway



- **Annex 2 – Quiz based on SCALA patient booklet**

Quiz – What do you know about alcohol?

(answers on slides)

1. Alcohol consumption can increase your risk of pneumonia

   true / false

2. Which types of alcohol do not cause cancer?

   a. Beer
   b. Wine
   c. Rum
   d. All types

3. Name 4 mental health or cognitive problems that are linked to alcohol consumption…

4. How many grams of alcohol are there in a standard drink?
   a. 8g
   b. 10g
   c. 12g
   d. 14g

5. Which typically has the highest alcohol content?
   a. A small glass of wine (100ml)
   b. A can or bottle of beer (330-355ml)
   c. A single shot of spirits (30-40ml)

6. What is the recommended upper limit for occasional/binge drinking which should never be passed to stay safe?

7. What percentage of the general population are high-risk drinkers or have probable AUD (AUDIT over 8)? (local tailoring)
   a. 5%
   b. 10%
   c. 17%
   d. 25%

8. What percentage of the general population are abstinent (don't drink at all)?

- **Annex 3 – Attitudes to alcohol**

You can print the sheets like the following page (one page (2xA5) for each small group, as shown in example below).

Full list of Statements from WHO Hand-out 2.1:

Statement	**Ranking**
You have to die of something, so you should enjoy life and not worry too much about lifestyle advice.	
Health advice changes so often that there is no point in trying to follow it.	
It is easy to spot someone who drinks too much alcohol.	
Alcohol problems affect children and young people in ways that smoking does not.	
Drinking to excess is embedded in our culture and is here to stay.	
It is rude not to join in if you are offered an (alcoholic) drink in company with others.	
All the fuss about alcohol is missing the point – drugs cause more problems.	
Standard drink measurements are too complicated for the general public to understand.	
Alcohol relaxes you when you are stressed.	
Men and women drink differently, think about alcohol differently, and are judged differently for it.	
People who drink heavily are not going to change after a short conversation; they will need intensive specialist treatment.	
Advising someone to cut down drinking when it is their main pleasure in life is unfair.	

***Tailoring**: The Latin American partners/CABs/UPs should rank the statements (1= most relevant → 12 = least relevant) to show the 5-10 priority statements which are <u>the most challenging in their countries</u> (e.g. because they are widely held by medical professionals or by the general population OR because they are never considered). Please note, there may also be cultural points to consider in addressing these statements in the training session (e.g. extended harm from drug wars being a particular problem)*

Instructions for the activity:

In small groups, discuss one or two statements for about 5 minutes. Use the questions as a guide:

Statement 1: You have to die of something, so you should enjoy life and not worry too much about lifestyle advice.

- As a group, do you generally agree or disagree with the statement?
- If you cannot reach consensus as a group, choose 'we are not sure' and write a list of points for and against the statement.

Statement 6: It is rude not to join in if you are offered an (alcoholic) drink in company with others.

- As a group, do you generally agree or disagree with the statement?
- If you cannot reach consensus as a group, choose 'we are not sure' and write a list of points for and against the statement.

- **Annex 4 - WHO Handout 5.1: Beginning the conversation**

Three ways in which alcohol can arise (***local tailoring****: pick 2 of each list*):

Opportunistic (practitioner-led) is when an opportunity arises to discuss alcohol in response to an issue, symptom or event. An issue or problem that could relate to alcohol use, or be affected by alcohol, may provide an opportunity to start a discussion about alcohol in a way that is relevant to the patient's concerns.

Practitioner links the presenting issue (social/medical/other) to alcohol

- Another aspect that can affect your condition is lifestyle, including drinking alcohol. Do you enjoy a drink? Could we talk about that a little?
- Some people with similar symptoms find that these issues can be affected by their alcohol use, without them realizing. … Can I ask you, do you drink alcohol?
- Some people find that alcohol helps them to ... (relax when they're stressed; sleep when they have problems with sleeping, escape from their worries). How have you been coping?
- It is surprising how even small amounts of alcohol can affect the symptoms you describe or the reason for your visit. By exploring your alcohol use we would be in a better position to know if this was a factor for you. Would that be okay? Can I ask you what you would usually drink in a week?
- We find that for many people who …. (get into fights/arguments, fall and injure themselves, can't sleep), alcohol can be a factor. Do you think your attendance here today is connected to alcohol in any way?
- We'll come back to treatment options in a moment, but one thing that might help us to get to the bottom of this is alcohol. Do you drink at all?
- I'm wondering if there are any other factors that might be affecting you at the moment. Something that we haven't picked up yet is alcohol. What do you know about how alcohol can affect this?

Patient-led is when a patient brings up the topic of alcohol or is looking for information on alcohol. This provides an automatic way in.

Patient mentions alcohol…

- It sounds as if you've been worrying about your drinking. Would you like to talk about that?
- You've mentioned that you've stopped drinking just now. Is there a particular reason for that?
- You mentioned that you were very drunk on Friday so are not clear how (an incident/injury) happened. Did you drink more than usual?
- Actually, I've got some information here about alcohol that I can give you to take away with you. Is drinking something that you're concerned about just now?
- You mentioned that your wife has been telling you to cut back on your drinking. She obviously cares about you. What about you, do you think you should cut down?

Planned (practitioner-led) is when a practitioner systematically raises the topic of alcohol with all patients, or all patients in a specific group, as part of a routine assessment or initiative.

Practitioner mentions alcohol to all patients

- We ask everyone who registers as a new patient some general lifestyle questions, and next on the list is alcohol. Would it be okay if I ask you about that?
- We are taking part in a new programme/campaign, and we're talking to everyone we see about their alcohol use. Would you mind if I ask you a few questions about this?
- We find that many of the people who visit the practice for … (disease/ condition) find their symptoms improve if they cut down on their alcohol consumption. So now we ask everyone here for … (disease/ condition) about that. Do you drink alcohol at all? Would you mind if I ask you a few questions?

- **Annex 5 – Video Plan + scripts**

We will make three model videos (of 3 different consultations, 3 different actors as patients). The final training videos can either be used or made in-situ for each country (at the country's cost).

For videos 1 and 2, parts a and b will be shown separately in the training sessions.

Videos 1 and 2 – patients where referral is **not** indicated

- Video 1 – (Pedro) - SBI consultation with patient with alcohol problems (same consultation separated into 2 parts):
    - Video 1a (0'0" → 5'14") – Screening administration and result – Alcohol positive, Depression negative
    - Video 1b (5'14" → 9'22") – Brief intervention for alcohol

- Video 2 – (Paola) - SBI consultation with patient with alcohol problems and mild co-morbid depression (Video of same consultation separated into 2 parts):
    - Video 2a (0'00" → 6'25") – Screening administration and result – Alcohol positive, Depression positive
    - Video 2b (6'25" → 11'44") – (refer to video 1b) + Brief intervention for depression (leaflet)

Video 3 – (Ana-Maria) - patient where referral **is** indicated (for depressive disorder)

- Video 3 – Consultation (post-screening) with patient with alcohol problems + co-morbid depression where referral is indicated – Alcohol positive, Depression negative – referral

Video script 1a and 1b – Pedro: alcohol +, depression -

(Important note: texts marked in red are AUDIT or PHQ questions, which have been modified in the conversation to make them more natural, and highlight key intervention points; these annotations will not be included in the conversation, but appear as written labels in the videos.)

1a – SCREENING

Voice-over: *Pedro is a 45-year-old man who comes one Monday morning for a primary care visit with his GP for severe stomach pain. Pedro and his doctor have known each other for years and have a friendly relationship. The doctor has diagnosed an acute gastritis and prescribes a proton-pump inhibitor. After this issue is dealt with, he decides to introduce the systematic identification of alcohol and depression.*

GP: OK then, Pedro, that medication should help with this problem of stomach-aches, and it should take effect quite quickly. These stomach problems are sometimes caused by what we eat or what we drink. Is it all right with you if I ask a few questions to see if your lifestyle habits are related to these stomach-aches?

Patient (P): Yes, yes, no problem.

GP: Perfect, so, here we have some questions. Could you tell me how often you have a drink containing alcohol? An alcoholic drink is a beer, a shot or a glass of wine for practical purposes they are the same. [AUDIT 1]

P: Well, I drink beer almost every day.

GP: You drink almost every day.

P: Yes.

GP: And how many beers would you usually have in a normal day? [AUDIT 2]

P: A couple of beers at midday with lunch and a couple at dinner.

GP: So that would be four beers a day.

P: Yes

GP: Tell me, do you sometimes drink more than that? How often would you say you drink 5 or more drinks in one day? [AUDIT 3]

P: Never on weekdays, with the job I have I can't drink a lot. But over the weekend, normally on Saturday, I'll have a dinner or some event and drink a little more and it could be I go over 5 beers on Saturday night.

GP: Once a week, say?

P: Mmm ... exactly.

GP: Okay. And on any drinking night, have you noticed that you weren't able to stop, that you had to keep drinking, that you could not put the brakes on? [AUDIT 4]

P: Mmm ... this can happen ... it's happened to me a few times, but very rarely. One of these dinners on a Saturday might go on a bit later and, yes, I've noticed that I found it difficult to control it. Roughly once every two or three months.

GP: That's, say, between 4 and 6 times a year.

P: Exactly

GP: Alright. And when this has happened, when you've drunk more than you intended, how often during the last year were you not able to do what was expected of you because of drinking? [AUDIT 5]

P: Well, a few times when I had arranged to go with my wife to a market or to do something in the house the day after, and in the end I didn't manage it because I was not in very good shape and had to stay in bed at home.

GP: I understand that this only happened those times you had too much to drink 4 or so times a year.

P: Exactly.

GP: OK. And did you find on any of these heavy drinking occasions in the past year that the day after you needed a drink at breakfast to recover? [AUDIT 6]

P: No, never.

GP: That's never happened. And on these few occasions that has gotten a little out of control, did you ever feel remorse or guilt after drinking? [AUDIT 7]

P: Yes, when I couldn't make it with my wife to the market or I couldn't go with her, or somedays you function okay but you have a headache and you say to yourself 'why did I do this, I could have stopped a little earlier'.

GP: Very good. In these episodes, has you ever found that could not remember what happened the night before because you had been drinking? [AUDIT 8]

P: only when I totally lose control.

GP: These 4-6 times a year you were telling me about before?

P: Yes.

GP: Have you or someone else ever been injured because of your drinking? [AUDIT 9]

P: No, the truth is that, fortunately, I never take the car when this happens and I'm a very quiet person, I never get into fights or anything like that.

GP: In general, has a relative, friend, o health care professional ever shown concern about your drinking or suggested you stop drinking? [AUDIT 10]

P: Yes, every time I say to my wife that I have stomach pain or I can't accompany her to the Sunday market, she tells me that it's because I drink too much and I have to try to drink less, and ... yes she already tells me that quite often.

GP: Your wife is worried.

P: Yes a little bit.

GP: And ... let me just ask a couple more questions and we're finished. Sometimes, all this also can have an impact on mood. How often would you say that during the last two weeks you were bothered by feeling a lack of interest or little pleasure in doing things? [PHQ 1]

P: No, the truth is that I enjoy the life I have

GP: You're in good spirits. Would you say that during the last two weeks you have felt down, depressed or hopeless at all? [PHQ 2]

P: Well, everyone can have a difficult day, but it's not a very common thing, not every day.

GP: That is, your mood is usually good.

P: Yes.

1b – BRIEF INTERVENTION

GP: Okay, thank you very much for answering these questions, Pedro. Is it all right if I give you some information on what results the questions can tell us all together, and seeing what impact this may have on your health?

P: Yes, it's true, after so many questions I'd like to know the result.

GP: Well, the questions I've asked are to see if you have any strong depressive tendencies and if you drink alcohol in a way that can be troublesome for your health. The good news is that you don't have any depressive symptoms and that's all going well; however, from the questions I've asked about your relationship with alcohol consumption, it appears that your drinking is what we call 'risky consumption', that is, that you drink amounts that put your health at risk, and it would be advisable to think about this. Have you ever thought about this issue? [Key intervention point 1: personalized feedback]

P: Yes, it's true, I drink too much, especially on weekends and those times that happen 4 or 5 times a year, it is true, I should do something about it - they are a bit dangerous for me.

GP: So you already think that sometimes maybe should drink less. I wonder would you like to know what the limits the health authorities advise to be sure that alcohol does not harm your health are? [Key point 2: change normative misperception]

P: Yes, that would be good.

GP: Good. As a rule, there as two very clear boundaries, and it would be good for you to make an effort in both of these. One thing is that the recommended daily intake doesn't exceed two drinks a day, in your case we are on four. And the other advice is never to drink more than four drinks even on occasional heavy drinking days, and on the weekends you tend to drink more. These are two points where you could get noticeable improvement with a reduction. How does that sound to you?

P: So, like, I don't know, instead of having two beers at every meal, to try to have one and ... trying to drink less at the weekends, right?

GP: Yes, that would be good. I don't know how that sounds to you ...?

P: Well, drinking less with meals during the week sounds very easy. Weekends I'll have to work harder, because that might be a bit trickier for me. [Key point 3: Agree on individual goals, exploring different options]

GP: Well, you already do one thing very well, which is that you never drive when you have drunk, this is very important. Just like if you're taking medication, operating machinery with alcohol has an added risk. If you cut down, you could avoid many alcohol-related diseases later on. Would you like me to give you some information on how alcohol acts and tips to reduce, so you can read it when you want at home? [Key point 4: Harm reduction]

P: Yes, that would be good.

GP: Here, you can read this booklet in your own time at home and you'll see that there are some tips for drinking less. Basically, it recommends only drinking with meals, never on an empty stomach, alternate alcoholic drinks with soft drinks, avoid situations where everyone drinks and you know that there will be a strong tendency to drink. And if at times you are stressed or bored … instead of drinking, doing some physical activity can be a much healthier and much better option for you.

If you feel like you need help you can call or ask for information in the places listed in the booklet, or we can talk about it when you next visit if you prefer. [Key point 5: Assist in the change]

P: I'll read it carefully – thanks.

GP: Perfect. I'm sure that if you can keep your drinking down under those limits we've talked about, you'll find your stomach aches get better. If you have any problems, you can come and see me again.

P: Okay. Thank you

GP: Well, thank you very much, Pedro, take care and see you again.

Video script 2a and 2b – Paola: alcohol +, depression + (mild)

(Important note: texts marked in red are AUDIT or PHQ questions, which have been modified in the conversation to make them more natural, and highlight key intervention points; these annotations will not be included in the conversation, but appear as written labels in the videos.)

2a – SCREENING

Voice-over: Paola is a 45-year-old woman who attends a Wednesday morning visit with her family doctor, who has known her for years. She has a tension headache that the GP has already looked into during the visit; the doctor has not detected any warning signs.

…

GP: Paola, good, thank you for answering my questions. So, I think I can give you good news: it seems that your headaches do not have an organic cause, no underlying disease. What is happening these days is that you are experiencing to a number of tensions that are causing these headaches. Would it be ok with you to ask a few questions to see if we can identify any of the possible factors causing this tension?

Paola: Okay, that sounds ok

GP: If you don't mind, I'll start with one of the factors which sometimes surprises people, but is important - alcohol consumption. Alcohol is a factor that may bring on these headaches. Could you tell me how often you have an alcoholic drink? [AUDIT 1]

P: Well, almost every day.

GP: Practically every day. And on those days when you drink, how many drinks would you have on a typical day? [AUDIT 2]

P: I usually drink with meals, a couple of beers at lunchtime and a couple of beers with dinner.

GP: If I understand correctly about four beers a day.

P: That's it.

GP: Are there times that instead of having 2 or 3, you end up drinking 5 or more drinks? [AUDIT 3]

P: That can happen someday when there is a party or a birthday or something like that.

GP: How often could that be?

P: Once a month or so.

GP: Once a month. Have you ever found on some of these days when you were drinking that you haven't been able to stop? Like you wanted to stop drinking but couldn't? [AUDIT 4]

P: Never.

GP: Alright. On any of those occasions, has drinking interfered with the things you had to do, so that you haven't been able to do something you had planned to do because of how much you drunk? [AUDIT 5]

P: On those days I've been at a party, the next day I get a bit of a hangover and then we put off doing things in the morning and stay at home.

GP: Ok. Has it ever happened to you that the day after drinking, you needed to drink at breakfast to feel better, to recover from what had drunk the night before? [AUDIT 6]

P: No, never.

GP: Okay, and has it ever happened that the next day after drinking you had feelings of guilt, of anxiety, related to drinking too much? [AUDIT 7]

P: On those days, if I can't do some activity on a Sunday with my daughters, yeah, then I feel bad.

GP: And have you ever had difficulty remembering what had happened the night before on any of these occasions? [AUDIT 8]

P: Sometimes, not always.

GP: Once a month or so?

P: No, less frequently.

GP: Less than once a month. And any of these times, having drunk, has anyone got hurt or injured, or someone who was with you had an accident? [AUDIT 9]

P: Once, years ago, after one of these parties, I twisted my ankle and had to go a month with crutches.

GP: This wasn't in the last year though, but a long time ago?

P: Yes.

GP: OK. Has anyone around you, like friends, family, doctors ... at any time made any remark that you should drink less, or that they worried about how much you drink? [AUDIT 10]

P: Yes, a few months ago my husband told me I had to try to drink less.

GP: Fine. Later we'll discuss the results. If it's ok with you, I'd like to look into another of the factors that may be associated with migraine, your mood. Do you think that we could continue with a few more questions?

P: Yes, sure.

GP: Has it happened to you lately that you've felt a lack of interest or experienced little pleasure doing things? [PHQ1]

P: Yes, for the last half a year or so, this happens to me every day, I find it difficult go to work, to accompany the girls for activities, to have fun with friends...

GP: Would you say that over this time you've felt down, depressed, with little hope? [PHQ2]

P: Not every day, but, some days I find I feel like that. The first part of the week especially is harder.

GP: Alright. Say 3 days a week. And any trouble getting to sleep or sleeping too much? How often does that happen? [PHQ3]

P: I have trouble falling asleep almost every day.

GP: Almost every day. Feeling like you have little energy, very tired, is that something that happens too? [PHQ4]

P: Say, the first half of the week, Monday through Wednesday I notice I don't have energy.

GP: So half the working week, is what you're saying. And feelings of having an irregular appetite, like having a poor appetite or overeating at times, does this happen? [PHQ5]

P: Yes, at the weekend I feel very anxious when I eat.

GP: Okay, just the weekend. So it happens less than half the days of the week. Do you ever feel bad about yourself, feelings of failure, that you are not good to yourself or your family? [PHQ6]

P: Yes, that happens to me at the beginning of the week, it's like very hard, very strong, not much point in anything - work, family ... I find it hard.

GP: OK. And lately have you had had difficulty concentrating on certain activities, like reading the newspaper or watching television? [PHQ 7]

P: No, that's no problem for me

GP: Good. Do you ever have the feeling that you are moving slowly, or that you are very fidgety, very restless? [PHQ8]

P: Yes, from Sunday night, knowing I have to go to work on Monday and the first part of the week I feel very anxious, very nervous.

GP: Half of the week is spent like that. One last question, have you at any point thought that would be better off if you were dead or if you disappeared? [PHQ9]

P: No, never.

GP: Very good. All these things you've told me about, to what extent do they hinder your daily life, insomnia, fatigue, sadness ... do make life more difficult, and work?

P: Quite a bit, the house and work feel pretty tough to me, and the girls too.

GP: It makes it very difficult to keep going.

P: Quite a lot.

GP: Paola thank you very much for answering the questions to find out what could be causing the tension. Do you think I could mention a little about what we can find out from this information and we could do?

GP: Yes, I would like to know what you think after these questions.

2b: BRIEF INTERVENTION

P: Why don't we work backwards; the answers you're giving about your mood inform us that you have some major depressive symptoms that may partly be causing your headaches. So, sometimes these depressive symptoms can be treated pharmacologically but often they can also be improved by taking a series of measures that help your mood gradually get better. Do you think that I could tell you about some of the things we could do?

GP: Yes, sure.

P: In your case, it looks like you have a mild depression, and, in these cases some changes in lifestyle, such as spending time doing activities that you enjoy, sports or physical activity, getting out and seeing people who

you like, eating and sleeping at regular hours, eating healthy food… these things can help. [Key intervention point 1: personalised feedback]

I'll give you this leaflet with more information.

I suggest that, in the next four weeks, you try several of the self-help measures that are described in there. Please pay attention on how they influence your mood [Point 2: self-vigilance – watch for changes] . If, later on, you feel worse or like it's not improving, we can have a look at other options like medication or psychotherapy; these are usually for moderate to serious cases of depression. The leaflet also has telephone numbers where you can get more information or help. [Point 3: Signposting – support and services] If you feel worse than before, or if you notice thoughts of self-harm, or a feeling that life is not worth living, don't hesitate to call there; there is a 24-hour service and people can help you [Point 2: self-vigilance – watch for changes in mood and suicide risk and seek help if necessary]

P: Well, I already do many of the things you've mentioned. It is true that I used to go swimming and I have stopped doing that, and I also really liked gardening and also gave up doing that. And those are things that could take up again.

GP: What you're saying all sounds good: swimming, gardening. [Key point 4: Agree on individual goals, exploring different options]

The last point that I made before was to you need to take care of your brain, avoid taking substances that are depressants. I'd like to emphasize this a little more. Do you remember we started talking about your drinking?

P: Yes, what about that.

GP: I think it's important to recognize that the amounts you drink regularly, although they may appear normal to you, are well above what your body can deal with on a regular basis, and therefore it is very likely that the alcohol you are drinking is having a negative impact on your mood, and also causing these tensions and headaches that have brought you here. I do not know if what I'm saying comes a as surprise or if you've ever thought about that? [Key intervention points 1 + 2: personalised feedback + change normative misperception]

P: Well, since I feel a bit down I've been drinking a bit more. I control what I drink, but it is true that previously I only drank at lunch-time, and now I drink with lunch and dinner; it helps me sleep. What you're saying doesn't surprise me, but I don't think that the situation is too serious.

GP: You're right that the situation is not too serious, but if we want to improve your headaches and your mood would be a great help if we made a drastic reduction in the amount of alcohol you drink. Do you think you might consider doing this? Do you think it might be worth a try? [Key point 3: Harm reduction]

P: What do you mean by drastic?

GP: Well, at the moment, we'd estimate you are drinking around four or five standard drinks every day, which is about 40 grams of alcohol, and, to avoid affecting your brain, we should reduce it to one standard drink a day at the most, one beer a day. That would be a good goal… and it would also be a good thing to avoid those occasional times when you drink a good deal more and it makes it difficult to lead the life you want to lead. How does that sound?

P: Well, to avoid drinking so much the weekends doesn't sound so difficult, because it doesn't happen so often and anyway, if I start gardening and swimming again, with all the girls' activities too, it should be easy. I think I'd find it a bit more difficult to cut right down from 4 or 5 glasses all in one go.

GP: What do you think would be feasible? [Key point 4: Agree on individual goals, exploring different options]

P: Maybe I could get back the situation before where only drank with lunch and not drink with dinner. Just have two beers at lunch, I could try that.

GP: How about if you do what we've discussed to improve your mood, and limit alcohol to two drinks with the midday meal? If you agree, what would be good is if you could note down in this booklet I'll give you if you actually manage to stick to two glasses or drink more and could check how your headaches and mood are ... in about a month. How does that sound to you? [Key point 5: Assist in the change]

P: Perfect, so we'll meet again in a month.

GP: Yes. Paola, if you agree, for the moment I won't prescribe any treatment for your migraines, and we can see if these changes alone make it better, meaning you do not need to take any medication. When you want to you can make an appointment and we'll talk again..

P: Ok.

GP: Thanks Paola, see you again soon.

Video script 3 – Ana-Maria: alcohol +, depression + (both severe)

VIDEO 3: REFERRAL

Voice-over: *Ana-Maria is a 40-year-old woman who attends a Wednesday afternoon visit with her family doctor, who she has known a couple of years ago. She has a set of common health problems (colds, conjunctivitis), but what bothers her most is that she has trouble sleeping and lower back pain. The doctor has not detected signs of alarm or organic causes, but the score from asking the screening questions was worrying (26 in the AUDIT and 16 in the PHQ-9), and referral to a specialist clinic was therefore advisable.*

M: Ana-Maria, thank you very much for answering so many questions, I know this is a bit cumbersome but it also allows us to understand your situation a little better. Is it ok if I sum up a bit about how I see the situation?

A: Yes, you've got me a bit worried with these questions.

M: I understand it's a bit surprising when you come in for a back pain problem and end up being asked about your mood, your drinking. [show empathy]

But this is important so I'd like to explain a little. First, the check-up we've done and these questions have made it clear to me that the pain is connected to being tense or stressed and therefore we explored the most common factors that can cause stress. In your case, it seems that you are suffering from a lot of stress; you have an underlying depression that comes out as tension that causes back pain and difficulty sleeping. On the other hand, another contributing factor to this depression could be the amount of alcohol you're drinking. Even if you are used to drinking a lot and have a high tolerance, these are significant amounts; Alcohol is a central nervous system depressant and contributes to you having more stress, lower defences and pain in the body. What do you think about what I'm saying? [Personalised feedback+ adjust normative misperception]

A: You're saying I drink too much and that stress and drinking too much is causing me back pain.

M: Yes, it's a bad combination, drinking when you're sad, or stressed, just makes things worse. I understand that you're having a hard time, that you're overwhelmed. [show empathy]

I would like you to be able solve these problems. [promote autonomy]

To really sort this out I think the best thing would be to make you an appointment to go to a specialized centre to help you turn this situation around and overcome these difficulties. [Assist in the change]

A: What do you mean by a specialized centre?

M: Well, we have specialists in dealing with problems to do with mood, in excessive drinking, who you can see, and who will listen and give you the most suitable treatment, the most appropriate advice. To make changes in these things, willpower is essential, but with specialist guidance and advice the probability of success is much greater. Of course I will stay in the loop, I'd like you to tell me how you get on, but what you're going through goes a bit beyond what I can help with here. I would like you to give it a go with these other doctors who I'm sure will be able to help you to make headway.

A: Well, I'm not so sure, but you've known me for years so if you recommend it, I'll give it a go.

M: Thank you very much for trusting my opinion, and now I'll sort you out a first appointment, and once you've had that, you can come one day and tell me how it goes.

A: Alright.

M: Thank you very much.

- **Annex 6 – Role-play cards**

The role-play cards are designed to allow training participants to act the role of a patient with a particular condition (alcohol problem, alcohol + co-morbid depression, patient requiring referral), so that the other can practice screening.

The cases are designed to challenge stereotypical ideas of the type of people who have alcohol problems, to reduce the preconceptions and, hopefully, the stigma these patients face.

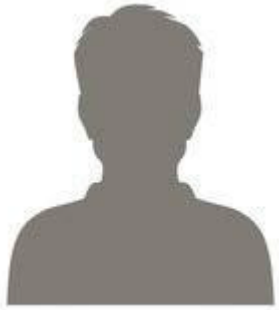
Print out as many as are needed for each pair to have one card (for the patient); mix them up and move all cards round one pair when they swap.

Patient 1: Marcela

- You are a 32-year-old woman married with Miguel (34 years old). You have two children (8 and 3 years old). You work in a call centre 10 hours a day, six day a week. Your husband is unemployed.
- This appointment with the GP is because you have recurrent headaches.
- You also feel stressed, sad, worried and tired.
- Since Manuel was made redundant, a year ago, you've progressively increased your alcohol intake. You drink two glasses of beer during lunch and two glasses during dinner. Each Saturday night, you drink around eight beers.
- On Saturday nights, you feel out of control with regards to your alcohol consumption. Other days you feel that you have your drinking under control. You waste Sunday morning doing nothing productive because of having a hangover and you often aren't able to keep your engagements with your husband and children (e.g. sport with children). Fortunately, you don't drink first thing in the morning and you don't have any memory problems when drinking, but you feel guilty after every Saturday binge drinking episode. Two years ago, after a birthday party you twisted your ankle under the effects of alcohol.
- Your husband is very concerned about your drinking behaviour and the state of your mood.
- During the last three months, you you've felt down and without interest about the children or leisure activities more than half the days. You don't do any leisure activity at the moment, either alone or with your husband.
- You feel you can't get to sleep without a beer on week days. You feel restless, don't have much energy, feel bad about yourself, trouble concentrating on things and without appetite from Sunday night until Friday morning. Fortunately, you don't have thoughts that you would be better off dead or of hurting yourself in some way.
- You have known your general practitioner for a long time and you feel very comfortable with him/her. You really appreciate his/her opinion, even though you don't like the idea of being referred to a specialized centre.

Alcohol + , Depression +, BI + referral

Patient 2: José Eleuterio



- You're 54-year-old man who is married with Anita (52 years old). You've three children, Marcos (30 years old, businessman, lives with his partner and their baby not far from you in the city), Laura (25 years old, university student, lives alone in the same city) and Pablo (15 years old, at school, living with you and Anita). You work in housing construction as the foreman. Your wife works as a homemaker.
- This appointment is because you have back pain since last week.
- You feel happy with your family and work, and spend every Saturday afternoon with your friend playing your favorite sport: soccer.
- In the last three years, since Laura and Marcos left home, you spend more time out and after work you drink four beers and a whisky shot with your colleagues. Saturday afternoon, you drink eight beers after football match.
- Saturday night, you feel out of control regarding alcohol. Other days you feel that you have your alcohol consumption under control. You are not able to keep your engagements (e.g. with your wife or 15-year-old son)or to be productive on Sundays because of having a hangover. However, you never drink first thing (before breakfast) and you don't experience any memory problems, but you feel guilty after every binge drinking episode. You never have accidents and nobody has ever been injured because of your drinking behavior. However, Anita has mentioned several times that you should try to drink less.

Alcohol + , Depression -, BI without referral

Patient 3: Marta

- You're a 28-year-old woman and single. You have a part-time job you love in a book shop (4 hours per day, four days per week). You have a very bad relationship with your parents and you've recently broken up with your long-term boyfriend (Tony) because he was having an affair.
- This appointment with the GP is because you have stomach ache.
- You feel alone, sad and angry.
- One year ago, you noticed the first signs that somewhat was going wrong in your relationship. Since then, after work you spend two or three hours drinking beers with your best friend (Amanda). Every evening, you drink four beers. On Friday night, you go out to a Club and drink four strong mojitos. Sometimes you go out drinking on Saturday night too.
- On Fridays/some Saturday nights, you feel out of control regarding alcohol. On week days you feel that you have your alcohol consumption under control. You often skip meeting up with friends (e.g. to go shopping or visit an exhibition), especially on Sundays because of having a hangover or not feeling able to face people. You feel guilty after every binge drinking episode, but hardly ever drink in the mornings to recover or cannot remember events of the drinking nights. Two years ago, on a night out, you were drunk and you hit your best friend because you thought she was flirting with your boyfriend.
- Amanda has told you that she doesn't want to go out with you if you don't drink less.
- During the last three months, you feel down and without interest in your work or in art (which has been your passion up till recently). You don't read books anymore.
- You can't sleep without a drink, except for Sunday and Monday. You feel restless, with low energy, bad about yourself, trouble concentrating things and without appetite from Sunday night until Friday morning. Fortunately, you don't have thoughts that you would be better off dead or of hurting yourself in some way.
- This is the first appointment with your new general practitioner and you have very good references. However, you want to know him/her better before accepting any referral to specialist or similar recommendation.

Alcohol + , Depression +, BI + referral recommended but may not be accepted

- **Annex 7 – Change-talk**

WHO Handout 7.1A. Evoking change talk using open questions – basic

Basic level: questions for change talk

<table>
<tr><td>Desire
✔ How would you like things to change?
✔ What do you hope you can change?
✔ Tell me what you do not like about how things are now.
✔ What would you like to be different?</td><td>Reasons
✔ What concerns you?
✔ Why would you want to cut down?
✔ What might be the benefits of drinking less?
✔ What are the reasons to change as you see them?</td></tr>
<tr><td>Looking forward
✔ How would you like your life to be in a year?
✔ What do you hope for over the next five years?
✔ In what way do you want to feel better?</td><td>Looking back
✔ Can you remember a time before you were drinking like you've described? What was different?
✔ How did you cope before?</td></tr>
<tr><td>Querying extremes: no change
✔ What most concerns you about your drinking in the long run?</td><td>Querying extremes: change
✔ If you cut down today, how would you hope to feel different?</td></tr>
<tr><td colspan="2">Whenever you hear change talk, you can ask open questions that encourage elaboration.
✔ In what way?
✔ Tell me more?
✔ What else?</td></tr>
<tr><td colspan="2">Avoid questions that will lead to sustain talk.
X Why do you drink in the way you've described?
X What's stopping you from cutting down?
X What worries you about drinking less?</td></tr>
</table>

- **Annex 8 – Tailoring questionnaire for barriers and facilitators for booster sessions**

The questions in this draft questionnaire to detect barriers and facilitators for booster sessions are guided by the SCALA intervention and training package, and the structure of Barrier Analysis (BA) questionnaires: https://www.fsnnetwork.org/barrier-analysis-questionnaires-0

This online questionnaire should be configured so that the responses are sent to the professional by e-mail once completed, with the recommendation that they can print it out for discussion at the forthcoming booster session.

Check there is not excessive overlap with process/evaluation questionnaires.

Question	Response field
1. Full Name	[free text]
2. Position / Health provider role	Nurse / GP / Psychologist
3. Have you carried out ***screening*** **for alcohol problems** since the SCALA programme started?	Yes/No
a. What aspects of screening for alcohol problems would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make screening for alcohol easier? (please identify personal, social or structural facilitators)	[free text]
4. Have you carried out ***screening*** **for co-morbid depression** since the SCALA programme started?	Yes/No
a. What aspects of screening for depression would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make screening for depression easier? (please identify personal, social or structural facilitators)	[free text]
5. Have you given ***brief advice*** **for alcohol problems** since the SCALA programme started?	Yes/No
a. What aspects of giving brief advice for alcohol problems would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make giving brief advice for alcohol problems easier? (please identify personal, social or structural facilitators)	[free text]
6. Have you given ***brief advice*** **for co-morbid depression** since the SCALA programme started?	Yes/No

a. What aspects of giving brief advice for depression would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make giving brief advice for depression easier? (please identify personal, social or structural facilitators)	[free text]
7. Have you **referred a patient to alcohol, depression or suicide prevention services** since the SCALA programme started?	[tick boxes] Alcohol / depression / suicide prevention services / none
a. What aspects of referral for alcohol, depression or suicide prevention would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make referral for alcohol, depression or suicide prevention easier? (please identify personal, social or structural facilitators)	[free text]
8. Have you **treated a patient for alcohol, depression or suicide prevention** where referral was not possible since the SCALA programme started?	[tick boxes] Alcohol / depression / suicide prevention services / none
a. What aspects of treatment without referral for alcohol, depression or suicide prevention would/do you find difficult? (please identify personal, social or structural barriers)	[free text]
b. What reasons, tools or support (would) make treatment without referral for alcohol, depression or suicide prevention easier? (please identify personal, social or structural facilitators)	[free text]

THANK YOU FOR YOUR VALUABLE INPUT!

Your responses will help us shape the training and support given in the next booster session (DATE) to overcome the barriers you have identified.

- **Annex 9 – step-by-step peer-led trouble shooting**

Although trainers may wish to adopt their own methods for the booster sessions, we provide here an example (based on experience of such a session for community participation initiatives in PHC) with detailed instructions of how a 45 minute peer-led trouble-shooting session might be carried out for a group of 30 participants.

Step	Method	Time
1. Introduce the activity	Ask professionals to reflect individually for 1 minute on what they have found difficult in carrying out the SCALA SBI techniques with real patients (they can jot these down to remember them) – remind them that they have been asked about this also in the barriers and facilitators online questionnaire.	1 min
2. Define main difficulty	Ask professionals to now pick the main difficulty or barrier that they experience, and write a short description of it (1-2 sentences). To add humour (always good for the atmosphere), you could ask them to give the problem a film title to characterize it (e.g. 'Lost in translation' to describe a difficulty in explaining clearly the system of standard drinks). If some have more than one problem, this is ok – ask them to write 2 brief descriptions/titles.	2 mins
3. Discuss main difficulty in small groups	Put professionals into mixed groups of 5-6 Each should present and explain their main difficulties (1 minute each explanation + 1 minute for immediate peer feedback) The group then has 5 minutes to decide on the most frequently occurring or tricky problem to solve.	18 mins
4. Vote on problem to discuss	Each group should present their most tricky problem to the whole group (1 min each), while the trainer notes the title and 2-word description on a board as a memory aid (use words the group have said) The whole group then votes on the problem they would most like to see addressed in the session (you can do this simply by showing hands or by giving all stickers to vote – which takes longer)	8 mins
5. Define and understand the problem	Ask the person who proposed the problem to describe the difficult situation in a little more detail and allow a few questions from members of the whole group to clarify any doubts (the trainer has to time manage this to avoid unnecessary in-depth explanations – the problem should resonate with many people, so remind them that we are trying to address the general problem, not specific situation)	4 mins
6. Suggest and receive possible solutions	Members of the whole group can then suggest ways to avoid or work around the problem identified – instruct those making suggestions to be brief, respectful and practical/constructive and to base their suggestions on their own experience where possible – remind those receiving suggestions not to be defensive or try to justify why they experience the problem. The suggestions are aimed to help ALL in the group.	10 mins
7. Summarise	Summarise the main suggestions made and ask the whole group to evaluate their usefulness. Take 1-2 other comments on this specific problem at this point, before returning to wrap up the session.	2 mins