Screening and Intervention

for Alcohol Use and Depression

A Guide for Health Care Professionals

OTHER LOGOS

SCALA

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

OTHER LOGOS

Contents

Introduction

Care Pathway

Alcohol Screening

Alcohol Brief Advice

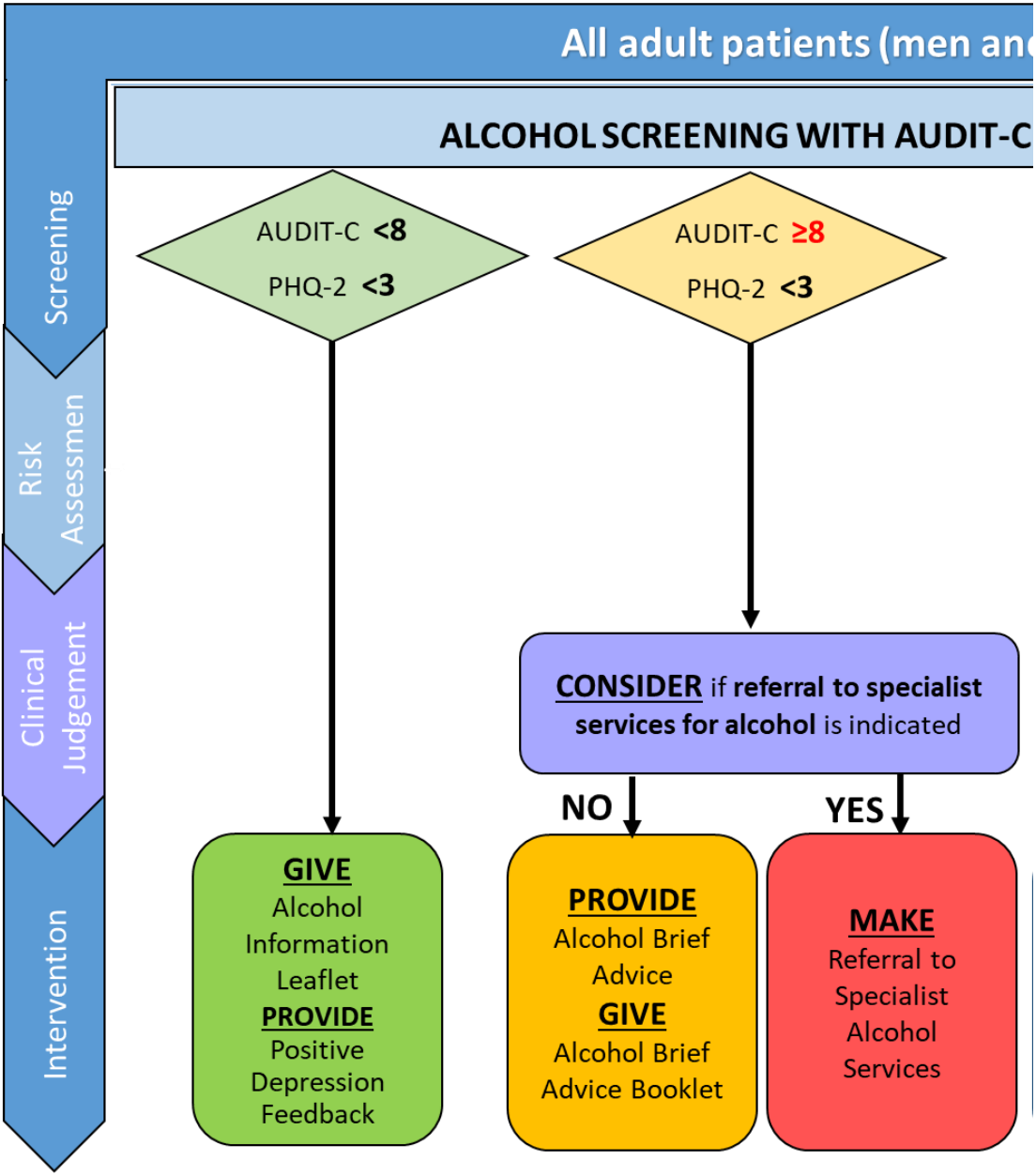
Depression Screening

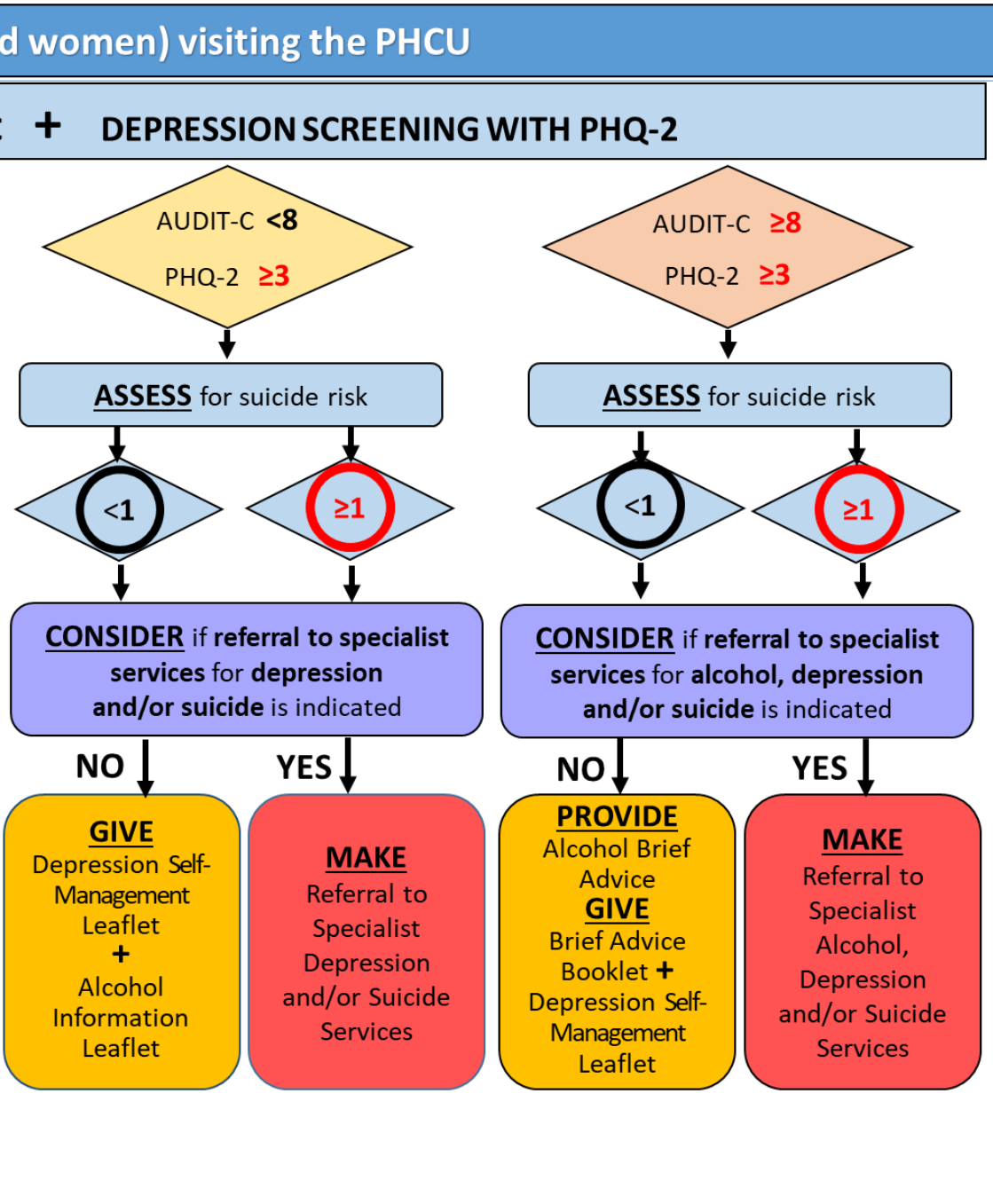
Referral to Specialist Services

Introduction

- Alcohol is a causal factor in over 60 different medical conditions, including cancer and cardiovascular disease.
- The World Health Organization (WHO) estimates that heavy alcohol use causes over three million deaths per year worldwide.
- Depression affects 1 in 5 people, is a leading cause of disability and a major contributor to the global disease burden.
- Risky alcohol consumption and depression often co-occur and can exacerbate one another.
- Increased numbers of patients are also at risk of depression as a result of the social and economic disruption caused by the COVID-19 pandemic.
- By identifying people who are drinking at increasing risk levels and/or are suffering from depression, the primary care provider can offer advice, support and referrals so that patients can reduce their risk of harm.
- Screening and brief intervention takes just a few minutes but can play an important role in harm reduction.
- This booklet will lead you step by step through the screening, identification, intervention and referral process. In combination with the training programme it will enable you to provide effective and appropriate screening and brief intervention.

Section 1
Care Pathway




d women) visiting the PHCU
+ DEPRESSION SCREENING WITH PHQ-2
AUDIT-C <8
PHQ-2 ≥3
AUDIT-C ≥8
PHQ-2 ≥3
ASSESS for suicide risk
ASSESS for suicide risk
<1
≥1
<1
≥1
CONSIDER if referral to specialist services for depression and/or suicide is indicated
CONSIDER if referral to specialist services for alcohol, depression and/or suicide is indicated
NO
YES
NO
YES
GIVE Depression Self-Management Leaflet + Alcohol Information Leaflet
MAKE Referral to Specialist Depression and/or Suicide Services
PROVIDE Alcohol Brief Advice
GIVE Brief Advice Booklet + Depression Self-Management Leaflet
MAKE Referral to Specialist Alcohol, Depression and/or Suicide Services

Section 2

Alcohol Screening

Introduction

The most effective way to identify patients who can benefit from brief advice or referral to specialist services is to employ a validated screening tool. We will use the three question AUDIT C.
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.

To complete the alcohol screening accurately you will need to know what a standard drink is and be ready to calculate the number of standard drinks each patient consumes.

What is a Standard Drink?

When we use the word 'drink' we mean a standard drink.
A standard drink contains approximately 12 grams of pure alcohol.

1 Standard Drink:	30ml Shot of Spirits (40%) (e.g. Rum, Whisky)	30ml Glass of Aguardiente (32%) 	30ml Glass of Spirits (40%)(e.g. Rum, Whisky) 	125ml Glass of Wine (12%) 	330 ml Can of Beer (4.7%) 	250ml Bottle of Beer (5.2%) 
2 Standard Drinks:	60ml Spirits (40%) (e.g. Rum, Whisky) 	60ml Glass of Aguardiente (32%) 	Mixed Drink containing 60ml spirits (40%) (e.g. Rum, Whisky) 	Cocktail 		

Alcohol Screening

AUDIT C						
Thinking about your drinking over the past year:	Scoring system					score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Scoring:…….						**Total**

Screening

Step 1 Introduce the Topic of Alcohol Use

EXPLAIN that you would like to take a few minutes to talk about alcohol use and **ASK** if this is ok.

Step 2 Start the AUDIT-C Screen

Establish if the patient drinks alcohol by asking
the first question of the AUDIT-C “How often do you have a drink that contains alcohol?”

Does the Patient Drink Alcohol?

YES: Continue to Step 3

NO: Provide positive feedback on non-drinking status, a copy of the patient leaflet for information and screen the patient for depression using the PHQ-2 (see **Section 4**).

Alcohol Screening

There is no completely safe level of alcohol use so avoiding alcohol entirely is the best thing you can do for your health. I would like to give you this leaflet about alcohol use just for information.

Step 3 Continue AUDIT-C Screen

Complete questions 2 and 3 of the AUDIT–C to identify how much alcohol the patient drinks and how often they have six or more standard drinks in one day.

Step 4 Does the Patient Score 8 or more?

YES: Provide brief advice for alcohol use (see **Section 3**) **AND** screen for depression (see **Section 4**)

NO: Provide positive feedback on low-risk drinking status (**below**), the patient information leaflet **AND** screen for depression (see **Section 4**):

There is no completely safe level of alcohol but your screening score suggests you are drinking in a way that is less likely to result in harm to yourself or others. However, it is important to keep track of your drinking to make sure it does not gradually increase. I'd like to give you this leaflet which contains some information about alcohol use and the low risk drinking limits.

NOTE: If you are concerned that the patient may be alcohol dependent or may need further help and support related to their drinking you should consider referral to specialist alcohol support services. More information about this can be found in **Section 5** of this booklet.

Section 3

Alcohol Brief Advice

Introduction

The Brief Advice Booklet contains information that patients may find helpful. It is likely that you will only have a minute or two to talk with each patient so you will not be able to go through all of this information.

This section will help you provide useful advice in a short amount of time.

In the time available you should:

- Give the patient a copy of the brief advice leaflet
- Explain that their screening score shows that they are at risk of experiencing harm from their drinking
- Point out that the best way to reduce the risk of harm is to cut down how much they are drinking.

The patient can then read the leaflet in their own time.

In order to provide helpful feedback and advice to patients it is useful for you to understand what we mean by lower risk drinking.

While there is no completely safe level of alcohol consumption, patients can lower their chances of experiencing harm by following lower risk drinking guidelines.

Lower Risk Drinking

- Do not have more than 2 standard drinks in one day
- Even on **special occasions** you should **never** have more than 4 standard drinks.
- Never drink alcohol when you:
  - Are pregnant or breast feeding
  - Drive
  - Are sad, tired or stressed
  - Are taking medication
  - Operate machinery
  - Have a history of drug or alcohol dependence

Alcohol Brief Advice

Patients who score 8 or more on the AUDIT C questionnaire should be given face to face advice about alcohol consumption, including a recommendation that they reduce the amount they are drinking, and a copy of the patient brief advice Patient booklet. Patient who score less than 8 should be given positive feedback about their lower risk drinking and a copy of the patient alcohol leaflet.

Step 1 Provide Feedback on Screening Score

Thank you for answering those questions. From your answers it appears that you are drinking in a way that could cause harm to yourself or others in the future. As such it would be advisable to think about cutting down.

TOP TIP:

Studies show tailored feedback on screening score is a key aspect of effective brief advice.

Step 2 Assign Responsibility

It is up to you whether you want to change your drinking but I would like to take a minute to talk about alcohol use so that you have the information to make the best choice for you.

Step 3 Explain High Risk Times

It's important to know that there is no completely safe level of drinking. There are times when you should not drink at all. For example if you are you should never drink before driving as there is more chance of being in a crash or collision.

Alcohol Brief Advice

TOP TIP:

For women of child bearing age you should also say “avoid drinking when pregnant or trying to get pregnant”

Step 4 Explain Other Risks

Any amount of drinking also increases your risk of health conditions such as cancer, liver disease and stroke and your chances of accidental injury. And drinking too much can affect your mood and mental health as well as your wider life.

TOP TIP:

If the patient has a health condition that may be linked to alcohol use be sure to mention it here.

Step 5 Explain Low Risk Drinking

If you do choose to drink you can lower the risk to yourself and others by limiting how much you drink. Firstly, you should not have more than 2 standard drinks on one day; Secondly, even on special occasions you should never have more than 4 standard drinks on one day.

Step 6 Introduce the Leaflet & Answer any Questions

I’d like to give you this leaflet which contains some information about the benefits of reducing your alcohol intake, how much alcohol is in different drinks and how to cut down if you want to.
How does that sound to you?
Do you have any questions?

Section 4

Depression Screening

Introduction

Depression is a common mental disorder, characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks.

Depression and alcohol consumption often co-occur and can exacerbate one another. Increased numbers of patients are also at risk of depression as a result of the social and economic disruption caused by the COVID-19 pandemic.

As with alcohol use, it is important to employ valid and reliable screening tools. We will use the two item PHQ -2 which you can find on the next page.

Step 1 Introduce the Topic of Depression

EXPLAIN you would like to take a few minutes to talk about depression. For patients scoring ≥8 on AUDIT-C, you could also explain that alcohol use and depression often co-occur. **ASK** if this is ok.

Step 2 Start the PHQ -2 Screen

Ask the patient the two PHQ–2 questions. Add up and assess their score as this will let you know what to do next.

Step 3 Assess the PHQ-2 Score

Does the Patient Score 3 or more?

NO: Provide positive feedback about current depression status.

Your score indicates that you do not have any signs of depression. However, it is worth knowing that depression is characterized by feelings of sadness, loss of interest in activities, and decreased energy. If in the future you feel this way for 2 weeks or more, you should get help from a health worker and should avoid alcohol.

Depression Screening

YES: Assess suicide risk **ASK** 'Over the last two weeks how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?'

Score 1 or less: Give the patient a copy of the depression leaflet:

> Your score indicates that you may have some symptoms of depression. Therefore I would like to give you this leaflet which contains some information about depression, some techniques that can help to improve mood and what to do if your symptoms worsen in the future.

Score 2: Consider if monitoring is indicated. If not give depression leaflet

Score 3 or more: Consider if referral or monitoring is indicated (see **Section 5**). If not give depression leaflet.

NOTE: If you are concerned that the patient may need further help and support related to their depression or may be at risk of suicide you should consider referral to specialist depression services. More information about this can be found in **Section 5** of this booklet.

PHQ 2

Over the last two weeks, how often have you been bothered by any of the following problems:	Scoring system				score
	0	1	2	3	
Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day	
Feeling down, depressed, or hopeless?	Not at all	Several Days	More than half the days	Nearly every day	
					Total

Section 5

Referrals

Sometimes patients may need more help or support than you can offer or they may need specialist treatment. In these cases the patient should be referred to specialist services. This section provides some information about when and how to make a referral but you should be guided by your clinical judgement.

Alcohol Use

You may want to consider referral for those patients who:

- Show signs of moderate or severe alcohol dependence
- Have not benefited from previous brief advice and wish to receive further help for an alcohol use problem
- Have a co-morbid condition such as liver disease or mental health problems related to alcohol use

REMEMBER: you should always use your clinical judgement to consider whether making a referral to specialist alcohol treatment services is appropriate. You may wish to provide these patients with the alcohol brief advice booklet to refer to whilst they wait to receive more specialist support.

INSERT DETAILS OF HOW TO REFER PATIENTS TO SPECIALIST ALCOHOL SUPPORT SERVICES

Referrals

Depression

You may want to consider making a referral for those patients who:

- Present a serious or considerable risk to themselves or others
- Have persistent depression which has not responded to treatment

REMEMBER: You should always use your clinical judgement to consider whether making a referral to specialist depression treatment services is appropriate. You may wish to provide these patients with the depression leaflet to refer to whilst they wait to receive more specialist support.

INSERT DETAILS OF HOW TO REFER PATIENTS TO SPECIALIST DEPRESSION SUPPORT SERVICES

Referrals

Suicide

You may want to consider making a referral for those patients who:

- Present a serious or considerable risk to themselves
- Report plans or intention to commit suicide

REMEMBER: You should always use your clinical judgement to consider whether making a referral to specialist suicide prevention services is appropriate.

INSERT DETAILS OF HOW TO REFER PATIENTS TO SPECIALIST SUICIDE SUPPORT SERVICES