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

A Protocol

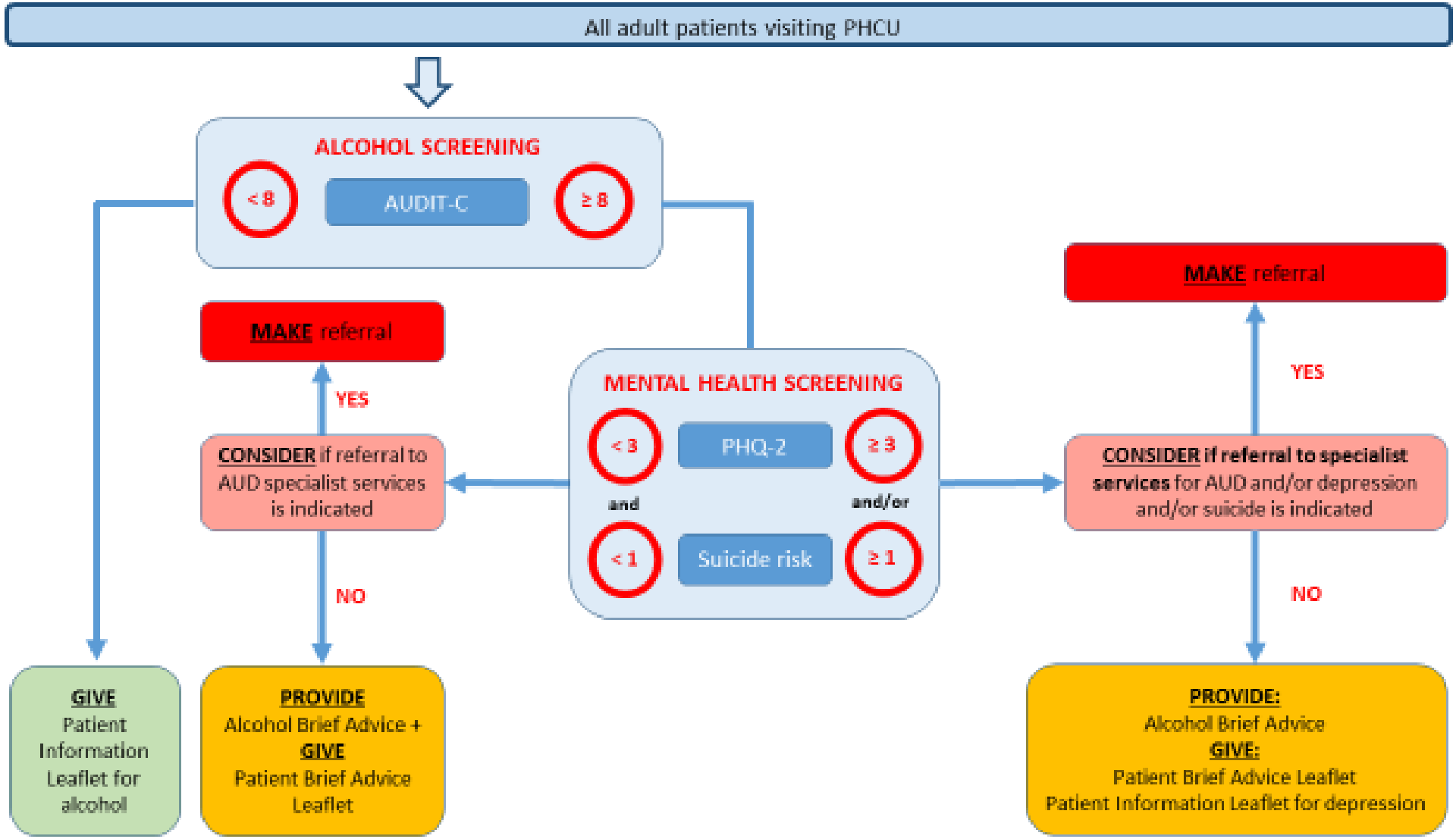
OTHER LOGOS

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 be provided with a few minutes of verbal brief advice and should be given the patient brief advice booklet to take away with them and should also be screened for depression using the PHQ 2.

If you are concerned that the patient may be alcohol dependent or may need further help and support related to their drinking you should use your clinical judgement to consider if referral to specialist alcohol treatment services is appropriate.

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 be provided with a copy of the 'Self Management for Low Mood and Depression' leaflet and assessed for suicide risk.

Patients who score 0-2 need no further screening or action.

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 use your clinical judgement to consider if referral to specialist services for treatment of depression is required .

Suicide Risk Screening

Patient s who score 3 or more on the PHQ 2 should be assessed for suicide risk with the question.

‘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?’

Patients who score 0 (Response: ‘Not at all’) on this question are not likely to present a risk of suicide. No further action is required for suicide risk.

Patients who score 1 (Response: ‘Several Days’) on this question could present a low risk of suicide. As such, use your clinical judgement to consider if monitoring is required. 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. Use your clinical judgement to assess whether referral to additional treatment and support is required or if monitoring is appropriate.