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

A Protocol

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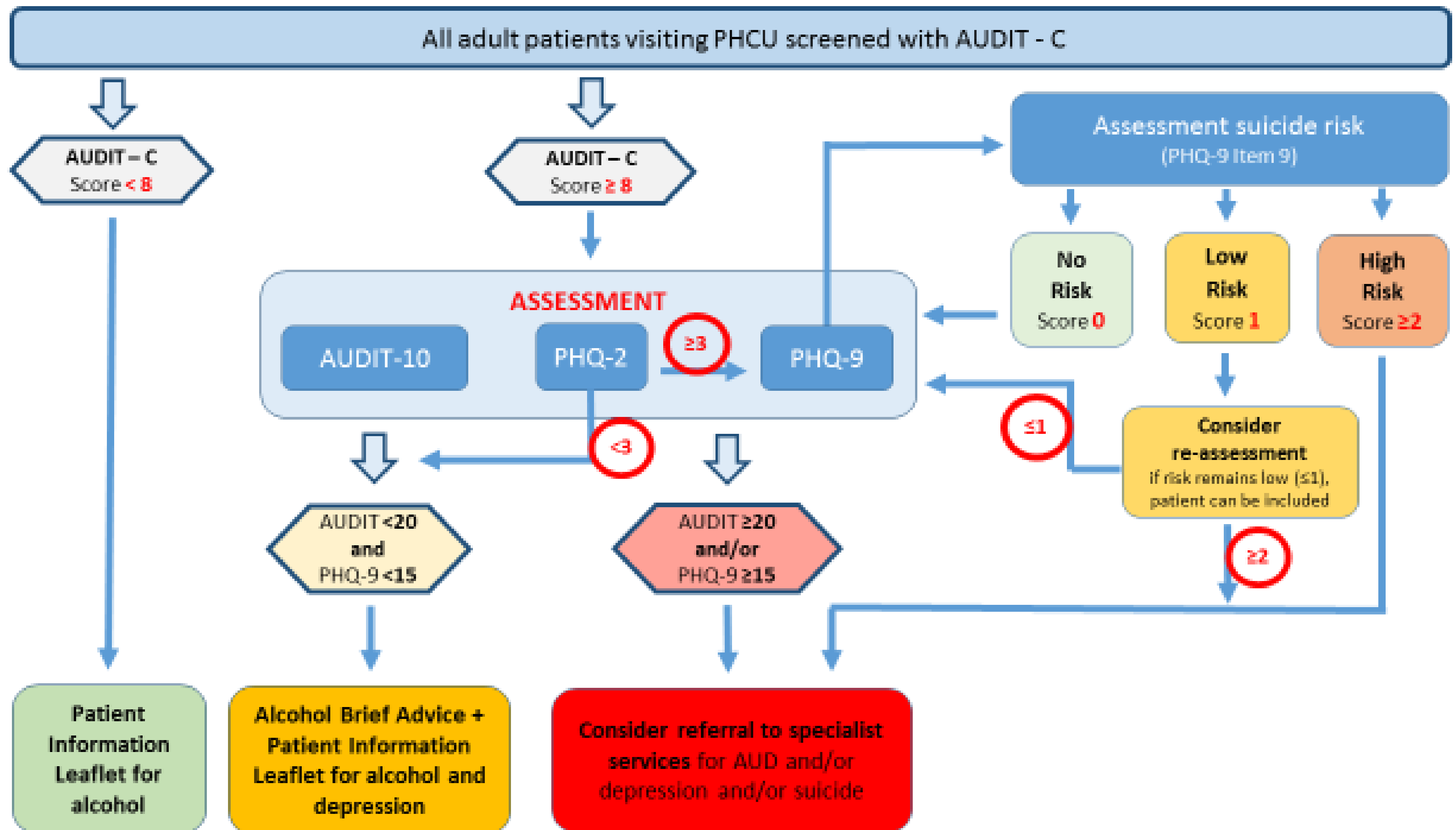
Care Pathway



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.

If you decide referral is appropriate but no suitable services are available you should follow the mhGAP guidelines.

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.

If you decide referral is appropriate but no suitable services are available you should follow the mhGAP guidelines.

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.

If you decide referral is appropriate but no suitable services are available you should follow the mhGAP guidelines.