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

Baseline Measurement Period

As part of the SCALA project (Scale-up of Prevention and Management of Alcohol use Disorders and Comorbid Depression in Latin America) we would like to know how often you currently:

- Conduct screening for alcohol use, depression or suicide
- Provide patients with any advice leaflets for alcohol use or depression
- Provide patients with any form of brief advice about alcohol
- Refer patients to specialist services for either alcohol use, depression or suicide risk.

Over the next four weeks we would like you to record how often you do any of the above activities.

To help you understand the baseline measurement process this document includes explanations of what screening, brief advice and referral means and how to record these activities.

Understanding Screening, Brief Advice and Referral

What is screening?

Screening involves asking patients about their alcohol use or depression in order to assess their level of risk. Screening uses validated 'tools' or questionnaires to generate a 'score' for each patient, this score can then be used to assess the patients level of risk and their need for help or support to reduce that risk.

There are many different alcohol and depression screening tools out there but **we are specifically interested in whether and when you use the AUDIT C or AUDIT to assess alcohol use and the PHQ2 and PHQ9 to assess depression symptoms or suicide risk.** Copies of these screening tools are included at the end of this document and are also part of the tally sheet.

What if a patient has already been screened?

It is recommended that screening for alcohol consumption is conducted once a year. If a patient has completed alcohol screening in the last year you do not need to repeat this.

I Use a Different Screening Tool, What do I do?

While many different screening tools are available we are particularly interested in when you use the AUDIT C, AUDIT, PHQ and PHQ2 and recommend that you use these for any screening you conduct. The questions from these screening tools are included in the tally sheet so you can record the scores for each patient screened.

What do you mean by 'Advice Leaflets'?

Some care providers have advice leaflets about alcohol use, depression and/or suicide risk that can be given to patients. These leaflets often include definitions of different conditions, information about how to reduce risk or improve symptoms and details of where further help and support can be accessed. We are interested in measuring when you give leaflets like this to patients.

What is Brief Advice for Alcohol Use?

Brief advice is a low cost, effective method of motivating people to change their drinking behaviour and reduce their risk of harm. It involves a short focussed conversation between the patient and health care provider about the patient's alcohol use, associated risks and often the possible benefits of reducing their alcohol intake. **When you have this kind of conversation with a patient you should record it on a tally sheet.**

What is Referral to Specialist Services?

Many communities have specialist care services available for the treatment of alcohol use disorders, depression and suicide risk. As a primary care provider you may refer patients to these services when you identify that they need additional care and support that cannot be offered as part of normal primary care. **If you refer a patient to these kind of services you should record it on a tally sheet.**

Recording What You Do

How do I record what I Do?

We have provided you with 'tally sheets' to complete when you conduct screening, give an advice leaflet, provide brief advice or make a referral for alcohol use, depression or suicide risk.

The tally sheets are very simple and do not take long to complete.

When should I complete a Tally Sheet?

You should complete 1 tally sheet for each patient even if you only do one or two of the activities on the tally sheet.

For many patients, you may not conduct any screening, provide any information leaflets or brief advice or make a referral to specialist treatment. In this case you do not need to complete a tally sheet at all.

What do I do with Completed Tally Sheets?

At the end of the four weeks, a researcher from the SCALA project team will come to your practice to collect the complete tally sheets.

What if I have Questions?

If you have any questions you can contact

[INSERT CONTACT DETAILS HERE]

AUDIT C Screening Tool

Questions		0	1	2	3	4	Score
1	**How often do you have a drink containing alcohol?**	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2	**How many standard drinks of alcohol do you drink on a typical day when you are drinking?**	1-2	3-4	5-6	7-9	10+	
3	**How often do you have 6 or more standard drinks on one occasion?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	Sum score AUDIT-C (possible range 0-12)						__ __
If AUDIT-C score ≥ 8 Apply remaining AUDIT and PHQ-2 questionnaire							

AUDIT Remaining Questions

Questions		0	1	2	3	4	Score
4	**How often during the past year have you found that you were not able to stop drinking once you had started?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5	**How often during the past year have you failed to do what was normally expected from you because of drinking?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6	**How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7	**How often during the past year have you had a feeling of guilt or remorse after drinking?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8	**How often during the past year have you been unable to remember what happened the night before because you had been drinking?**	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9	**Have you or someone else been injured as a result of your drinking?**	No		Yes, but not in the past 3 months		Yes, during the past 3 months	
10	**Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?**	No		Yes, but not in the past 3 months		Yes, during the past 3 months	
	Sum score questions 4-10 (possible range 0-28)						__ __
	Sum score full AUDIT-10 (possible range 0-40)						__ __

PHQ2 Screening Tool

Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
Sum score (possible range 0-6)			__ __	
If PHQ-2 score ≥ 3 Apply remaining PHQ questionnaire				

PHQ 9 Remaining Questions

Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Sum score questions 3-9 (possible range 0-21)			__ __	
Sum score full PHQ-9 (possible range 0-27)			__ __	