Screening and Intervention for Alcohol Use and Depression

A Guide for Health Care Professionals

OTHER LOGOS

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

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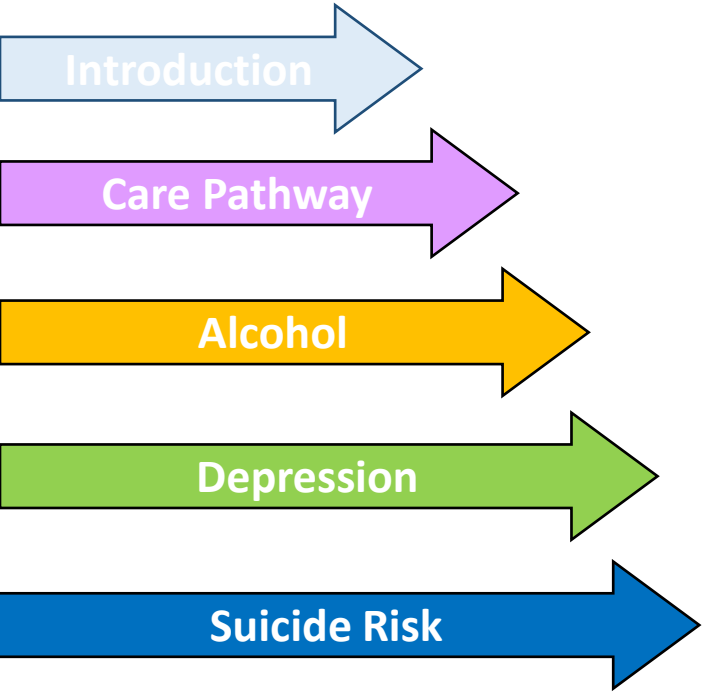
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Introduction

Why is this important?

- 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.
- As well as worsening individual health outcomes, heavy alcohol use and depression can have negative consequences for families, local communities and society as a whole. These include high economic costs through lost productivity and increased demand on health care and law enforcement services.
- By identifying people who are drinking too much and/or suffering from depression, primary care providers can offer advice, support and referrals as needed to prevent more complex or serious issues developing in future.

Introduction

What is screening and Brief Advice?

Screening and Brief Advice is an evidence based approach to identifying and addressing risky alcohol consumption. It involves the use of short, validated tools to identify individuals who may be at risk from their drinking. This is followed by a short focussed discussion, known as 'brief advice', between the patient and health care provider. Brief advice aim to be non-judgemental and support the patient's decisions whether or not they wish to change their behaviour.

Does it work?

Systematic reviews of clinical evidence have shown that screening and brief advice is effective in reducing alcohol use among those drinking at risky levels, especially when delivered in primary care.

Results show that one year after brief intervention, patients alcohol consumption had reduced by between 20 and 50 grams of alcohol per week, equivalent to around 2-5 less drinks per week. This may not seem like a lot but it can be enough to bring an individuals drinking within 'lower risk' drinking limits and even small changes at individual level can have a big impact at societal level.

What if the patient doesn't want to change?

Not all the patients that you speak to will want to change but some will. Brief advice also allows you to check patients' understanding of risks and help them to make informed decisions about their health.

It's also good to remember that motivation to change is not fixed. Sometimes what you say during brief advice won't lead to an immediate change in behaviour but may increase motivation to change making the patient more open to change at a later date.

Am I the right person to deliver this?

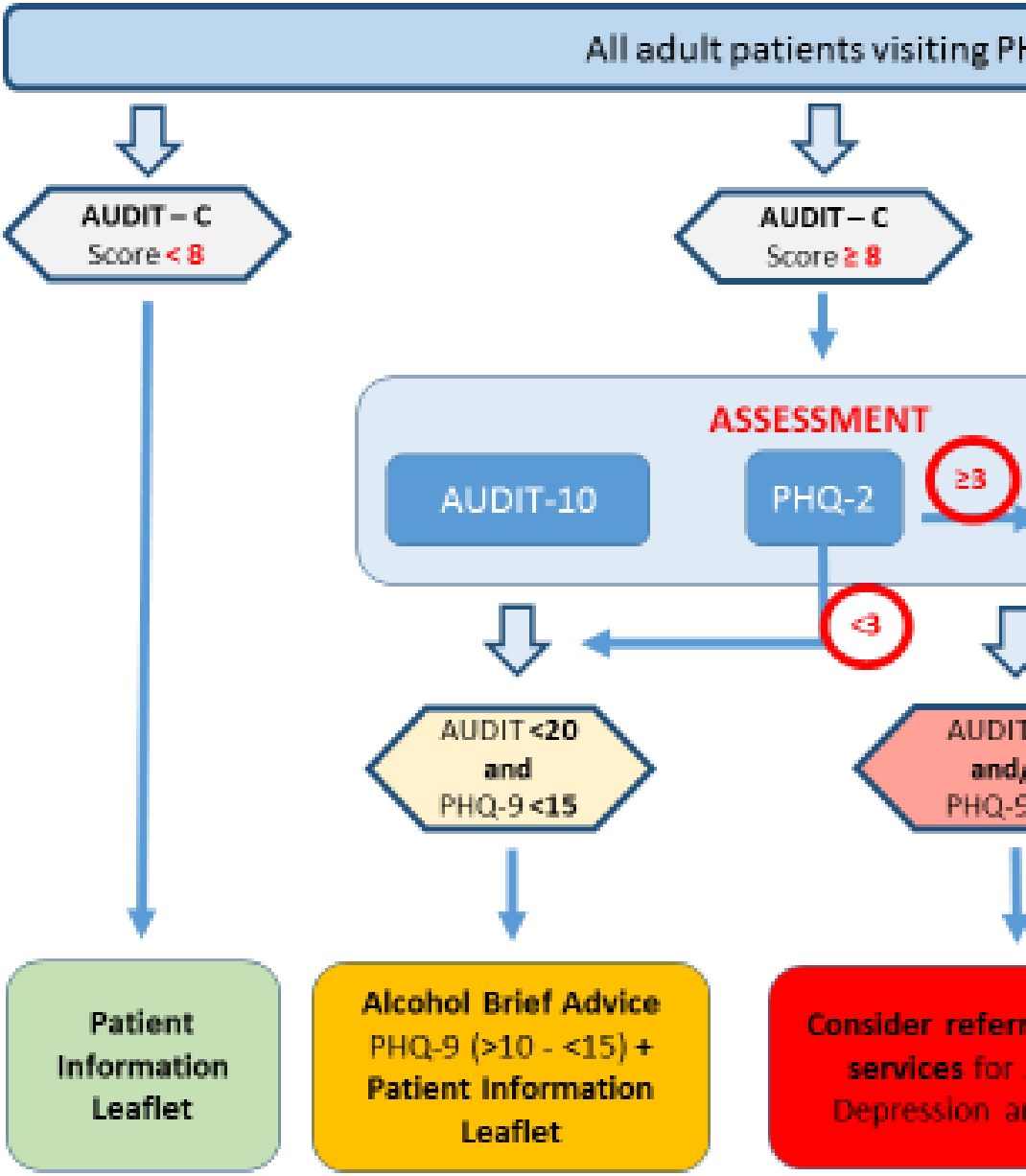
Because most people do not come into contact with specialist services but do visit their primary care provider you are well-placed to identify alcohol use and depression in your patients.

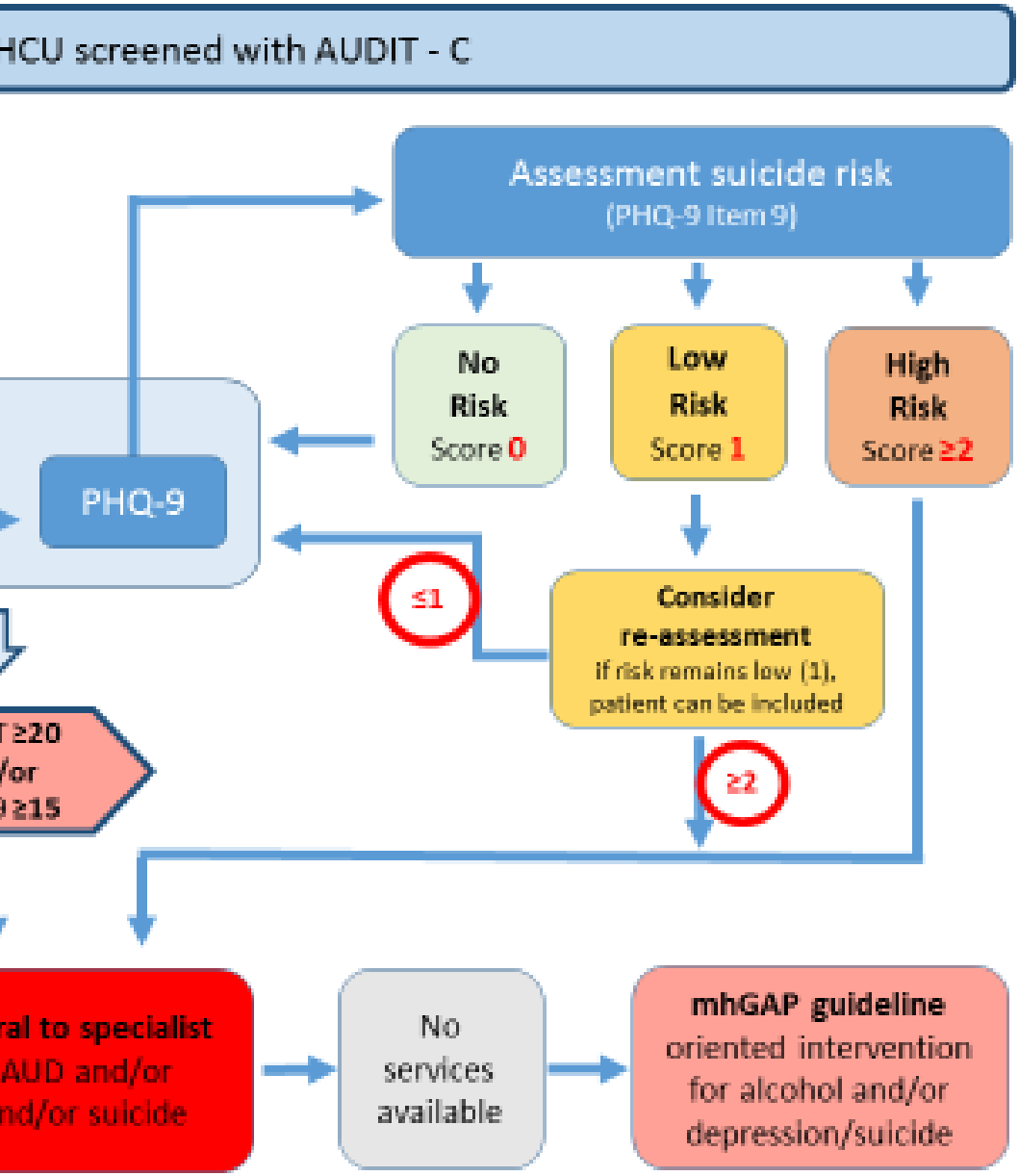
Screening and brief advice is not difficult to deliver. With the right training and support, many different healthcare professionals are able to deliver screening and brief advice effectively.

What's in this booklet?

This booklet sets out the recommended screening, advice and referral pathway for alcohol use and depression in primary care.

Care Pathway




HCU screened with AUDIT - C
Assessment suicide risk
(PHQ-9 Item 9)
No Risk Score 0
Low Risk Score 1
High Risk Score ≥2
PHQ-9
≤1
Consider re-assessment
if risk remains low (1), patient can be included
≥2
T ≥20
/or
9 ≥15
ral to specialist
AUD and/or
nd/or suicide
No services available
mhGAP guideline
oriented intervention for alcohol and/or depression/suicide

Alcohol Screening

Alcohol screening takes only a few minutes of your time. You should aim to conduct alcohol screening with all adult patients.

The AUDIT C and AUDIT 10 are validated screening tools for alcohol use.

> **Note:** If you see a patient who has already completed the 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 can be used with all patients over 18.

Does the Patient Score 8 or more?

No: Patients who score less than 8 should be given positive feedback on their lower risk drinking status.

Yes: Patients who score 8 or more should go on to complete the seven additional questions that make up the full AUDIT 10 questionnaire. These patients should also be screened for depression and suicide risk.

Alcohol Screening

AUDIT 10

Patients who score 8 or more on the AUDIT C should complete the 7 questions that make up the full AUDIT 10.

Does the Patient Score 20 or more?

NO: Provide alcohol brief advice AND screen for depression.

> **Note:** 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 more from referral to specialist services.

Yes: Use your clinical judgement to consider if referral to specialist alcohol treatment services is appropriate AND screen for depression.

> **Note:** If you decide that the patient does not require referral to specialist services then alcohol brief advice should be provided.

Alcohol Brief Advice

- Patients who score eight or more on the AUDIT questionnaires should be offered brief advice.
- This should take around 5 minutes.
- It is recommended that you use an evidence-based resource including:
  - The potential harms associated with alcohol consumption
  - Reasons for changing behaviour
  - Strategies to help reduce alcohol consumption
  - Goal setting

Referral to Specialist Services

You should consider making a referral to specialist alcohol treatment services for those patients who:

- Score 20 or more on the AUDIT 10 questionnaire
- 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
- Score close to the cut off point of 20 and there are indications the patient would benefit from referral to specialist services.

Depression Screening

Aim to conduct depression screening with all patients who score 8 or more on the AUDIT C questionnaire.
The PHQ-2 and PHQ – 9 are validated tools for depression screening.

Depression Screening

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 and suicide risk should be assessed. Patients who score 0-2 need no further screening or action.

PHQ-9

Does the Patient Score 15 or more?

YES: Use your clinical judgement to decide if referral to specialist services for treatment of depression is required AND remember to assess suicide risk.

NO, score 10-14: Provide information on self management and action to take if symptoms persist or worsen AND remember to assess suicide risk.

NO, score less than 10: Provide positive feedback AND remember to assess suicide risk.

Referral to Specialist Services

- You should use your clinical judgement to consider whether making a referral to specialist depression treatment services is appropriate. You may want to consider making a referral to for those patients who:
- Score 15 or more on the PHQ-9
- Present a serious or considerable risk to themselves or others
- Have persistent depression which has not responded to treatment
- OR score close to the cut off point of 15 and there are indications (as above) that the patient would benefit from referral to specialist service.

Note: If you decide that the patient does not require referral to specialist services then information on self management and action to take if symptoms persist or worsen should be provided.

Suicide Risk Screening

Assess PHQ – 9 Question 9 score

Score of 0

The patient does not present a risk of suicide. No further action is required.

Score of 1

Monitoring is indicated. Use your clinical judgement but arranging a two week follow up visit to reassess suicide risk is recommended.

Score of 2 or 3

Referral is indicated. Use your clinical judgement to assess whether referral to additional treatment and support is required or if monitoring is appropriate.

Referral to Specialist Services

You should use your clinical judgement to consider whether making a referral to specialist suicide prevention services is appropriate. You may want to consider making a referral to for those patients who:

- Score 2 or 3 on question 9 of the PHQ 9
- Present a serious or considerable risk to themselves
- Report plans or intention to commit suicide