SCALA FRAMEWORK

Asking and advising about alcohol in primary health care at municipal level
Asking and advising about alcohol is an evidence-based public health and clinical program that measures an adult's alcohol consumption during a consultation in a primary health care centre or other similar service and offers advice to those with an increased level of alcohol consumption to cut down; referral is offered to those with the most severe pattern of alcohol use or alcohol-related organ damage.

The program can take different forms. The preferred option at municipal level is to implement a face-to-face program within a primary health care centre. However where the opportunity for face-to-face programs is limited, an alternative is to offer tele-medicine or digital approaches.

Costs will vary by size and scope of the program. Evidence from SCALA suggests that it is likely to be between Int$30K and Int$60K for between 10K and 20K individuals whose alcohol consumption is measured and advice given through face-to-face consultations in a primary health care centre.

Returns on investments can be large. Evidence from SCALA suggests that just considering savings as a result of reduced hospital admissions (a fraction of the total societal costs due to alcohol consumption), for every Int$1K spent on the programme, Int$1.8K could be saved.

THE SCALA FRAMEWORK provides a step-by-step approach to consider the best approach to implement the ask and advise about alcohol program through primary health care at municipal level.

Further reference material can be found in the Appendix.
Contents of Framework

1. Purpose of the SCALA FRAMEWORK
2. Dealing with alcohol
3. Systems approach
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   b) Structure, implementation steps, timeline
4. Key steps to implement and sustain program
   Phase 1) Plan
   Phase 2) Implement
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5. Conclusion
6. Appendix
   a) Materials
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Purpose of the **SCALA FRAMEWORK**

**Purpose**

The **SCALA Framework** is intended to help primary health care centres and municipalities develop and implement effective asking and advising about alcohol programs by providing simple practical guidance learned from **SCALA** and other international research projects.

**It will help to:**

1. Identify the best program for a primary health care centre or municipality;
2. Create, tailor, & implement an effective primary health care-based program to ask and advise adults who are drinking too much alcohol;
3. Monitor and collect data to determine the effectiveness of the program and to refine it as needed.

**Who is the framework for?**

Program directors and managers working in primary health care centres and municipal health departments; professional groups supporting primary health care providers; and, primary health care providers themselves who are active in their communities to help decrease heavy drinking and the harm done by alcohol.
Alcohol is a carcinogen (causes cancer) and there is no level of consumption that is risk-free. Forty-year-old men and women who regularly drink five drinks a day (50 grams of alcohol) lose between 4 and 5 years of life compared with those who drink less than one and a half drinks a day (15 grams of alcohol).

Some **key consequences** are...

1. **For those under 70 years of age, alcohol results in 2 million deaths** worldwide each year, representing 7% of all deaths in this age group;

2. **Worldwide, the three most common causes of alcohol-related death are:** liver disease; accidents; and tuberculosis;

3. **Alcohol is a causal factor in at least 200 different diseases and injuries;**

4. **Alcohol is a common cause** of high blood pressure and depression (see Appendix for comorbid depression);

5. **Alcohol results in social and economic loss** to local communities and municipalities.
Effectiveness of asking and advising

Average reduction in drinking amounts $>12\%$

through asking and advising about alcohol programs in primary health care

Some key elements are...

1. The most important element is a conversation about alcohol between a health care provider and their patient;
2. The profession of the provider seem to make little difference - nurses and doctors seem just as effective;
3. The primary health care setting seems to make little difference - whether in the centre itself or through an outreach service;
4. The length of the advice seems to make little difference - even just asking about alcohol can help;
5. The mode of advice seems to make little difference - simple advice can work as well as more in-depth motivational interviewing.
Asking and advising more patients

Providing training leads to more patients being asked and advised.

In SCALA, primary health care centres with training asked 12 times the number of patients about their alcohol consumption, as centres with no training.

Key elements of training that lead to more patients being asked and advised:

1. Training should be brief (2 to 4 hours) to fit in with busy schedules of providers;
2. Training should be skills-based, helping providers to build their capacity to ask and advise;
3. Training should focus on patient centred conversations with providers;
4. Training can use videos to illustrate skills - see: https://www.scalaproject.eu/index.php/project-outputs;
5. Training should use role-play to practice the skills and conversational techniques.
Asking and advising more patients

Providing community support leads to more patients being asked and advised

In SCALA, primary health care providers who received community support asked 28% more patients about their alcohol consumption, as providers with no community support

Key elements of support that lead to more patients being asked and advised:

1. Appoint a project champion to advocate for the program;
2. Involve providers and patients in tailoring and adapting the clinical package and training course;
3. Provide performance review feedback;
4. Exchange ideas between providers to improve the program;
5. Build in sustainability plans from the outset;
6. Mount communication campaigns to normalize the program amongst providers and patients.
Experiences of three international research projects

**Program overview**

**Asking and Advising** is an evidence-based action during primary health care consultations which help patients drink less alcohol.

- Asking and advising should be kept brief and simple.
- Primary health care providers should be trained in the skills of asking and advising.
- Primary health care providers should be supported with local municipal action.

Estimated cost: $30K-$60K to cover 10K to 20K individuals, depending on delivery method, staff costs, and scope.

In Colombia, Mexico and Peru, the SCALA project measured and advised 25,000 patients

In Catalonia, England, Netherlands, Poland, and Sweden, the ODHIN project measured and advised 100,000 patients

In Australia, Belgium, Catalonia, England, and New Zealand, the WHO Phase III project measured and advised 60,000 patients

The SCALA framework is a compilation of best practices derived from international experiences.
## Systems approach to asking and advising about alcohol in primary health care

<table>
<thead>
<tr>
<th><strong>Primary health care centre actions</strong></th>
<th><strong>Enabling Actions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Core action to ask and advise</td>
<td>Ensures asking and advising is a community-based programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Asking and advising</strong></th>
<th><strong>Partnership Development</strong></th>
<th><strong>Community Engagement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-person asking &amp; advising</strong></td>
<td>Build and maintain relationships with municipalities which can lead to program sustainability.</td>
<td>Raise awareness of asking and advising about alcohol among community members and build allies, making every contact count between a service and a person.</td>
</tr>
<tr>
<td>Ask and advise patients in-person during consultations at primary healthcare centres.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tele asking and advising</strong></th>
<th><strong>Advocacy work</strong></th>
<th><strong>Social norms campaign</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use telephone consultations by a range of health care providers to ask and advise, and make referral, as needed.</td>
<td>Work with municipalities to advocate for effective local regulations on price, availability and advertising.</td>
<td>Use print, video and radio advertisements to promote behaviour change, and normalize the practice of asking and advising about alcohol in primary health care among citizens and health care providers.</td>
</tr>
</tbody>
</table>

| **Digital asking and advising** | | |
|-------------------------------| | |
| Use websites, apps, or chatbots that ask and advise via the primary health care centre or remotely. | | |
### Health system cost components for primary health care-based program based on SCALA project in Latin America

<table>
<thead>
<tr>
<th>Component</th>
<th>% distribution of total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Set-up costs</strong> (engaging primary health care centers and providers)</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Tailoring costs</strong> (tailoring and adapting questionnaires and training material, websites etc.)</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Training costs</strong> (training primary health care providers)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Personnel</strong> (implementation by primary health care providers)</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Support</strong> (community and primary health care center support)</td>
<td>5%</td>
</tr>
</tbody>
</table>

Cost varies by size and scope of program but is estimated to be **INT$30K-$60K** for **10K-20K individuals** asked and advised about their alcohol consumption.

Return on investment varies by size and scope of program but is estimated to be **INT$1.8K for every INT$1.0K invested**.
TEN steps to implement an ask & advise program in a municipal area

**PLAN**

- Design a program tailored to the municipal area and prepare to implement

1. Select municipal area
2. Involve key stakeholders
3. Design, prepare, tailor
4. Set a goal
5. Set evaluation criteria
6. Select and train trainers and providers

**IMPLEMENT**

- Launch program and revise and adapt as needed

7. Implement program
8. Collect and monitor data

**SUSTAIN**

- Deal with risk and ensure sustainability of program

9. Manage risk
10. Sustain and scale
Implementation timeline requires three years of initial input

Timeline for new municipal areas:
Invest sufficient time during first year to plan and prepare for the program, adapted and tailored to the local context, so as to maximize the likelihood of long-term success.

Shorter timeline for adjacent municipal areas:
Timeline can be shortened if expanding into municipal areas that neighbour existing successful programs.
## Step 1 | Identify municipal area using six dimensions

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **1** Community need | Extent of alcohol problems in the municipal area  
How prevalent is alcohol use and alcohol-related harm in the municipal area? Any recent policy changes? |
| **2** Community interest | Level of interest in reducing the harm done by alcohol  
Has the municipal area identified reduction of the harm done by alcohol as a priority to address? |
| **3** Local partners & support | Support from and capacity of local organizations  
Building on existing connections with organizations, are there local organizations (e.g., non-governmental organizations) and government agencies who can assist with implementation? |
| **4** Sustainability | Ability of municipal area to sustain program long-term on its own  
How likely is it that the municipal area can sustain and expand the program in the long-term? |
| **5** Anticipated impact | Degree of anticipated impact on the community  
How many people can be covered? How much reduction in heavy drinking will this lead to? |
| **6** Social norm change | Changing the social norm on heavy drinking  
Is there a lack of media coverage of the harm done by alcohol in the municipal area? How can implementing the program lead to local conversations and changing social norms on the topic? |

At a minimum, municipal area and healthcare centre buy-in essential.

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**Outcome**

- **4** Sustainability
- **5** Anticipated impact
- **6** Social norm change

**Implementation**

- **3** Local partners & support
- **4** Sustainability
- **5** Anticipated impact

**Environment**

- **1** Community need
- **2** Community interest
- **3** Local partners & support

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Step 2 | Bring together key stakeholders for a successful program

**Program coordinator**
Oversees the program, ensuring the program is on track and on time

**Trainers**
Responsible for training the primary healthcare providers who will be carrying out the program

**Primary healthcare providers**
Responsible for implementing the program through asking and advising patients

**Government institutions and others**
Creates a support system for the program; increases community awareness in-line with program goals; complements primary healthcare providers

**Monitor and Evaluator**
Responsible for monitoring and evaluating the program, quantifying impact and identifying issues

**Academics and Technical experts**
Provide insight on program topic and advice on program development

**Local champions**
Help identify municipal areas and primary health care centres and establish local relationships; critical to the success of the program

**Other local public organizations**
Organizations that can add credibility and momentum to the program
### Step 3 | Adapt and tailor six technical materials

<table>
<thead>
<tr>
<th>Materials</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical package</td>
<td>AUDIT-C measurement instrument, care pathway instructions for providers (see Appendix)</td>
</tr>
<tr>
<td>2. Information materials</td>
<td>Information and advice materials, including leaflets and booklets, for providers and patients regarding measurement and advice</td>
</tr>
<tr>
<td>3. Training course &amp; user manual</td>
<td>Training course and instructions, training videos</td>
</tr>
<tr>
<td>4. Community support and campaigns</td>
<td>Materials for local communities and primary health care centres</td>
</tr>
<tr>
<td>5. Monitoring framework</td>
<td>System to document program aims, activities, outcomes, and process measures (see Appendix for RE-AIM framework)</td>
</tr>
<tr>
<td>6. Data collection</td>
<td>Results of the measurements, and achievement of coverage</td>
</tr>
</tbody>
</table>

Adapt and tailor the guideline content based on (see Appendix):

- Local and national guidelines and plans
- Individual healthcare provider factors
- Patient factors
- Involvement of local patient and provider groups
- Interactions between different professional groups
- Incentives and resources available
- Capacity for organizational change
- Social, political and legal factors
Step 4 | Set goals

Set both **quantitative** and **qualitative goals**

Goals should take into consideration:
- Available resources and capacity;
- Mode of implementation;
- Likely municipal reception to asking and advising program.

**Five-year goal**

Aim to make alcohol measurements as widespread as similar measurement programs such as for blood pressure.

The goal should be at least **25% of the adult population** that has had their alcohol consumption measured within the first five years of the program, which could lead to a 6% reduction of alcohol consumption in the community; a goal of 50% measurement would lead to a 11% reduction of alcohol consumption in the community.
Qualitative measures

Ongoing qualitative feedback can be gathered using surveys or verbally during check-in meetings with providers and centers. Qualitative evaluation to be provided by four groups:

- Relevant community stakeholders involved (e.g., government, academics, professional organizations);
- Primary healthcare managers;
- Primary healthcare staff;
- Patients and users.

Qualitative evaluation to cover:

- Stakeholder satisfaction;
- Interaction and engagement with the program;
- Barriers and facilitators to implementation.

Quantitative measures

Ongoing quantitative measures include:

- **Coverage**: Proportion of the population in the target community that has had their alcohol consumption measured.
- **Advice ratio**: Proportion of those who were identified as drinking at heavier levels who received advice or another form of support.
## Step 6 | Select and train both trainers and providers

<table>
<thead>
<tr>
<th>Trainers</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selection</strong></td>
<td><strong>Considerations:</strong></td>
</tr>
<tr>
<td></td>
<td>• Experience with training related to alcohol and primary health care</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of the municipal area's culture and customs</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td><strong>Considerations:</strong></td>
</tr>
<tr>
<td></td>
<td>• 1 day training</td>
</tr>
<tr>
<td></td>
<td>• Cover common questions and concerns raised by primary healthcare providers</td>
</tr>
<tr>
<td></td>
<td>• Experience the training program (for providers) itself</td>
</tr>
<tr>
<td></td>
<td>• Consider trainings across municipal areas</td>
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<tr>
<td></td>
<td>• Initial training: 2-4 hours, depending on providers’ existing familiarity with topic</td>
</tr>
<tr>
<td></td>
<td>• Follow-up training: 1-2 booster trainings</td>
</tr>
<tr>
<td></td>
<td>• Motivate providers to want to offer program</td>
</tr>
<tr>
<td></td>
<td>• Take into account high provider turnover and provider schedules by offering several training times</td>
</tr>
<tr>
<td></td>
<td>• Limit content to only the essentials; offer role play</td>
</tr>
</tbody>
</table>

- Training should be **experiential**
- Courses should not exceed 24 attendees
- Develop internet skills-based training simultaneously when designing the face-to-face training
## Step 7 | Implement, based on roles and qualifications

<table>
<thead>
<tr>
<th>Role description</th>
<th>Centre Manager or local administrator</th>
<th>Primary health care providers</th>
<th>Telehealth professionals</th>
<th>Specialists</th>
<th>Measuring &amp; Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role description</td>
<td>Oversees the operations and management of program at primary health care centre</td>
<td>Implement asking and advising during patient consultations</td>
<td>Implement asking and advising over the phone</td>
<td>Provide clinical support to severe cases; provide basic training on managing difficult cases</td>
<td>Designs and oversees data collection, maintains systems, and analyses of outcomes</td>
</tr>
<tr>
<td>Qualifications</td>
<td>Project management experience; technical knowledge</td>
<td>Trained in asking and advising about alcohol; experience of local health systems; basic knowledge of digital tools</td>
<td>Clinically trained to manage severe alcohol cases; track record of training healthcare providers</td>
<td>Experience designing and monitoring data collection; programming and analytical skills</td>
<td></td>
</tr>
</tbody>
</table>
Step 8 | Collect and monitor data

**COLLECT**
- Patient characteristics (age, sex, delivery method)
- Patient’s AUDIT-C score
- Information on advice and support provided
- Stakeholder and provider feedback on program

**CALCULATE**
- Coverage, numbers and percent
- Advice given to at-risk drinkers, numbers and percent
- Change in number of alcohol measurements over time
- Cost per measurement administered
- Stakeholder satisfaction

**OUTCOMES**
- Information on number of heavy drinking patients identified
- Provider performance / productivity report (monthly)
- Summary of measurements administered (monthly)
- Program impact to date
### Possible risks

<table>
<thead>
<tr>
<th>Regulatory &amp; Political</th>
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</thead>
</table>
| Regulatory changes can impact a community's consumption of alcohol, impacting scope or effectiveness of the program.  
Example: The price of alcohol is reduced. |
| Political leadership changes can lead to changes in health directors and managers in some municipalities requiring renegotiation of programs. |

<table>
<thead>
<tr>
<th>Natural disasters (including COVID)</th>
</tr>
</thead>
</table>
| Natural disasters may either shift health system focus away from preventative services, delay or stop initiatives, while increasing the harm done by alcohol.  
Example: In 2020, the COVID-19 pandemic resulted in pauses and diminished activities of SCALA program in Colombia, Mexico and Peru. |

<table>
<thead>
<tr>
<th>High turnover of primary care staff</th>
</tr>
</thead>
</table>
| Use of short-term contract staff and burnout means inconsistent number of providers measuring alcohol consumption of patients, and potential difficulty with continuity and institutionalizing program.  
The mobility of personnel, variability of types of contracts and working conditions and workload. |

### Description & Example

| Regulatory changes can impact a community's consumption of alcohol, impacting scope or effectiveness of the program.  
Example: The price of alcohol is reduced. |
| Natural disasters may either shift health system focus away from preventative services, delay or stop initiatives, while increasing the harm done by alcohol.  
Example: In 2020, the COVID-19 pandemic resulted in pauses and diminished activities of SCALA program in Colombia, Mexico and Peru. |
| Use of short-term contract staff and burnout means inconsistent number of providers measuring alcohol consumption of patients, and potential difficulty with continuity and institutionalizing program.  
The mobility of personnel, variability of types of contracts and working conditions and workload. |

### Possible solutions

| Leverage partners and stakeholders as soon as possible to create a coalition for change and approach governmental bodies. |
| Report program achievements regularly to reduce risk preemptively.  
Establish written agreements with civil society organizations.  
Establish official agreements for the implementation of the program so that it is carried out independently of changes in leaders. |
| Implement internet-based training and digital/telemedicine approach.  
Adapt training and implementation program to infrastructure and resources available.  
For COVID, remind healthcare providers that alcohol is a risk factor for respiratory tract infection. |
| Adapt training and implementation program to provider needs and culture.  
Schedule regular, recurring trainings to ensure new staff are trained; existing providers can train other colleagues.  
Consider offering online trainings.  
Consider involving the unions in discussing solutions. |
Step 10 | Sustainability and Scaling Plan

**Obtain explicit commitment** from authorities like:

- Country, regional or local Department of Health
- Community Health Systems
- Directors of the Primary Healthcare Centers
to continue and adopt the program, integrating the program as part of the health system norm

**From the outset, develop a transition plan together** including mandating the program, guidelines and actions, and ensuring that training is included in professional curricula

Fully **integrate the measuring instruments** and data recording into existing electronic medical systems and records
1. **Face-to-face contact** between a provider and a patient in a primary health care centre is the core of an asking and advising program, that can be supplemented with tele-medicine and digital approaches.

2. **Stakeholders** at local, regional and national levels should be involved at all stages of the program from design to implementation to scale-up.

3. **From the outset**, plans for sustainability should be built in to all aspects of the program.

4. **Increasing coverage** is the goal - with the aim that 25% or more of the adult population within the catchment area of the centre has had their alcohol consumption measured by the fifth year of the program.

5. **Tracking progress** in coverage, and adapting delivery as needed is vital for the long-term success and sustainability of the program.
Appendix
# AUDIT-C Questionnaire

Patient Name ___________________________   Date of Measurement ____________

*Please circle your response to each question below:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are</td>
<td>Monthly or</td>
</tr>
<tr>
<td>drinking?</td>
<td>less</td>
</tr>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male,</td>
<td>2-4 times</td>
</tr>
<tr>
<td>on a single occasion in the last year?</td>
<td>per month</td>
</tr>
<tr>
<td></td>
<td>2-3 times</td>
</tr>
<tr>
<td></td>
<td>per week</td>
</tr>
<tr>
<td></td>
<td>4+ times per</td>
</tr>
<tr>
<td></td>
<td>week</td>
</tr>
<tr>
<td>Total score</td>
<td></td>
</tr>
</tbody>
</table>

*Please circle your response to each question below:*
If you have

- **No time**
  - Give a leaflet on the benefits and recommendations to drink less alcohol

- **1-2 minutes**
  - Use Very Brief Advice
  - Ask First AUDIT-C Qu. on drinking frequency
  - Score 4: Advise On the benefits and best ways to drink less alcohol
  - Act By offering help on ways to drink less alcohol
  - Offer that your help will always be available

- **3-5 minutes**
  - Use 5A's Model
  - Ask Three AUDIT-C questions on alcohol
  - Score 5+: Advise On the benefits and best ways to drink less alcohol
  - Assess Patient’s readiness to change
  - Assist With helping to develop a plan to drink less alcohol
  - Arrange Follow-up session and referral, if needed

- **More than 5 minutes**
  - Use 5A's Model
  - Ask Three AUDIT-C questions on alcohol
  - Score 5+: Advise On the benefits and best ways to drink less alcohol
  - Assess Patient’s readiness to change
  - Assist With helping to develop a plan to drink less alcohol
  - Arrange Follow-up session and referral, if needed

**Flow chart for asking and advising about alcohol**

- **5R's Model**
  - Relevance Identify the relevance to drink too much or to drink less alcohol
  - Risks Identify potential risks in drinking alcohol
  - Rewards Identify potential benefits in drinking less
  - Roadblocks Identify barriers to drinking less
  - Repetition Re-assess readiness

- If patient isn’t ready
<table>
<thead>
<tr>
<th>Domain</th>
<th>Determinant of practice</th>
<th>Factor influencing program implementation</th>
<th>Is this factor relevant for the local setting?</th>
<th>How can the program be tailored to mitigate the factor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline factors</td>
<td>Clarity</td>
<td>Guidelines for alcohol measurement and giving advice for heavy drinking are not clear enough</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effort</td>
<td>Alcohol measurement and giving advice for heavy drinking is too much work to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feasibility</td>
<td>Alcohol measurement and giving advice for heavy drinking in our everyday practice is not feasible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural appropriateness</td>
<td>Alcohol measurement and giving advice for heavy drinking is not appropriate in our culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual health professional factors</td>
<td>Skills needed to adhere</td>
<td>Providers do not have the skills to implement alcohol measurement and brief advice programmes for heavy drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expected outcome</td>
<td>Providers think that alcohol measurement and giving advice for heavy drinking will not help their patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intention and motivation</td>
<td>Providers consider that alcohol measurement and giving advice for heavy drinking is not their responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-efficacy</td>
<td>Providers believe they cannot help their heavy drinking patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotions</td>
<td>Providers are reluctant to screen for heavy drinking due to social and cultural barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capacity to plan change</td>
<td>Providers do not have enough time to screen and give advice for heavy drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient factors</td>
<td>Patient beliefs and knowledge</td>
<td>Most heavy drinking patients think that their drinking is normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient preferences</td>
<td>Patients do not like to discuss their alcohol consumption with their doctor or nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional interactions</td>
<td>Referral processes</td>
<td>There are difficulties with access to referral services for patients with alcohol problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentives and resources</td>
<td>Availability of necessary resources</td>
<td>Instruments for alcohol measurement and giving advice to heavy drinkers do not exist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial incentives and disincentives</td>
<td>There is lack of financial incentives for providers to carry out alcohol measurement and advice</td>
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<tr>
<td></td>
<td>Nonfinancial incentives and disincentives</td>
<td>There is lack of non-financial incentives for providers to carry out alcohol measurement and advice</td>
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<tr>
<td></td>
<td>Assistance for clinicians</td>
<td>There is lack of on-going support for providers to carry out alcohol measurement and advice</td>
<td></td>
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<tr>
<td>Capacity for organisational change</td>
<td>Capable leadership</td>
<td>There is lack of support by the leadership in PHC centres to support and implement programmes of alcohol measurement and advice</td>
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<td></td>
<td>Assistance for organisational changes</td>
<td>There is lack of necessary organizational changes in PHC centres to implement alcohol measurement and advice</td>
<td></td>
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<tr>
<td>Social, political and legal factors</td>
<td>Economic constraints on the health care budget</td>
<td>There is lack of sufficient staff in PHC centres to implement programmes for alcohol measurement and advice</td>
<td></td>
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<tr>
<td></td>
<td>Legislation</td>
<td>Laws and regulations in the country that influence the price and availability of alcohol are too lenient, encouraging cultural tolerance to alcohol</td>
<td></td>
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</tbody>
</table>
**REACH**
- To maximise coverage of measuring exposure of adult patients to alcohol use;
- To maximise coverage of giving advice to patients identified with risky exposure

**EFFECTIVENESS**
- To assess, at the population level, the short (over one year) and long (over ten years) impact of the program in reducing exposure to alcohol use and in reducing disease outcomes, both hospitalizations and deaths, assessing evidence of differentiation by index of deprivation.
- To estimate costs and economic returns on investment of the program
- To assess potential negative outcomes of the program

**ADOPTION**
- To assess the proportion of primary health care centres and primary health care providers, differentiated by professional group, that are engaged in delivering the program, with an assessment of extent of involvement (i.e., proportion of catchment population (registered adult patients) measured)

**IMPLEMENTATION**
- To assess the fidelity and costs of implementing the measurement and advice package at primary health care centre and provider levels
- To evaluate which factors affect the implementation of the measurement and advice package at primary health care centre and provider levels

**MAINTENANCE**
- To assess sustainability of implementing brief intervention package at primary health care centre and provider levels
- To understand how the program can be maintained and achieve longevity of implementation at primary health care centre and provider levels.

### Program activities
- Ensure that necessary clinical guidelines are in place that promote measurement and brief advice programs to reduce exposure to alcohol use as accepted clinical practice
- Support and manage ongoing recruitment of primary health care centres and providers into the program
- Ensure that the necessary incentives are in place to engage primary health care centres and providers, including contractual and quality improvement obligations, and financial incentives

- Design and implementation of a monitoring and evaluation system based on electronic medical records, with linkages to hospitalization and mortality data
- Document and assess costs of implementation of program and estimate returns on investment for averted health care costs
- Undertake qualitative surveys of samples of patients to assess potential negative outcomes of program

- Design of a pragmatic, easy to use and replicable primary health care-based measurement and advice package and associated care pathway
- Tailoring of the ask and advise package according to local needs by using local stakeholder groups and advisory boards and local user panels of patients
- Provision of specific practice-based training and ongoing support to primary health care providers
- Implementation of system wide ongoing support structures

- Continuous feedback on primary health care level drivers to brief intervention implementation gathered via ongoing qualitative and quantitative metrics
- Application of logic framework to map and understand progress towards effective implementation

- Support at the system level to make relevant primary health care practice changes for sustainability
- Monitoring system on long-term reach
- Monitoring system on long-term effectiveness
- Monitoring system on performance at primary health care centre level
- Production of ongoing iterative step-by-step Framework to guide system-wide implementation at primary health care centre level

### Main outcome/process measures
- **Target**: 25% of adult patients measured for exposure to alcohol use over 5-year period, with no evidence of differentiation by index of deprivation.
- **Target**: 75% of adult patients identified with risky exposure offered advice to change, with no evidence of differentiation by index of deprivation

- Sustained reduction in exposure to alcohol use
- Sustained reduction in prevalence of alcohol-related diseases as assessed by hospitalizations and premature deaths
- Evidence of positive return on investment of program

- Availability of tailored and simple to use measurement and advice package to reduce exposure to alcohol use in primary health care settings
- Adoption rate and representativeness of primary health care centres and providers

- Extent primary health care measurement and advice package delivered as intended
- Multi-level evaluation of barriers/facilitators to scale-up
- Extent that implementation is delivered as intended using developed logic model
- Cost of package implementation

- Ongoing assessment of outcomes, with annual reporting
- Indicators of program-level maintenance
- Measures of cost of maintenance
- Regular review of program adjustment

**Re-AIM framework for monitoring program**
Co-morbid depression

There is a strong **reciprocal relationship** between heavy drinking and depression:

- Heavy drinking increases the risk of developing depression;
- There is a high proportion of heavy drinkers amongst those with depression

In the **SCALA** project, as many as two fifths of patients with an AUDIT-C score of 8+ (very heavy drinking) had a PHQ-2 score of 3+ (indicative of depression)
**Depression questionnaire | PHQ-2 ; score 3+ = depression**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following two problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sum score (possible range 0-6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Suicide risk | PHQ-9 question; score 1+ = risk**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problem?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
All adult patients visiting PHCU

**Care pathway for alcohol and co-morbid depression**

- **ALCOHOL MEASUREMENT**
  - <5
  - ≥5
  - MAKE referral
  - CONSIDER if referral to specialist alcohol services is indicated

- **ASSESS MENTAL HEALTH**
  - <3 (PHQ-2)
  - ≥3
  - <1 (Suicide risk)
  - ≥1
  - MAKE referral
  - CONSIDER if referral to specialist services for alcohol and/or depression and/or suicide is indicated

- **GIVE**
  - Patient Information Leaflet for alcohol
  - PROVIDE: Alcohol Brief Advice +
  - GIVE: Patient Brief Advice Leaflet

- **MAKE** referral
- **PROVIDE:**
  - Alcohol Brief Advice
  - GIVE:
  - Patient Brief Advice Leaflet
  - Patient Information Leaflet for depression
Additional Resources

Materials from the SCALA Project, implementing programs in Latin America, including:

- Clinical guidelines and patient material
- Training courses, materials and videos
- Community support and communication material
- Survey and data collection instruments
- Project reports (deliverables) and scientific publications, with publications summarizing the evidence base

Can be found: https://www.scalaproject.eu/index.php/project-outputs