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

SCALA FRAMEWORK

Asking and advising about alcohol in primary health care at municipal level

Overview

- **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**
   a) Overview of asking and advising about alcohol program
   b) Structure, implementation steps, timeline
4. **Key steps to implement and sustain program**
   Phase 1) Plan
   Phase 2) Implement
   Phase 3) Sustain
5. **Conclusion**
6. **Appendix**
   a) Materials
   b) Comorbid depression
   c) Link to further resources

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.

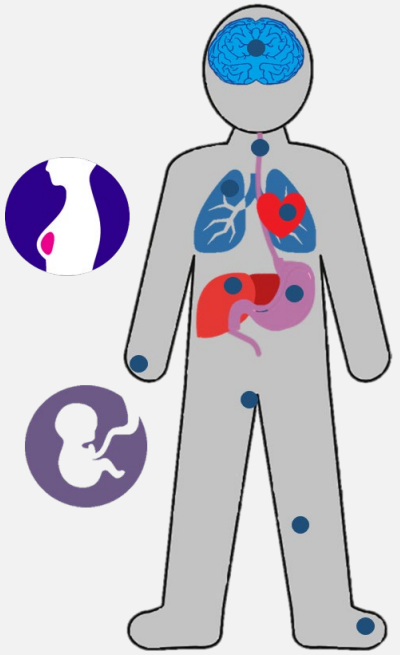
It will help to:

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.

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.

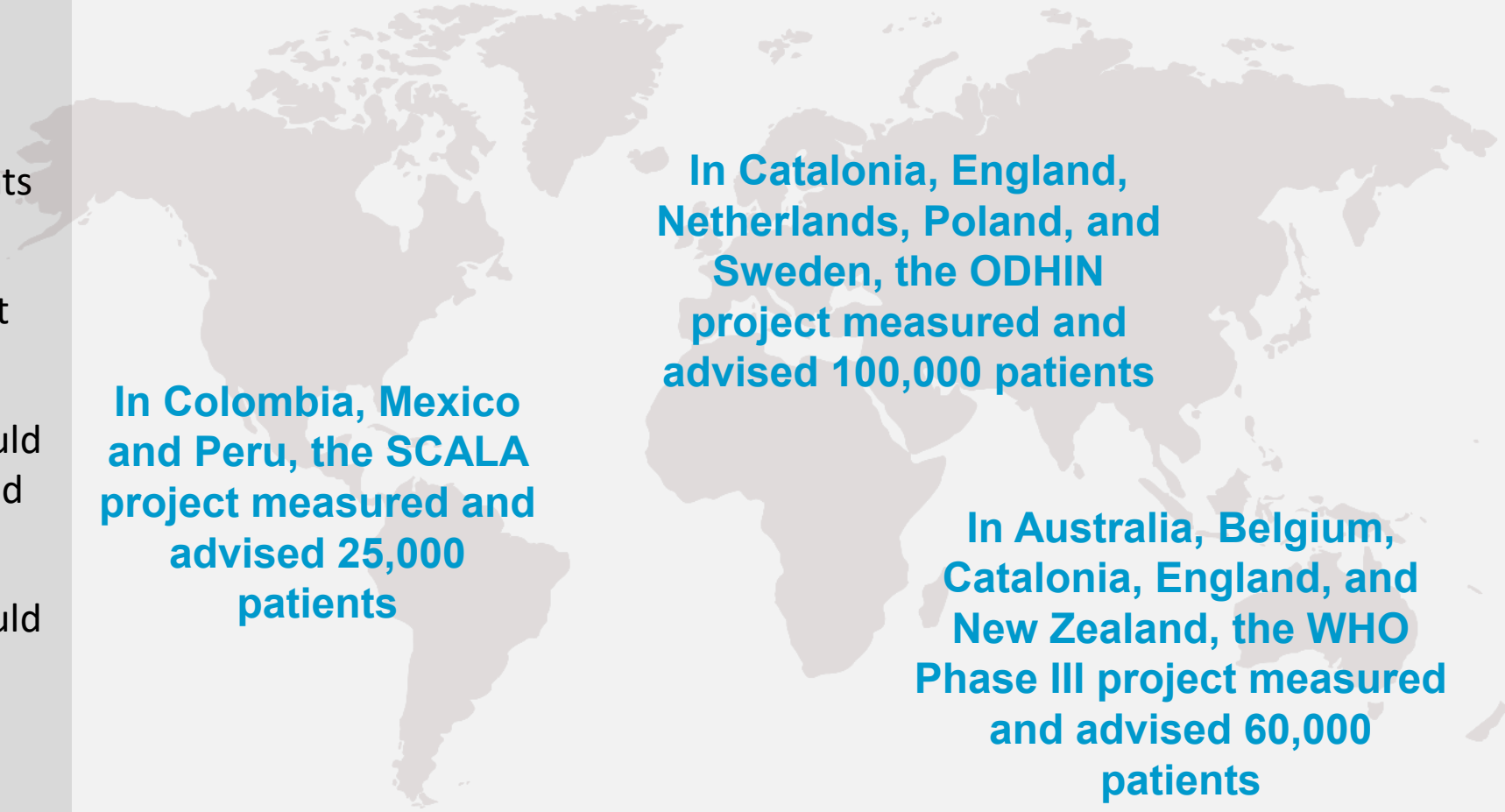
Experiences of three international research projects

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

Primary health care centre actions Core action to ask and advise	***Enabling Actions*** Ensures asking and advising is a community-based programme	
Asking and advising	**Partnership Development**	**Community Engagement**
In-person asking & advising	**Government relations**	**Community engagement**
Ask and advise patients in-person during consultations at primary healthcare centres.	Build and maintain relationships with municipalities which can lead to program sustainability.	Raise awareness of asking and advising about alcohol among community members and build allies, making every contact count between a service and a person.
Tele asking and advising	**Advocacy work**	**Social norms campaign**
Use telephone consultations by a range of health care providers to ask and advise, and make referral, as needed.	Work with municipalities to advocate for effective local regulations on price, availability and advertising.	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.
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

	% distribution of total cost
Set-up costs (engaging primary health care centers and providers)	5%
Tailoring costs (tailoring and adapting questionnaires and training material, websites etc.)	5%
Training costs (training primary health care providers)	10%
Personnel (implementation by primary health care providers)	75%
Support (community and primary health care center support)	5%

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

Year 1
Plan & Prepare

Year 2
Implement & Revise

Year 3
Sustain & scale

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

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

	Dimensions	Criteria
Environment	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?
Environment	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?
Implementation	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,?
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?
Outcome	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?
Outcome	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?

Step 2 | Bring together key stakeholders for a successful program

Organizer

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

Implementation Partners

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

Academic partners

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

Advocates

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

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

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 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.

Step 5 | Define evaluation criteria

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.

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.

Step 6 | Select and train both trainers and providers

	Trainers	Providers
Selection	**Considerations:** • Experience with training related to alcohol and primary health care • Knowledge of the municipal area's culture and customs	**Considerations:** • In-person: support from Director or Manager of healthcare centre is required, ensuring that time is available to attend training during working hours
Training	• 1 day training • Cover common questions and concerns raised by primary healthcare providers • Experience the training program (for providers) itself • Consider trainings across municipal areas	• Initial training: 2-4 hours, depending on providers' existing familiarity with topic • Follow-up training: 1-2 booster trainings • Motivate providers to want to offer program • Take into account high provider turnover and provider schedules by offering several training times • Limit content to only the essentials; offer role play

Best practice

- ✓ 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

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

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

Step 9 | Manage and address possible risks

Possible risks	*Description & Example*	*Possible solutions*
 **Regulatory & Political**	Regulatory changes can impact a community's consumption of alcohol, impacting scope or effectiveness of the program Example: The price of alcohol is reduced	Leverage partners and stakeholders as soon as possible to create a coalition for change and approach governmental bodies
	Political leadership changes can lead to changes in health directors and managers in some municipalities requiring renegotiation of programs	Report program achievements regularly to reduce risk pre-emptively 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
 **Natural disasters (including COVID)**	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	Implement internet-based training and digital/tele-medicine 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
 **High turnover of primary care staff**	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	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

Conclusion

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

Measurement questionnaire | AUDIT-C Form

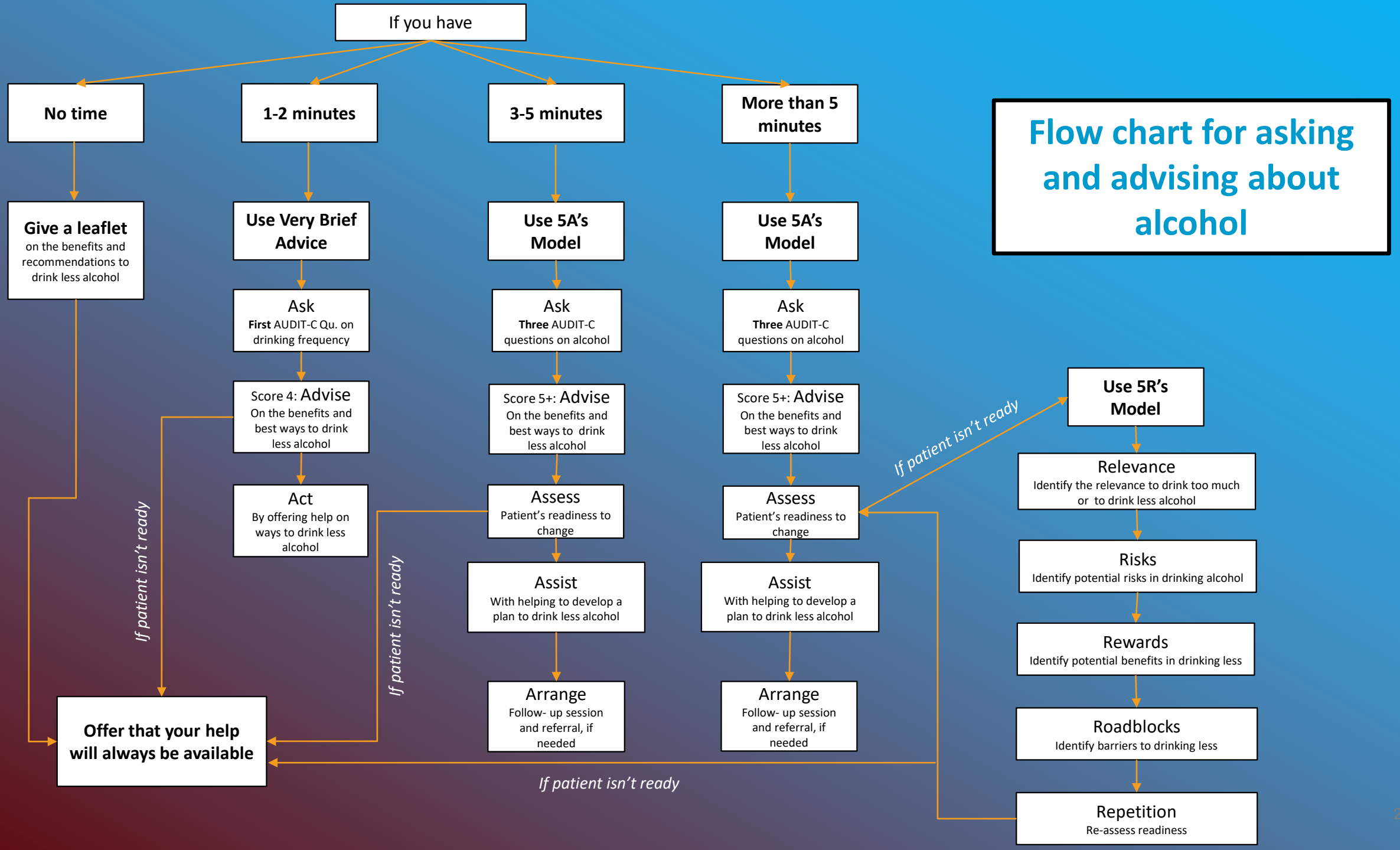
AUDIT-C Questionnaire

Patient Name _____ Date of Measurement _____

Please circle your response to each question below:

Questions	Scoring system				
	0	1	2	3	4
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
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Total score					

Flow chart for asking and advising about alcohol



Checklist to aid with program tailoring

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

Re-AIM framework for monitoring program

RE-AIM Dimension, Program aims	Program activities	Main outcome/process measures
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	•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	•**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
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	•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	•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
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)	•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	•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
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	•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	•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
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.	•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	•Ongoing assessment of outcomes, with annual reporting •Indicators of program-level maintenance •Measures of cost of maintenance •Regular review of program adjustment

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

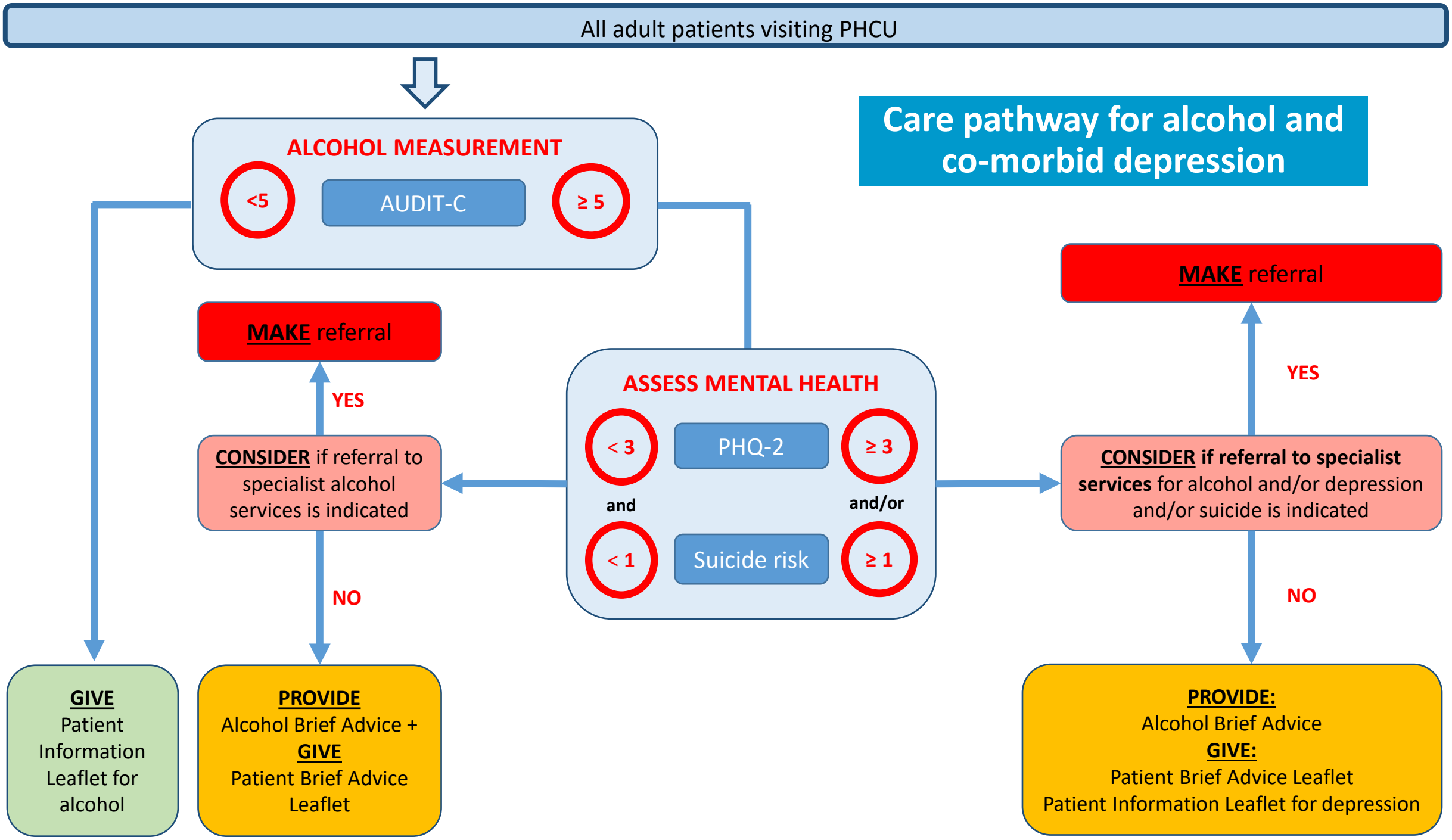
In the **SCALA** project, as many as two fifths of patients with an AUDIT-C score of 8+ (very heavy drinking) had a PHQ-2 score of 3+ (indicative of depression)

Depression questionnaire | PHQ-2 ; score 3+ = depression

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

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

Over the last 2 weeks, how often have you been bothered by the following problem?					
	Not at all	Several days	More than half the days	Nearly every day	
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	


All adult patients visiting PHCU
Care pathway for alcohol and co-morbid depression
ALCOHOL MEASUREMENT
<5
AUDIT-C
≥ 5
ASSESS MENTAL HEALTH
< 3
PHQ-2
≥ 3
and
and/or
< 1
Suicide risk
≥ 1
MAKE referral
YES
CONSIDER if referral to specialist alcohol services is indicated
NO
MAKE referral
YES
CONSIDER if referral to specialist services for alcohol and/or depression and/or suicide is indicated
NO
GIVE
Patient Information Leaflet for alcohol
PROVIDE
Alcohol Brief Advice +
GIVE
Patient Brief Advice Leaflet
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