Scale-up of Prevention and Management of Alcohol Use Disorders and Comorbid Depression in Latin America

SCALA

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

Training Package

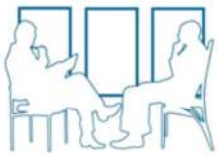
Session 2

Date

Recap

What do you remember from the 3 units in Session 1?

- Alcohol - concepts and attitudes
- Screening for alcohol and depressive symptoms
- Brief advice for alcohol – what to do and how..



Trainers' notes:

- Elicit and run very quickly over the 3 main areas covered in session 1 units (concepts and attitudes, screening, BI for alcohol)
- You may wish to do this verbally (without visual cues on slides)
- **TAILORING:** You may wish to include images of some challenging material for that particular group from the 1st session.

Time = 2 mins

Unit 4

Advice/information for co-morbid depressive symptoms

Total Time = 30 mins

The approach to managing co-morbid depressive symptoms in SCALA

- Multiple links and causal pathways between risky alcohol use and depressive symptoms →
- Reducing alcohol use will already have a positive impact on depressive symptoms

Trainers' notes:

- Explain the links between high-risk alcohol use and depression – and highlight that whichever causal mechanism there is for any particular case (e.g. drinking as self-medicating, alcohol use exacerbating depressive tendencies), reducing alcohol use will always have a positive effect on mental health.

Time = 2 mins

The approach to managing co-morbid depressive symptoms in SCALA

- SCALA strategy - Based on MHGap
  - Information and advice – healthy lifestyle and habits
  - Signposting – support and services
  - Vigilance – watch for changes in mood and suicide risk and refer if necessary

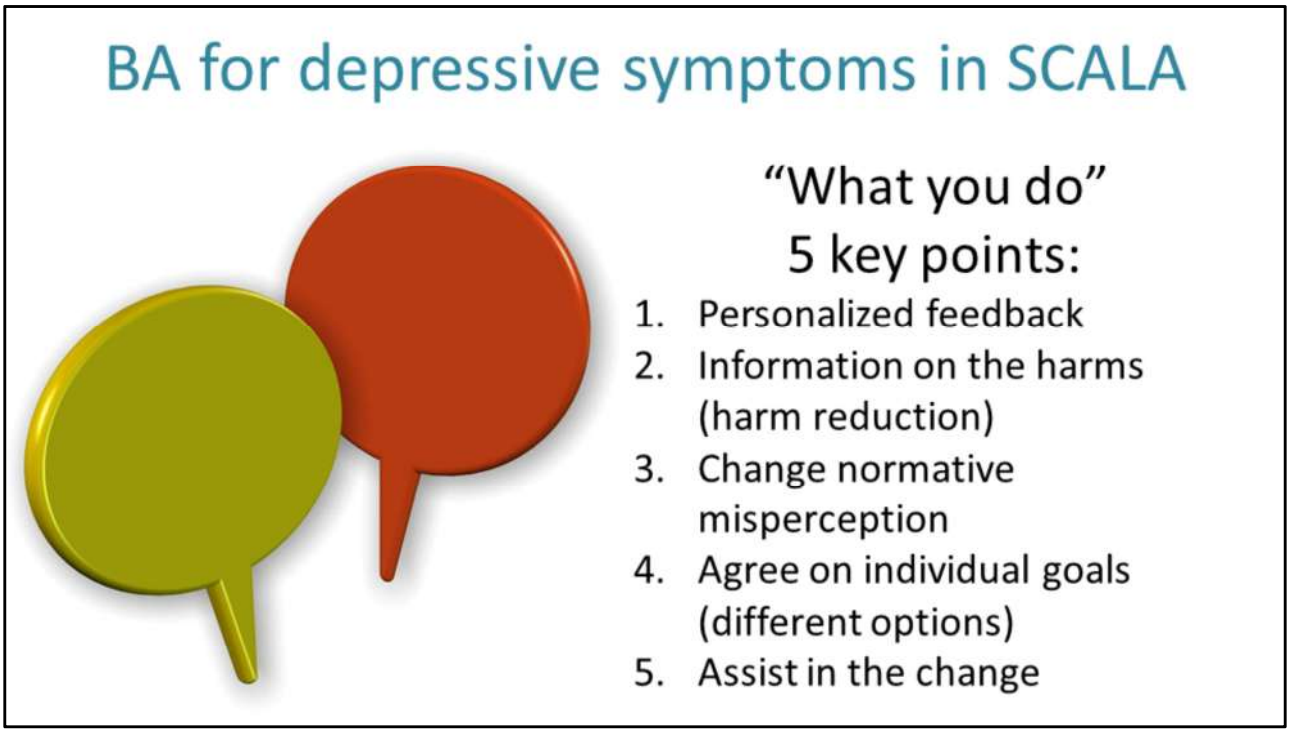
Pending issue to be decided: Should we remove slides 6, 7 & 8 (to avoid repetition with session 1 and/or because they are not considered in line with SCALA approach to depression)

<u>TAILORING</u>: Trainers should change the image for that of the local version of the depression leaflet

Trainers' notes:

- Explain the links between high-risk alcohol use and depression – and highlight that whichever causal mechanism there is for any particular case (e.g. drinking as self-medicating, alcohol use exacerbating depressive tendencies), reducing alcohol use will always have a positive effect on mental health.
- Present the SCALA strategy and materials (depression leaflet)

Time = 3 mins



Pending issue to be decided: Should we remove slides 6, 7 & 8 (to avoid repetition with session 1 and/or because they are not considered in line with SCALA approach to depression)

- Point out that the key points in the conversation about co-morbid depressive symptoms are essentially the same as in the brief intervention for alcohol (and both will be dealt with in a single conversation), although the emphasis is on highlighting the links between alcohol and mood problems, and assistance is in the form of a leaflet for depressive symptoms.

Time = 1 mins

BA for depressive symptoms in SCALA

"How you do it"

Motivational approach:

- **Collaboration** – (dance, don't wrestle)
- **Empathy** – avoid value judgments
- Building **Self-efficacy** – reinforcing positive intention
- Promote **Autonomy** – Respect; responsibility onto the patient

Pending issue to be decided: Should we remove slides 6, 7 & 8 (to avoid repetition with session 1 and/or because they are not considered in line with SCALA approach to depression)

- Remind participants of the motivational techniques (and 'dance, don't wrestle' analogy), which should also be used throughout, and which they will see in the modelling videos.

Time = 1 mins

Modelling and practice - depressive symptoms

Watch model video 2b on offering advice and information to patients with high-risk alcohol use and co-morbid depressive symptoms.

- **Video 2b – Paola** – The doctor talks about lifestyle and mood and negotiates a change in drinking behaviour with Paola, a hazardous drinker who is also experiencing depressive symptoms.

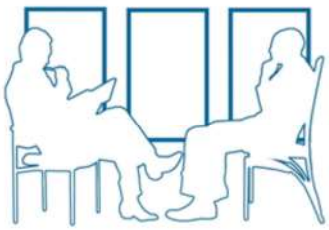
- Explain that they will watch a model video of the doctor giving Paola brief advice for alcohol and co-morbid mood problems (caso de Paola), before practicing themselves.
- Highlight that all the skills they will learn in this course need practice, and will be difficult and slower at first, but should get better the more the use them in their daily consultations.
- The group should look out for the “what” and the “how” (motivational skills) of brief advice that have been mentioned are used
- Afterwards, they will split into pairs and practice the BA interaction for alcohol and depressive symptoms

Time = 5 mins

Modelling and practice - depressive symptoms

Practice brief advice techniques

1. One is the professional, the other the patient
2. The professional should give feedback on the screening (AUDIT= 15 / PHQ-9 = 11), and advise action with the patient in 5 minutes
3. The patient can use the cards or invent their personal motivations where necessary
4. When you've finished, or the facilitator says stop, swap roles and repeat with a new card.

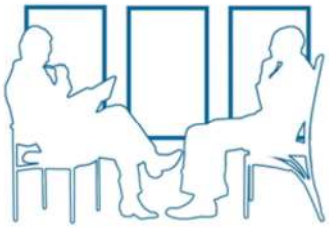


- Put the participants into pairs (e.g. next to each other). They can use the first 2 patient cards from the screening exercise on Day 1, as well as imagine their own motivations for the patient.
- Tell them to follow the instructions and monitor the time – tell them when a minute is left, after 5 minutes ask them to stop and swap roles

Time = 15 mins (3 minutes to set up exercise, 5 mins per role play, 2 mins to stop and swap)

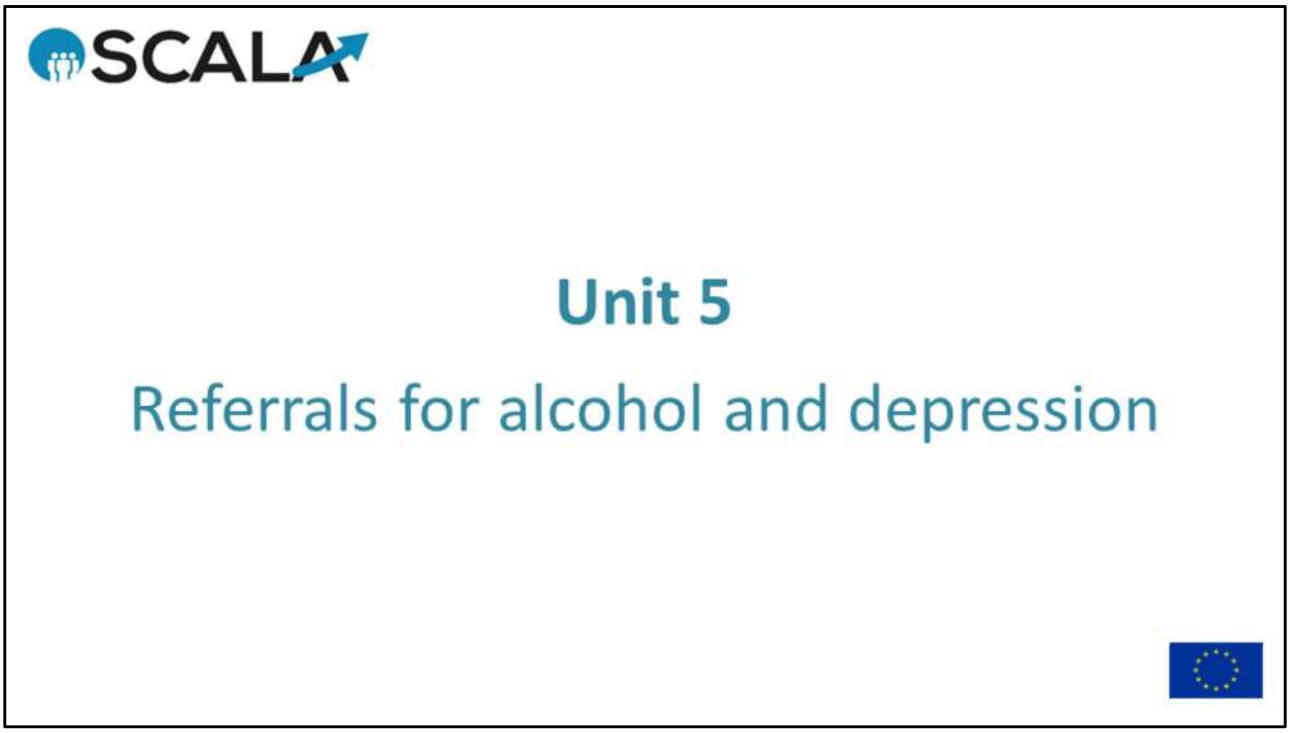
Modelling and practice - depressive symptoms

How did it go?



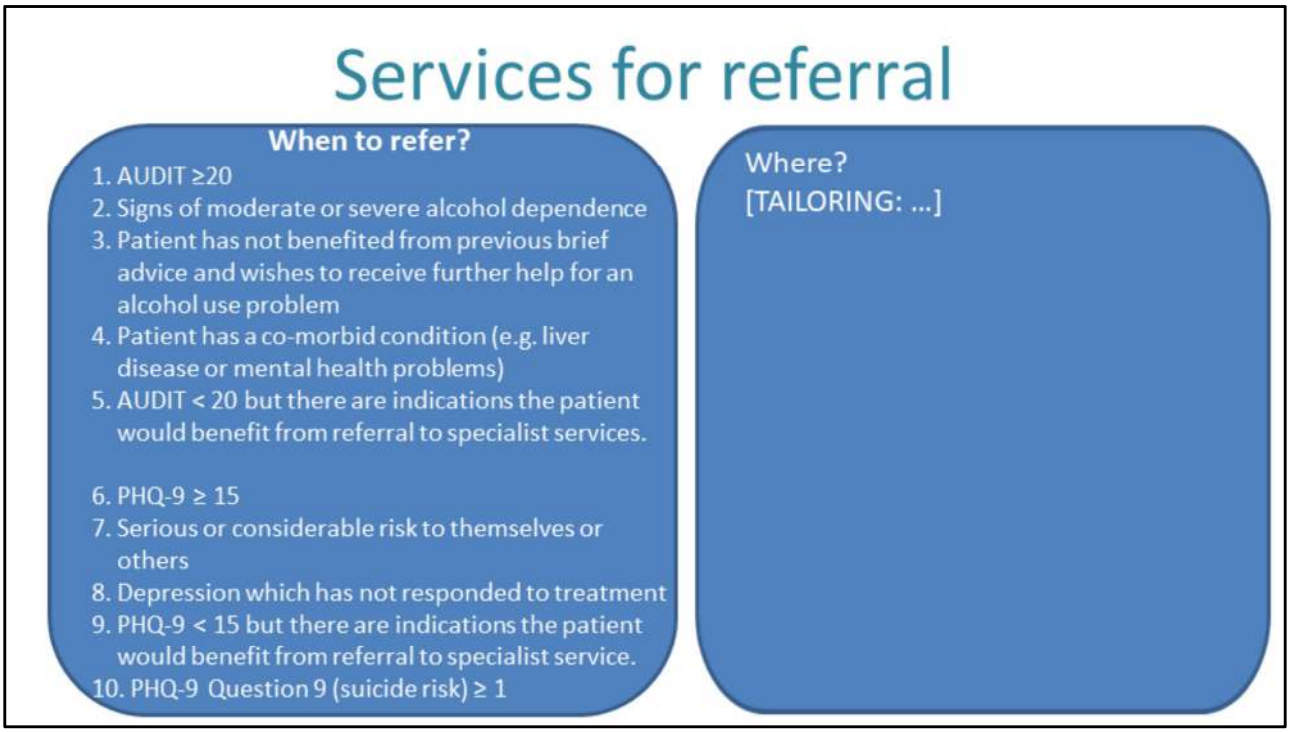
- As a whole group, ask for feedback on how it went – elicit with questions:
    - Did they manage to successfully advise their partner and negotiate goals?
    - Which of the motivational techniques did they use?
    - Did the interview feel comfortable to both sides?
- reinforce any positive comments and try to address any obstacles encountered (especially in motivational skills).
- Remind the professionals that the conversation will become more easier and quicker over time and with practice (as they become familiar with the process and develop their own phrases and styles), and the main objective is to give advice in such a way as to avoid confrontation and resistance and increase the self-efficacy and autonomy of the patient.

Time = 10 mins



Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

Time = (40 mins)



<u>LOCAL TAILORING</u>:

- **Add details of the referral services available in this slide**…
- **change to local term for referral: Derivación / Remisión / Referencia**

- Run through the situations in which referral would be appropriate
- Highlight the local services available for referral for different problems

These points come from the initiative MHGap which provides guidance on managing and referrals for a variety of mental health problems in primary care. For the full guidance pack in ES, please see: http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf

Time = 1 mins

Modelling and practice advice for depression

Watch model video 3 on referral of patients to specialised services for more severe alcohol problems or depressive symptoms.

- **Video 3 – Ana Maria** – The doctor talks about alcohol and mood problems with Ana Maria, a high-risk drinker who is also experiencing depressive symptoms.

Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

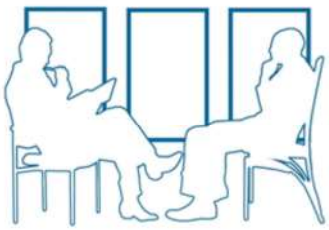
- Explain that they will watch a model video of the doctor giving Ana Maria brief advice and referral to treatment or alcohol and co-morbid depressive symptoms (caso de Ana Maria), before practicing themselves.
- The group should look out for the “what” and the “how” (motivational skills) that were mentioned in previous practice sessions are used in this interaction
- Afterwards, they will split into pairs and practice the referral conversation for alcohol and depressive symptoms

Time = 5 mins

Modelling and practice screening

Practice referral techniques

1. One is the professional, the other the patient
2. The professional should give feedback on the screening (AUDIT = 26 / PHQ-9 = 15), and try to agree a referral with the patient in 5 minutes
3. The patient can use the card or invent their personal characters if they wish
4. When you've finished, or the facilitator says stop, swap roles and repeat with a new card.



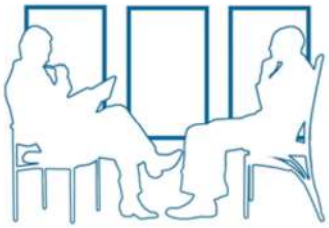
Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

- Put the participants into pairs (e.g. next to each other). They can use the 3rd patient card from the screening exercise on Day 1, as well as imagine their own motivations for the patient.
- Tell them to follow the instructions and monitor the time – tell them when a minute is left, after 5 minutes ask them to stop and swap roles

Time = 15 mins (3 minutes to set up exercise, 5 mins per role play, 2 mins to stop and swap)

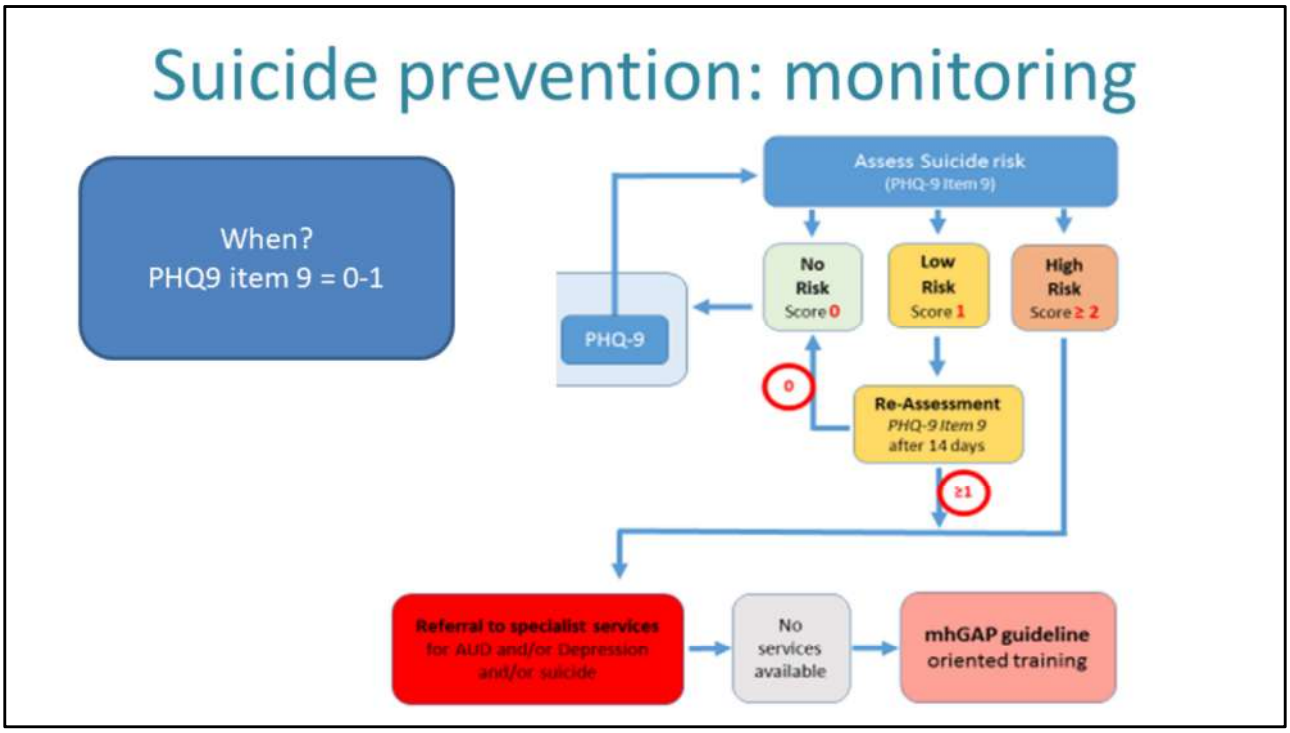
Modelling and practice screening

How did it go?



- As a whole group, ask for feedback on how it went – elicit with questions:
    - Did they manage to successfully agree a referral with their partner?
    - Which of the motivational techniques did they use?
    - Did the interview feel comfortable to both sides?
- reinforce any positive comments and try to address any obstacles encountered (especially in motivational skills or confrontation with 'difficult' patients).
- Remind the professionals that the conversation will become more easier and quicker over time and with practice (as they become familiar with the process and develop their own phrases and styles), and the main objective is to suggest a referral in such a way as to avoid confrontation and resistance, and leave the door open in the case that the referral is refused or for any future crises or doubts.

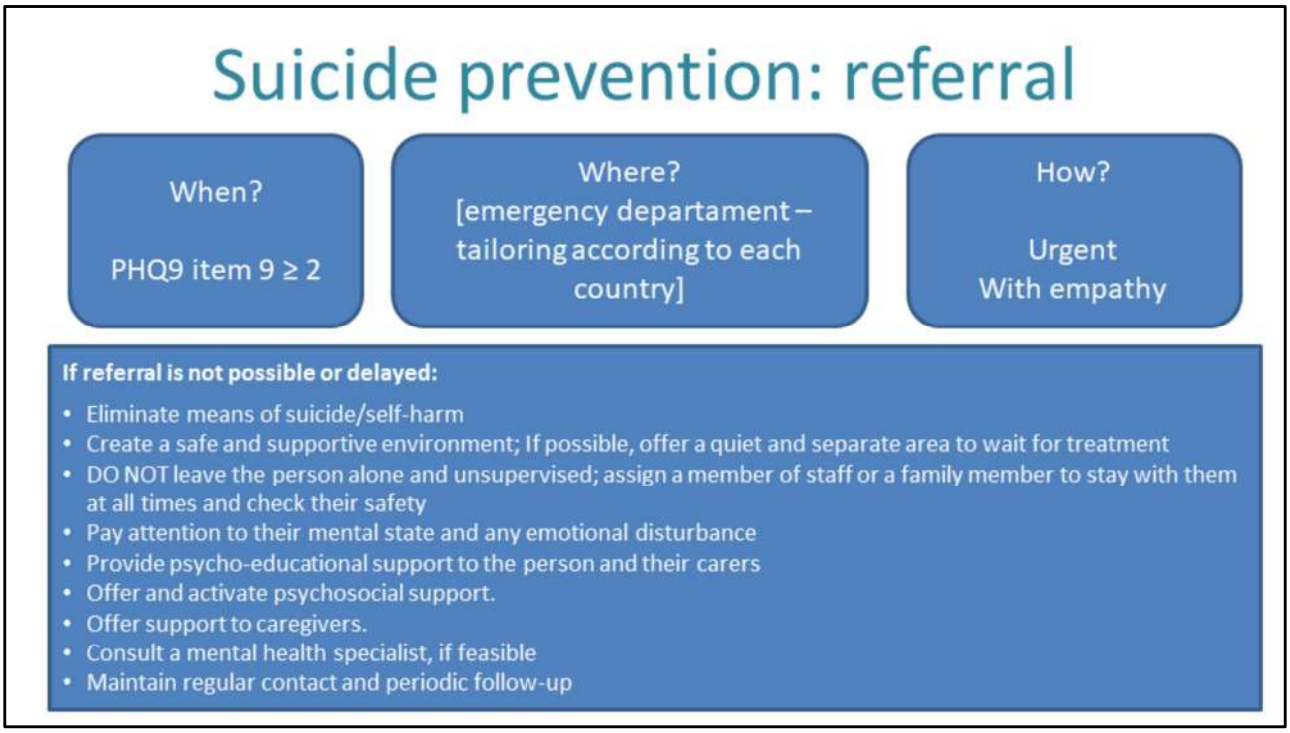
Time = 10 mins



Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

- Discussion on detecting suicide risk and suicide prevention (elicit existing knowledge)
- Reinforce key messages (referral for suicide risk must be urgent, if available)

Time = 5 mins

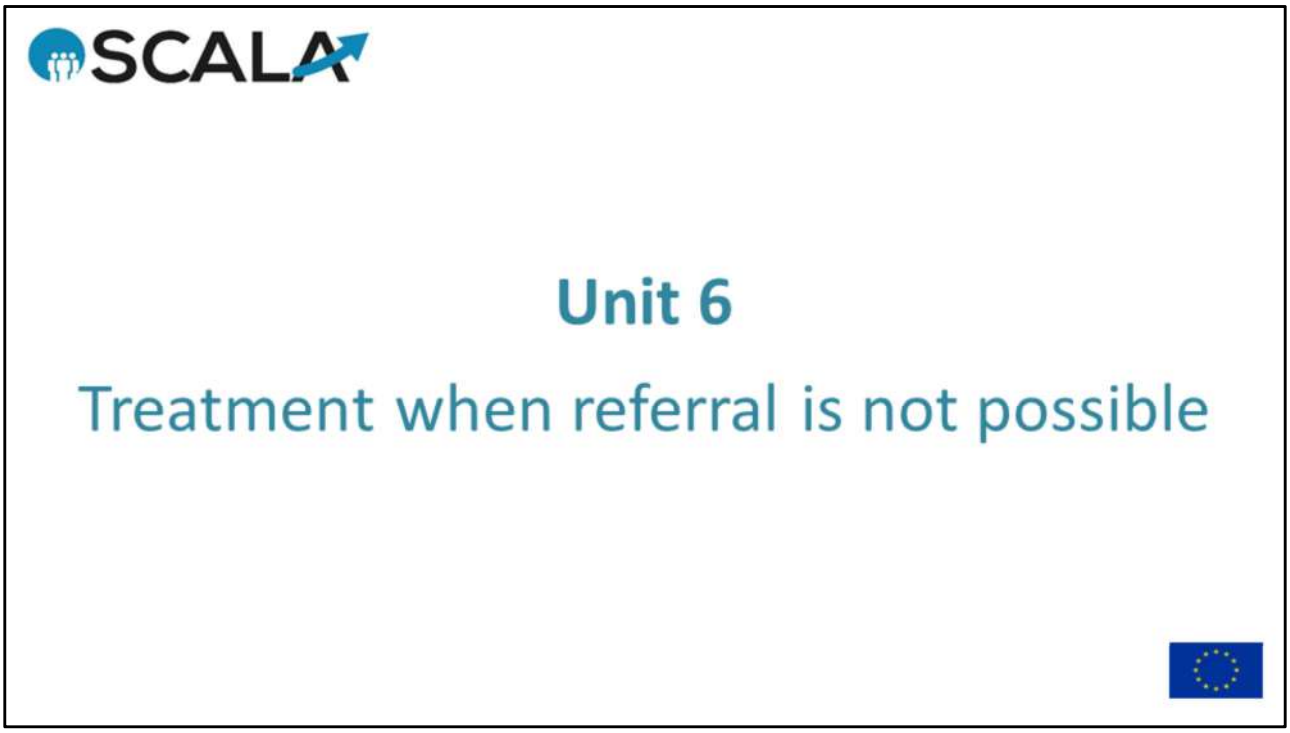


<u>TAILORING</u>:

- **Add details of the referral services available in this slide**…
- **change to local term for referral: Derivación / Remisión / Referencia**

- Discussion on detecting suicide risk and suicide prevention (elicit existing knowledge)
- Reinforce key messages (referral for suicide risk must be urgent, if available; draw on environmental support – family and services)

Time = 5 mins



Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

Reinforce that referral is the preferred option when cases are serious or at risk of becoming complicated.
If this is not possible, a series of recommendations based on the World Program of Action are provided, which provide guidance on management and referral for a variety of mental health problems in primary care. For the complete orientation package in Spanish, see:
http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf
However, this is the exception and not the norm. Typically, the identified cases can be managed in primary care (mild / moderate) or if they require a referral to a specialized center, it is possible and accepted by the patient.

Time = (30 mins)

When referral is not an option: alcohol

- Advise the patient to completely stop alcohol use (if withdrawal syndrom is not a risk) or use it at a non-harmful level (using BI and motivation techniques)
- Verbalise your intention to support the person to do this. Ask them if they are ready to make this change.
- Explore *strategies for reducing or stopping use and strategies for reducing harm* (from BI)
- Address food, housing, and employment needs.
- Arrange a follow up visit within 2 weeks
- Provide psycho-education.

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

- Advise to completely stop the consumption of the substance or decrease it to a non-harmful level, if it exists.
- Verbalize your intention to support the person to do this. Ask them if they are willing to make this change.
- Explore strategies to reduce or stop use and strategies to reduce damage.
- Follow-up
- If the person is a teenager, a pregnant or lactating woman: see SPECIAL POPULATIONS

These points come from the World Action Program that provides guidance on management and referral for a variety of mental health problems in primary care. For the complete guidance package in Spanish, see: http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf

Time = 3 mins

Time = 3 mins

When referral is not an option: alcohol (2)

- Organize detoxification services if necessary or treatment in an inpatient setting when feasible. Treat withdrawal symptoms as necessary.
- Provide a brief intervention using the motivational interview to encourage the person to participate in the treatment of their substance dependence.
- Consider long-term psychosocial treatment for people with problems related to their substance use, if they do not respond to initial brief interventions. Psychological therapies based on scientific data for substance use disorders include individual and group structured programs, which are carried out for 6-12 weeks or more and employ techniques such as cognitive behavioral therapy, motivational reinforcement therapy, Contingency management therapy, community reinforcement approach and family therapy. Evidence-based social support methods include support for employment and housing

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

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Time = 3 mins

Detox: Where referral is not an option and withdrawal syndrome is present

- Provide as quiet and non-stimulating an environment as possible; well-lit during the day and lit enough at night to prevent falls if the person wakes up at night.
- Ensure adequate fluid intake and that electrolyte requirements are met, such as potassium and magnesium.
- **ADDRESS DEHYDRATION**: Maintain adequate hydration including i.v. hydration, if needed, and encourage oral fluid intake. Be sure to give thiamine before glucose to avoid precipitating Wernicke's encephalopathy.

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

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Time = 3 mins

Detox: Where referral is not an option and withdrawal syndrome is present

Pharmacological treatment:

- Administer diazepam in an initial dose of up to 40 mg / day (10 mg four times a day or 20 mg twice a day) for 3-7 days, orally. Gradually reduce the dose or frequency as soon as the symptoms improve. Supervise the person frequently, since each person can respond in a different way to this medication.
- In the hospital environment, diazepam can be administered more frequently (for example, every hour) and in higher daily doses, up to 120 mg / day orally during the first 3 days if necessary, according to a frequent evaluation of the symptoms of abstinence and the mental state of the person.
- In people with impaired hepatic metabolism, (for example, people with signs of liver disease or the elderly), initially use a low single dose of 5-10 mg orally, since benzodiazepines may have a longer duration of action in these population groups. Alternatively, a shorter-acting benzodiazepine such as oxazepam can be used instead of diazepam.
- Evaluate the prescription of naltrexone, acamprosate or disulfiram

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

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Time = 3 mins

Special considerations

The following cases require hospitalisation for detoxification:

- Hepatic encephalopathy
- Respiratory disease
- History of Wernicke Syndrome, Delirium Tremens, seizures.
- Other organic or psychiatric pathology
- Very marked clinical withdrawal syndrome
- No social support
- Previous detox attempts have not been successful

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

- These cases, although exceptional, are extremely serious and their management in primary care is discouraged due to the high vital risk

Further details on the protocol to follow in any of these cases can be found in the mhGAP guidelines:
http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf?sequence=8&isAllowed=y
Hospitalización

Time = 3 mins

When referral is not an option: depression

Psychosocial intervention

1. Psycho-education: fundamental messages for the person and caregivers
2. Reduce stress and strengthen social support
3. Promote proper functioning in daily activities and in the life of the community
4. Brief psychological treatments for depression (see MH GAP)

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

Local tailoring: change to local term for referral: Derivación / Remisión / Referencia

- Further details on the protocol to follow in any of these cases can be found in the mhGAP guidelines: http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf

Time = 5 mins

When referral is not an option: depression

Pharmacological intervention

1. Discuss all effects (and side-effects) with the person and decide together whether antidepressants will be prescribed
2. Start with a single medication at the lowest initial dose.
3. Antidepressant medications, in general, should continue to be administered for at least 9 to 12 months after the remission of symptoms.
4. Medications should never be stopped just because the person experiences some improvement.
5. Instruct the person about the recommended time to take the medication.

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

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Time = 3 mins

anti-depressants: Situations for special consideration

- Teens and young adults
- Women who are breastfeeding or pregnant
- Old age
- Cardiovascular disease
- Suicidal ideation
- Appearance of manic symptoms
- Combination with other drugs

Source: Adapted from 'Guía de intervención mhGAP para los trastornos mentales, neurológicos y por consumo de sustancias en el nivel de atención de salud no especializada.' Versión 2.0. Washington, D.C. : OPS; 2017.

- In adolescents and young adults the adverse effects of the use of antidepressants is greater (e.g., Risk of suicide), therefore it is preferable that prescription is done by a specialist. In any case, the follow-up has to be sooner.
- Avoid amitriptyline in the elderly and patients with cardio-vascular disease. The use of other drugs (e.g. Fluoxetine) is possible but be vigilant for interactions with other drugs and a higher incidence of adverse effects, especially if kidney or liver function are impaired.
- In the next slide the interactions with other drugs of the two main antidepressants are explained.
- For suicidal ideation see the specific section earlier in this training. In any case, the use of antidepressants can increase suicidal ideas (usually it decreases them). Therefore, when an antidepressant is started, this aspect must be evaluated repeatedly.
- Antidepressants are contraindicated when there are manic symptoms (explain briefly). In this case the referral to a specialist is necessary.

These points come from the World Action Program that provides guidance on management and referral for a variety of mental health problems in primary care. For the complete guidance package in Spanish, see: http://iris.paho.org/xmlui/bitstream/handle/123456789/34071/9789241549790-spa.pdf

Time = 3 mins

anti-depressants: overview guidance

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS / CAUTIONS
AMITRIPTYLINE (a tricyclic antidepressant (TCA))	**Start** 25 mg at bedtime. **Increase** by 25-50 mg per week to 100-150 mg daily (maximum 300 mg). Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses. **Elderly/Medically ill:** Start 25 mg at bedtime to 50-75 mg daily (maximum 100 mg). **Children/Adolescents:** Do not use.	**Common:** Sedation, orthostatic hypotension **(risk of fall)**, blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction. **Serious:** ECG changes (e.g. QTc prolongation), **cardiac arrhythmia, increased risk of seizure.**	Avoid in persons with **cardiac disease**, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma, and bipolar disorder (can trigger mania in people with untreated bipolar disorder). **Overdose can lead to seizures, cardiac arrhythmias, hypotension, coma, or death.** Levels of amitriptyline may be increased by anti-malarials including quinine.
FLUOXETINE (a selective serotonin reuptake inhibitor (SSRI))	**Start** 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg (maximum 80 mg). **Elderly/medically ill:** preferred choice. **Start** 10 mg daily, then increase to 20 mg (maximum 40 mg). **Adolescents** **Start** 10 mg daily. Increase to 20 mg daily if no response in 6 weeks (maximum 40 mg).	**Common:** Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction. **Serious: bleeding abnormalities** in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.	**Caution in persons with history of seizure.** **Drug-Drug interactions:** Avoid combination with **warfarin** (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers. Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).

- Go over both drugs briefly

Time = 3 mins

Follow-up

- Initially: every 1 or 2 weeks
  ↓
- **If condition improves**: space progressively until every 3 months. Withdraw medication (if prescribed) at 9-12 months of remission
- **No improvement**: consider psychotherapy or pharmacotherapy if not done yet, assess participation and experience of the person in psychotherapy, reassess dose of drug and compliance

Insist on personalization according to each case.

Time = 3 mins

Wrap up

Topics covered

1. Managing co-morbid depressive symptoms
2. What services exist for referral
3. Practicing making a referral for alcohol and/or depression
4. Suicide prevention
5. When referral is not an option

Next: Booster session - *date*

- Feedback on difficulties
- Trouble-shooting and peer-led solutions

Any comments or questions?

Local tailoring:
- Add date of noxt session
- change to local term for referral: Derivación / Remisión / Referencia

- Quickly run through the topics covered in session 2 (on this slide), and dedicate some time (5-10 mins) to comments and questions
- Remind the participants of the date and time of the 1st booster session – explain that there will be a questionnaire for them to give information on what they are finding difficult and trouble shoot in the booster session

Time = 15 mins


thank you
danke
謝謝
ngiyabonga
شكراً جزيلاً
teşekkür ederim
спасибо
gracias
dank je
mochchakkeram
tapadh leat
dziękuje
obrigado
go raibh maith agat
sukriya
kop khun krap
arigatō
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