CLUSTERING TOGETHER
Newsletter for GPs
and
Practice Managers

Issue 43
November 2015

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INTRODUCTION

Welcome to our November Newsletter.
At the end of last week Chris Provan stepped down as Clinical Lead. Chris has worked tirelessly over the last 3 year on a whole variety of issues involving primary care in the City. He's been a fantastic advocate for primary care within GHB and has never lost any opportunity to impress on the Health Board that the answer to many of our current Grampian wide healthcare issues is continuing (and increasing) investment in the people and organisations we work within daily. On a personal level he's been a great "leader" within the cluster system and great fun to work with. He'll be sadly missed although I'm sure his partners at Elmbank are looking forward to seeing him around a bit more.

There is much happening in sexual health. We've included in this newsletter some information about their drop in service, new arrangements for patient self referral for terminations and a contact number for urgent queries - information worth filing away for reference.

We've also included a variety of other articles that we hope are of interest plus our regular updates on community nursing and pharmacy. If there are any other topics you'd like us to cover in future newsletters please get in contact.

Stephen Lynch
Interim Clinical Lead,
Aberdeen City Health & Social Care Partnership

DR CHRIS PROVAN

We live in interesting and in some ways challenging times but I still feel being a GP is a fantastic job. It is hugely rewarding working with patients over the years and we do receive a huge amount of positive feedback for the work we do. It is also very encouraging watching our trainees, the next generation, developing and growing in confidence. Aberdeen now attracts more trainees and we have a very talented group of young doctors coming through the training scheme. It is up to us to continue to do everything we can to retain their skills in Aberdeen and make the city a rewarding place to work as a GP. There is a lot of work going on around recruitment locally and nationally around these issues and the new GP contract in 2017 needs to make Primary Care an attractive place to practice medicine.

Nothing stands still however and we do need to change to meet the increasing tide of demand. In some ways we have been forced to try out new models of working and expand the Primary Care Team to include other professions. We have been trying support the development of Advanced Nurse Practitioners and some practices are employing Physicians Associates. In the future GPs may be more of the coordinator of care with other team members seeing the less complex patients. GPs need to be seeing the people that make use of our skills the most e.g. the complex elderly.

Health and Social care integration has been progressing over the last few years across Aberdeen and we have now built many more relationships with our social care colleagues at many levels within the system. There are still problems with finding enough paid carers but we have recently been given funding to attract and train more carers while providing affordable accommodation for them in Aberdeen. The high house prices in Aberdeen are a barrier for many professions re-locating to the city.

The Northfield Medical Practice recently won the RCGP innovation prize for their work on the Silver City Project which involves close integrated working in new ways with social care and the Third Sector. Congratulations to Claire Rebello, her attached Geriatrician Bob Caslake and the team who took this work forward (Link to Silver City Report). Aberdeen is now seen nationally as a place where new ways of working are being tested for the benefits of patients and staff.

The new body in charge of Health and Social care integration the shadow Integrated Joint Board will publish soon the Strategic Plan for Primary Care. This is an opportunity for us to work in a much more joined up fashion and link back into our communities through the development of our Clusters/Localities. There are huge resources and Third Sector organisations which we do not link into as well as we could and we will hopefully be developing link workers to support practices to help patients self manage more. The Integrated Care Fund will help us try out new ways of working and develop the infrastructure around our Clusters/Localities.

I have enjoyed my time as Clinical Lead and I am returning to my practice full time to help during a time when we have doctors retiring. The Health and Social Care Partnership have a strong team lead by the Chief Officer Judith Proctor and Dr Stephen Lynch. We are at the start of a journey with integration and the new Strategic Plan and it is important we all still continue to help shape our future.

Dr Chris Provan

NEWS IN BRIEF

New Dyce Medical Practice

The new Dyce Medical Practice opened on the 1st of October. Supervised by the Scotstown Medical Group and operating from the Dyce Health Centre the clinical team includes general practitioners, advanced practitioners, clinical associates and pharmacists. A share of Practice Nursing, administrative staff, district nursing and health visiting staff previously with the Brimmond and Gilbert Road practices complements the new clinical team.

Sexual health urgent cases contact number

Sexual health have a direct line number if GP's wish to discuss urgent cases. The number is 01224 655525 and will put the doctor through to a health advisor or they can leave a message with their contact details and someone will call them back. This answer phone is checked regularly. This number is also advertised on ROTAWATCH- If you put rota watch into the browser of any NHSG PC this number will come up as on call today under Sexual Health

Please note other articles in this newsletter regarding "drop in clinic "times and patient self referral service for termination of pregnancy.

DATIX lite ----PLEA FOR MORE REPORTING

Just a reminder and plea to continue to complete DATIX lite feedback forms for ALL inadequate discharges.

Please use the following link;

http://nhsg-sql-datix.grampian.scot.nhs.uk/datix/live/index.php?form_id=5&module=PAL

Reports are now generated every week/month and this feedback is now looked at in the following forums;

-Quality Safety Huddle every Monday morning
-Monthly Discharge Collaborative Meeting chaired by Dr Steven Close
-Monthly report to go to City Clinical Governance Group meeting

These are all important meetings that are able to facilitate change and improvements based on the data we collect via DATIX lite.

So please continue to report on all your inadequate discharges – no matter how small – if we don't report these incidents then no improvements can be made.

If you have any questions please email Dr Caroline Howarth on caroline.howarth1@nhs.net

SELF REFERRAL FOR TERMINATION

- ***70% of women seeking TOP should have the procedure completed before 9 weeks gestation as this is associated with fewer complications***.

Some women will delay seeking medical advice as they have not decided what to do about the pregnancy. But access to health professionals may also introduce delays.

- ***Two thirds of women attending for TOP in Aberdeen have been referred by their General Practitioner first.***

To minimise delays in women accessing the TOP service we have looked at a number of initiatives to improve access. In addition, we have made information available for women to receive prior to being seen in the TOP to allow them to make an informed choice. **Currently, this applies for women in Aberdeen City and Aberdeenshire only.**

Women can self referral for TOP unless they specifically wish to see their General Practitioner.

Women can call the TOP clinic on (01224) 655535 between 9 am and 2 pm Monday to Friday to make an appointment.

When women call they are asked three questions by our administrator:

are you aged over 16 years?
have you had a positive home pregnancy test?
have you had a normal period in the last 3 months ?

NO to any question a nurse/doctor will phone back as they may need to be seen urgently.

YES to all questions they will be offered the next available assessment appointment or at a date and time of their choosing.

Women are sign posted to our website to access the NHS Grampian information leaflet on TOP and also offered to be sent a link to video clips on what will happen at the clinic.

Women are offered a text message to be sent with the date and time of their appointment along with postcode and directions to Health Village and link to the website.

At the assessment appointment they will be seen by **senior medical and nursing staff** for counselling.

All women have:

- transvaginal ultrasound scan
- swab for Chlamydia and gonorrhoea and offered full STI screen (HIV and syphilis)
- discussion about pregnancy options and reasons for termination
- information and consent about fetal tissue disposal
- discussion about options for TOP and consent
- future contraceptive plan in place

- leave with arrangements in place for TOP
- a Certificate A signed by two doctors at Health Village

We encourage all women to let us inform their General Practitioner about their TOP.

Although women aged under 16 can consent to TOP without parental consent we do ensure an adult (over 18 years) must accompany the young person for her procedure to provide support. We will arrange for an accompanying adult if they do not have an adult who can attend with them.

Women who present up to 20 weeks gestation can have a TOP in Aberdeen. However, if she is more than 20 weeks gestation we will assist in making arrangement for the TOP to be funded and performed in England.

If you suspect a patient is more than 16 weeks gestation please contact our pregnancy advisory nurses as soon as possible on (01224) 553466 or ARI switchboard and Bleep 2396 or 2137. We will arrange to see them soon.

CHANGES TO SEXUAL HEALTH DROP-IN SERVICES WILL IMPROVE ACCESS FOR PATIENTS.

From Monday August 3rd Sexual Health Drop in Clinic Times at Aberdeen Community Health and Care Village will be:

- Monday and Wednesday 1pm-3pm (all ages)
- Friday 12.30pm-2.30pm (all ages)

We will also continue to offer drop-in clinics for Young People (under 18s) as follows:

- Tuesday & Thursday 4pm-5.30pm

These changes will free up 4 doctors and nurses who will be providing telephone consultations and booked clinics instead of drop in, so there will be no lost patient contact time. In fact we will probably see more patients this way and hopefully improve the patient journey. Triage (both face to face and telephone) will allow patients to be diverted to the most appropriate booked appointment or drop in with the most appropriate member of our team. It will take time to embed this new change and we will be sensitive to patients who were unaware of changes.

GPs should continue to refer patients to the specialist service via SCI gateway or by calling 0345 337 9900 (number from 1/8/15) to discuss a specific patient urgently with specialist staff who can then make an arrangement for the patient to be seen by the most appropriate person . There will be daily appointments for such emergencies.

Women who are established on a contraceptive method should seek repeat supplies from their GP practice.

Further information is available at www.nhsgrampian.org/sexualhealth

COMMUNITY NURSING UPDATE

We are currently experiencing a situation where it is extremely difficult to recruit trained staff to fill the vacant Band 6 District Nurse posts. We have placed a number of trainee and newly qualified District Nurses into these vacancies, however, it is important these staff receive full support and mentoring whilst transitioning to the trained District Nurse role.

We have no such problems recruiting experienced Band 5 staff, however new staff also require support and mentoring until they are competent to work in the community setting.

As a result of the above, it is necessary for us to continually review staffing levels across the City and sometimes move experienced community nursing staff to ensure we have safe staffing in place and that caseloads are covered. One of the rationales behind our current model of delivery was the ability to move staff to aid their professional development and ensure a better understanding of the roles of the PAT and DDT teams.

The work we are currently undertaking in relation to the staffing issues, whilst challenging, is helping to inform as we move to take community nursing into the integrated partnership.

On behalf of the Service Manager team and the Community Nursing teams, we would like to ask for your support and understanding whilst we deal with these staffing issues which will help us to ensure we continue to deliver a quality nursing service to patients in Aberdeen City.

Heather MacRae
Lead Nurse
Aberdeen City Health and Social Care Partnership
(Community Health)

THE SINGLE ACCESS POINT (SAP) @ THE CITY HOSPITAL

We are very proud of our Single Access Point which has been in place since February 2012. On average we receive 520 new referrals each month.

We thought it would be helpful to clarify what the SAP is for and how it can help you with making referrals. The SAP enables you to send referrals via SCI-Gateway, email, fax, phone or send by post to one place to obtain a service from the following professionals: Occupational Therapists (NHSG), Domiciliary Physiotherapists, Community Geriatric Nurses, Geriatricians and the Supported Discharge Team for Stroke.

These staff who previously provided services through, Community Therapy Services (CTS) and the Falls and Frailty Intervention Team (FFIT), still provide all previous services (including falls assessments) but the teams have merged and are now known collectively as CAARS which stands for Community Adult and Assessment and Rehabilitation Service.

The SAP is manned by administration staff who will take your call and deal with your referrals sent by SCI-Gateway, post, fax or email. Any urgent referrals with an 'acute' medical or nursing need will be triaged directly to the CGN/Geriatrician via a dedicated administrator. If this is the service you require please ask to be put through to this service when you call. All other referrals are screened and triaged daily by a qualified Occupational Therapist and Physiotherapist and prioritised according to need.

The numbers you need are Tel 01224 558324 Fax 01224 558202
email - nhsg.sap@nhs.net

We hope this is helpful, but if you have any feedback on how the SAP could be improved then please do not hesitate to phone or drop me an email.

Thank you. Beth Thomson, Lead OT, bethhomson@nhs.net 01224 558314

PHARMACY UPDATE - PALLIATIVE CARE GUIDELINES

The Scottish Palliative Care Guidelines have been developed by a multidisciplinary group, including community, hospital & specialist palliative care services and provide readily accessible, practical guidance on a range of common issues.

The NHS Grampian Palliative Care Clinical Guidance Intranet site has now been updated to reflect the Scottish Palliative Care Guidelines. The site contains a wealth of information on topics such as symptom control, pain management, use of syringe pumps and end of life care (including anticipatory prescribing).

It is worth noting that there have been some changes to the dosage recommendations for 'Just in Case' medication:-

- Morphine **2mg** subcutaneously up 1 hourly for pain or 2 hourly for breathlessness (was previously 2.5mg)
- Midazolam **2mg** subcutaneously up to 2 hourly for agitation (was previously 2.5mg)
- Levomepromazine **2.5mg-5mg** once daily for nausea (was previously 6.25mg)

Work is ongoing to update the Vision electronic formulary in line with these changes.

Blank prescription charts for syringe pumps and 'Just in Case' medication can be ordered from stores using code **ZOP 573**

Dual Antiplatelet Treatment – Ticagrelor + Aspirin

Ticagrelor has become the antiplatelet of choice (in addition to aspirin) for Acute Coronary Syndrome (ACS). Dual antiplatelet therapy is recommended for a number of cardiac conditions and, although the duration of treatment may vary depending on indication / individual patient, the combination is typically continued for 12 months.

We would recommend that stop dates for ticagrelor are documented in the patient notes but also on their prescription. This ensures that the GP, dispensing pharmacist and the patient are all aware of when ticagrelor should be discontinued. Practices may have used a similar system in the past to highlight stop dates for clopidogrel (in combination with aspirin).

MEDICINES RECONCILED, NOT MEDICINES WRECKED! – PALLIATIVE CARE GUIDELINES

Reconciling a patient's medicine is about getting an accurate record of what a patient is on and what their allergies are. From this the prescriber can make safe decisions based on the patients' current health as to what should be stopped, with-held or continued. It covers the whole of the patients' journey across primary and acute care. The poor accuracy of, and/or lack of information on discharge letters is a hot topic, and is being addressed in a variety of ways. For instance, standardising the Medicine Reconciliation ("*MedsRec")* process helps improve patient safety - NHS Grampian launched a *MedsRec* protocol in July 2015, which aims to ensure each care setting understands their responsibilities around *MedsRec*.

There is also a mandatory e-learning module on *MedsRec* being promoted mostly to Acute staff - to date more than 2000 staff have completed this. *MedsRec* teaching has been incorporated further into the undergraduate medical curriculum and induction programme of Foundation Year doctors within NHS Grampian.

Primary Care can also help improve medicine safety by having a structured process for dealing with discharge prescriptions, and / or medicine changes to ensure a patient's electronic prescribing records are up to date. The responsibilities of the Primary Care team are detailed in the protocol, in section 2.4, which is available on the intranet at **http://tinyurl.com/NHSGmedrec**

Process mapping is a good way that Practices can use to identify the various steps in the current *Medsrec* process. This can then lead to discussion and agreement of what the essential steps are, and clarifies what each member of the Practice team (from GP to receptionist) is responsible for in the process.

There is an established data collection tool and care bundle for *MedsRec* in Primary Care available as part of the Scottish Patient Safety Programme which can be found at

http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/safer-medicines

Care Bundle Measures:
Measure 1: Has the immediate discharge document (IDL) been forwarded to a clinician on the day of receipt?
Measure 2: Has medicine reconciliation occurred within 2 working days of the IDL being received by the practice?
Measure 3: Have changes to the medication following reconciliation been updated in the clinical record?
Measure 4: Significant changes to medications have been discussed with the patient or their representative within 5 working days of the IDL being received by the practice? (significant changes include repeat medications being started or stopped or an alteration in dosage)
Measure 5: Have all measures have been met?
Read codes are available within Practice clinical systems to identify when *Medsrec* has occurred:

#8B318 Medicines reconciled	**#8B3A3** New Medication Commenced
#8B3A1 Medication Increased	**#8B3R** Drug Therapy Discontinued

#8B3A2 Medication Decreased	**#8B396** Treatment Stopped – alternative therapy undertaken
#8B313 Medication Commenced	**#67IM**. Advice to GP to Change Patient Medication

Thank-you for your continued support in improving the accuracy of *MedsRec* in Primary Care.

If you have any queries please do not hesitate to contact your Practice Pharmacy team, or myself, Lyn McDonald (Medication Safety Advisor) at lyn.mcdonald@nhs.net

WEIGH FORWARD

Grampian Specialist Weight Management Service
Referral Guidelines for Healthcare Professionals

Weigh Forward is a team of specialist Psychologists and Dietitians who can offer regular and structured support for patients to help with long term weight loss and lifestyle changes.

Who is this service for?

Weigh Forward is for patients who have made several unsuccessful attempts at weight loss in the past through attending structured group education e.g. Health Helpings or commercial programmes. We are looking for patients who are motivated to make the changes required for sustained long term weight loss.

What does our service offer?

The service involves 12 fortnightly sessions to cover a range of topics including diet, activity and lifestyle changes. The programme has a strong emphasis on the psychology behind eating, helping patients to identify and overcome many of the issues that may have hampered weight loss attempts in the past.

After the initial group sessions patients will remain within the service for a further 12 months when they will have regular contact with the team to ensure continued weight loss or maintenance. We will also run one to one appointments covering similar content as offered in the groups as required.

How can I refer my patient?

- We accept referrals from Healthcare Professionals - GP, Consultant, Practice/Specialist Nurse, and Allied Healthcare Professionals.
- Referrals can be made through SCI-Gateway Nutrition Mailbox.
- Referrals can also be made by completing a referral form and sending by post or email to

  Grampian Specialist Weight Management Service,
  Rosehill Annexe,
  Aberdeen Royal Infirmary,
  Aberdeen,
  AB25 2ZN
  E-mail to nhsg.swms@nhs.net

Referral Criteria:

- Aged 18 and over
- BMI ≥ 35
- BMI ≥ 30 (with associated co-morbidities)
- Motivated to change and engage with a 6 month programme
- Engaged with structured weight management programme eg. Healthy Helpings or similar
- *16 and 17 year olds may be considered depending on circumstances*

Service Exclusions:

- Unstable psychiatric or medical disorder
- Acute infection
- Acutely unwell
- Pregnancy
- Physically unable to attend outpatient appointments

What Happens Next:

- Referral will be assessed by the MDT team and if appropriate an opt in appointment letter will be sent to the patient to invite them to attend our assessment clinic.
- At the assessment clinic they will be offered the opportunity to complete an intensive weight management programme over 6 months delivered by a specialist team of Psychologists, and Dietitians with follow up, at 12 months on completion of the intensive programme.
- The programme involves group and one to one sessions in diet, physical activity, behaviour change, motivational enhancement, disordered eating and cognitive behaviour therapy.
- We will keep the referring professional updated of their patient's progress at 6 months and on discharge.

Service Evaluation

NHS Grampian has received 2 years of initial funding to set up the service. By the end of this time period we need to provide evidence of how successful the service has been. Evaluation of the service will involve looking at changes in patient's weight, eating behaviour, activity levels, relevant biochemistry and blood pressure. We will also be looking at measuring a range of psychological aspects including self efficacy, quality of life and emotion regulation.

We will be asking the patients GP to measure biochemistry and blood pressure at the start of the programme then at 6 monthly intervals in order to aid with evaluation.

More information on the service can be found on the NHS Grampian Hi-Net
www.hi-netgrampian.org

Grampian Specialist Weight Management Service,
Rosehill Annexe, Aberdeen Royal Infirmary,
Aberdeen,
AB25 2ZN
Tel: 01224 553743
Email: nhsg.swms@nhs.net June 2015

THE BIG BLETHER

As part of the redesign of services at Northfield/Mastrick GP Practice, the nurse practitioner has 2 sessions per week to visit older adults at home. This is used to optimise health, discuss anticipatory care and assess need for input from other services, including social work, allied health, nursing and wellbeing. There is an integrated multi-disciplinary group in the practice where patients can be discussed. Social isolation is a commonly found problem.

In June, two 'Big Blether' events were held in Northfield and Mastrick to support socially isolated older people to regain connectedness within their local community.

A partnership approach between Northfield/Mastrick GP Practice, ACVO and ACC Communities & Wellbeing staff, people were invited to drop in for a cuppa and a fine piece to meet new friends, learn about local groups and activities and most importantly, have fun! Although a mail drop was carried out, the majority who attended had been invited by the nurse practitioner at the practice.

The events were a great success, with 15 attendees in total, including one couple who met for the first time in sixty years having shared their first kiss! For another lady it marked her first trip out in a year, and a further two attendees have since met for lunch together.

Attendee Betty has since shared the below poem to capture her experience.

All attendees received information about social transport, local community groups and will be sent a thank you card for their attendance. The partnership hopes to repeat the Big Blether events locally to increase understanding of how people may be supported to maintain social connectedness.

ALTENS ARCHERY CLUB

A few folk local to the Cove & Altens area highlighted a need for some outdoor Archery in Aberdeen. After a few serendipitous discussions it was identified that each of these folk had different skills, knowledge and contacts to bring to the table. Conversations with the Kincorth Learning Partnership, local businesses and Altens Community Centre helped overcome some former and fairly consistent barriers to the project and a summer of Archery began with funding from the Health Improvement Fund.

Those conversations highlighted issues such as social isolation, affordability, varied apprehensions about joining in and other barriers to engagement. The project aimed to overcome these issues and attempt to bring families / generations together in a fun way.

Despite some dismal weather the Club has been very well attended with lots of great feedback. See our FB page -

https://www.facebook.com/AltensArcheryClub?fref=nf

Over the 'summer' we saw about 200 attendances with around a quarter of attendees offered free access to sessions. The 50+ festival was our first indoor event and the feedback on the day was tremendous. That event and the Golden Games is likely to help us be sustainable over the years. Our participation in 'fun' fund-raising events for Cove Gala and Cove Youth Football Club allowed us to raise funds for other local groups.

One great aspect has been how the bottom up approach (ABCD*) of volunteers and neighbors has enabled much greater opportunities for inclusion as well as create inter-generational activities by involving the wider community. From gaining the support of local business, to the formation of the Youth club at Altens Community Centre where 81 boys and girls turned up one Friday evening, the opportunities for a much wider network of inclusion spread from a chance discussion of a need by a few Citizens.

Roughly 700 volunteer hours over the summer resulted in a range of sustainable involvement that enhances inclusion within the community.

Going forward this project using the assets of active citizens provides wide ranging opportunities to influence aspects of health and well-being. An avenue for support, when needed from a local Community Health Worker within a community setting has been set up to encourage participation.

A full report to follow after an analysis of information collected from project

*(ABCD = Asset Based Community Development)

Alcohol and Depression

Factsheet

Introduction

Depression is one of the most common mental health problems in the UK- experienced by as many as one in ten people in any year,[1] - and it shares a complex, mutually reinforcing relationship with excessive alcohol consumption.

This means regardless of whether heavy alcohol consumption or depression came first, having one condition makes it significantly more likely the other will develop. In both cases however, **the risk increases with greater consumption of alcohol:** excessive drinking increases the chance of developing depression, and drinking while depressed both exacerbates depressive symptoms and makes recovery more difficult. [iii iv v]

What is Depression?

Sufferers of depression experience persistent feelings of sadness for prolonged periods of time.[2] This can include experiencing no happiness or pleasure from any activity, finding it hard to sleep or get up, loss of appetite, fatigue, poor concentration, feelings of worthlessness, hopelessness and even suicidal thoughts.[3]

As well as having a devastating impact on individuals, depression also substantially impacts on public finances. It is estimated in England alone the cost of depression was nearly £11bn in 2010[4] - both in direct medical care and lost revenue from time taken off work.

Biological Effects

The full effects of alcohol on the brain are not yet fully understood. A number of clinical research studies have found that regularly drinking alcohol disrupts the brain's chemistry, altering the way it operates. Lowering the level of serotonin in the brain[5] – the chemical responsible for regulating people's mood – and disrupting other chemicals, may lead to the development of depressive-like symptoms.[6]

Alcohol and Depression, Depression and Alcohol – What's the link?

There is no definitive causal link between alcohol and depression. Depression is found in heavy drinkers at a significantly higher rate than in the general population,[7] [ii] and suffering from depression increases the likelihood of excessive alcohol consumption and dependence in the future.[iii iv] Alcohol dependence is roughly three times more likely amongst those experiencing depression, compared with non-depressive populations.[ii] A complex & mutually reinforcing relationship exists between the two. Alcohol's effect on the human body (especially excessive alcohol consumption over a long period of time) has been shown to cause depressive symptoms.

'Self-medicating'

Many people suffering from depression and experiencing acute feelings of sadness and anxiety may drink alcohol in an attempt to relieve those symptoms, this is known as 'self-medicating'.

Alcohol Concern
Promoting health; improving lives

Alcohol and Depression

Temporarily, the effect alcohol has on the body may relieve some of them – by depressing the central nervous system, alcohol helps 'numb' emotions to avoid dealing with difficult issues.[11]

However, 'self-medicating' has been shown to be one of the least effective methods of dealing with depression.[11] Suffering from depression is often experienced before the development of problematic drinking, particularly in women, which suggests that people attempting to self-medicate accounts for a substantial amount of the number of concurrent alcohol problems in depressed people. [11] Ultimately, self-medicating with alcohol not only fails to reduce depressive symptoms, but can exacerbate them and contribute to the development of problematic drinking it its own right.

Alcohol Exacerbates Symptoms and Increases Risk

Consuming greater amounts of alcohol may contribute to harsher, more acute depressive symptoms.[3] [18] Sufferers of depression who have a harmful relationship with alcohol have a higher risk of committing suicide, having marital problems and being divorced, spending more time in hospital and overall a lower chance of recovering from depression in the future.[4]

Dual Diagnosis

In clinical contexts experiencing a mental health and substance misuse problem at the same time is known as 'dual diagnosis.' Between a third and a half of people of who have a mental health problem also use drugs or drink to excess.[16]

The complex nature of dual diagnosis conditions has often led to inadequate treatment.[17] Professionals may incorrectly diagnose one condition as being entirely symptomatic of the other – opting only to treat one element, and ignoring the complexity of the relationship. It is important treatment is coordinated and tackles both diagnoses.[16]

Those experiencing depression while seeking treatment for alcohol dependence are both more likely to relapse [11] and to relapse earlier.[19] Studies have shown that alcohol treatment often only has an impact on alcohol related-depressive symptoms.[11] Whilst, treatment for alcohol dependence in those who develop an alcohol problem *after* the onset of depression is much less effective.

Suffering from depression can make reducing alcohol consumption more difficult, and vice versa – it is harder to treat depression while drinking large amounts of alcohol.[19] It is important that the NHS and treatment services are equipped to deal with people who have a dual diagnosis, and ensure dual diagnosis patients receive comprehensive care.

Reducing alcohol reduces depressive symptoms

Fortunately, reducing ones drinking can result in fewer, and less intense, depressive symptoms.[11] [18] In people who suffer from a dual diagnosis, cutting out alcohol for five weeks resulted in a substantial reduction in depressive symptoms.[4]

Final Word

There is a complex, powerful and mutually reinforcing relationship between alcohol and depression. Consuming heavy amounts of alcohol increases the chance of developing depression, results in harsher depressive symptoms and can make it harder to recover. Many sufferers of depression use alcohol to 'self-medicate' and the treatment system does not always satisfactorily support those who experience a dual diagnosis. Reducing alcohol consumption can help to reduce depressive symptoms and cutting out alcohol altogether may be an important lifestyle change necessary for those suffering from depression.

Reducing alcohol consumption can help to reduce depressive symptoms and cutting out alcohol altogether may be an important lifestyle change necessary for those suffering from depression.

Alcohol and Depression

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