

Global Guideline

for Type 2 Diabetes

Chapter 4: Psychological care

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Recommendations

■ Standard care

PS1 In communicating with a person with diabetes, adopt a whole-person approach and respect that person's central role in their care (see also *Education, Lifestyle management*).

Communicate non-judgementally and independently of attitudes and beliefs.

PS2 Explore the social situation, attitudes, beliefs and worries related to diabetes and self-care issues.

Assess well-being and psychological status (including cognitive dysfunction), periodically, by questioning or validated measures (e.g. WHO-5 [1]).

Discuss the outcomes and clinical implications with the person with diabetes, and communicate findings to other team members where appropriate.

PS3 Counsel the person with diabetes in the context of ongoing diabetes education and care.

PS4 Refer to a mental health-care professional with a knowledge of diabetes when indicated. Indications may include: adjustment disorder, major depression, anxiety disorder, personality disorder, addiction, cognitive dysfunction.

■ Comprehensive care

PS_c1 Principles of communication will be as for *Standard care*.

PS_c2 A mental health specialist (psychologist) would be included in the multidisciplinary diabetes care team.

PS_c3 Periodic assessment and subsequent discussion would be as for *Standard care*, but could use additional measures [2-4] and computer-based automated scoring systems. The mental health specialist in the team would be able to provide a more comprehensive (neuro)psychological assessment, if indicated.

PS_c4 Counselling would be as for *Standard care*, but the mental health specialist in the team would be available to offer psychological counselling, to participate in team meetings, and to advise other team members regarding behavioural issues.

■ Minimal care

PS_M1 Principles of communication will be as for *Standard care*.

PS_M2 Be alert to signs of cognitive, emotional, behavioural and social problems which may be complicating self-care, particularly where diabetes outcomes are sub-optimal.

PS_M3 Refer for mental health specialist advice according to local availability of such professionals.

Rationale

Psychological well-being is itself an important goal of medical care, and psychosocial factors are relevant to nearly all aspects of diabetes management. Being diagnosed with diabetes imposes a life-long psychological burden on the person and his/her family. Having diabetes can be seen as an additional risk factor for developing psychological problems, and the prevalence of mental health problems in individuals with diabetes is therefore likely to exceed that found in the general population. Poor psychological functioning causes suffering, can seriously interfere with daily diabetes self-management, and is associated with poor medical outcomes and high costs [5-7]. More serious psychological disorders need to be identified, and referral to a mental health specialist for diagnosis and treatment considered.

Ways in which health-care professionals can directly or indirectly help resolve behavioural and psychological issues, with the aim to protect and promote emotional well-being (quality of life) can be considered in terms of: 1. communication with the patient; 2. assessment or monitoring; and 3. counselling.

Evidence-base

Psychosocial aspects of diabetes care are included (to varying extents) in the guidelines from the CDA [8], SIGN [9], NICE (Type 1) [10] and ICSI [11] and, for the first time in 2005, in the ADA standards of care [12]. NICE examined evidence from studies including people with Type 2 diabetes, particularly in the area of depression, which is the only topic addressed by ICSI and (for adults) by SIGN. Depression has been found to be twice as prevalent in people with diabetes compared with the general population [13] and is often under-detected [14].

Evidence-based guidelines for psychosocial care in adults with diabetes have been published under the auspices of the German Diabetes Association (DDG), indicating the

level of evidence for psychological interventions in different problem areas [15].

There is RCT support for efficacy of antidepressant treatment (in a mixed group of Type 1 and Type 2 diabetes with major depressive disorder), and for cognitive behaviour therapy (in Type 2 diabetes with major depression) [8,14]. There is growing evidence that psychological counselling can contribute to improved adherence and psychological outcomes in people with diabetes [16]. A systematic review and meta-analysis has shown that, overall, psychological interventions are effective in improving glycaemic control in Type 2 diabetes [17].

Consideration

People coping with diabetes are more likely to be affected by mental health problems, and self-management is likely to be more difficult in the presence of such disorders. Detection of emotional problems in relatively brief consultations with diabetes professionals is likely to be problematic without a formal or structured approach. Lastly there is a clear need for some basic training for diabetes professionals in management issues in this area, and for appropriate referral pathways to mental health specialists with a knowledge of diabetes for people more seriously affected.

If followed by adequate treatment or referral, screening for mental health problems as part of routine diabetes care can help to improve patient satisfaction and psychological outcomes.

Implementation

Agreement on the importance of psychological factors, and the underpinning philosophy of empowerment of people with diabetes, implies agreement within the care team on the relevance of psychological issues in diabetes. There is then a need for training of diabetes care team members in communication/interview skills, motivational techniques

and counselling. Training of health-care professionals in the recognition of psychological problems will also be needed. Where resources allow, psychological assessment tools should be made available to diabetes teams, and health-care professionals should be trained in applying assessment/monitoring procedures. Collaboration with mental health specialists who already have an interest in diabetes can help to extend the education/training of other mental health specialists in relation to diabetes.

Evaluation

Evaluate by number of psychological assessments in a given time-period, level of well-being and satisfaction in the managed population over a period of time (overall and by subgroups), and by number of referrals to mental health specialists, indications and outcomes. The training, and continuing education, of diabetes health-care team members can also be evaluated.

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