

# Knowledge & Information Repository

## Emotional and Psychological Support in Diabetes



## Reader Page

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<b>Author</b>	Dr. Louise Richards  Reviewed by: Dr. Gav Eyres Dr. Grace Sweeney Dr. Roger Gadsby Dr. Peter Trigwell
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<b>Contact details</b>	Dr. Gav Eyres <a href="mailto:gav.eyres@diabetes.nhs.uk">gav.eyres@diabetes.nhs.uk</a> Research and Evaluation Manager NHS Diabetes

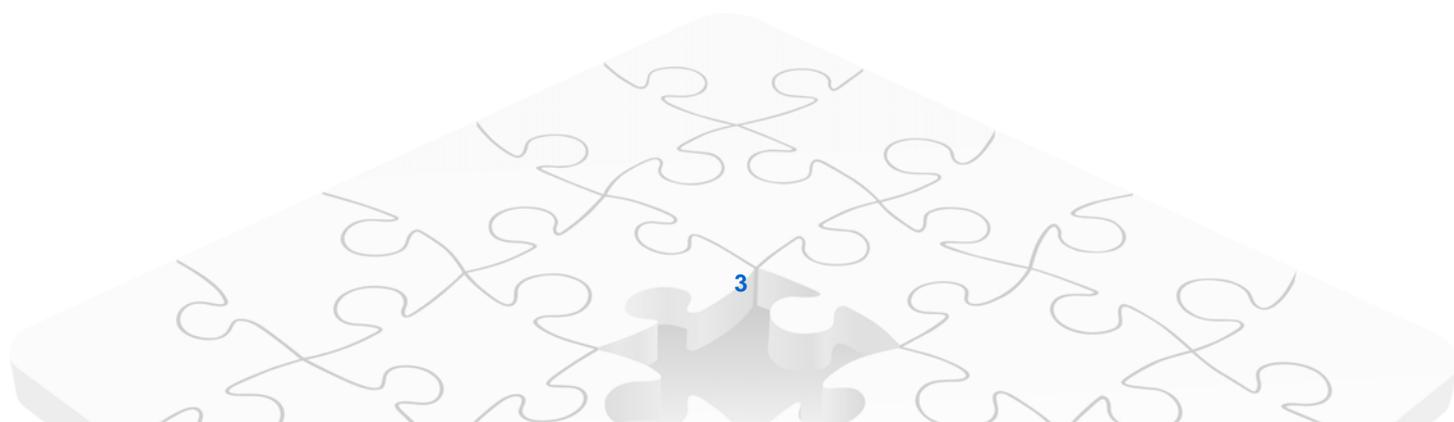
## Knowledge and Information Repository

The purpose of the knowledge and information repository (KIR) is to provide easily accessible summaries of the latest guidance and important research relating to specific key topics of relevance to NHS Diabetes. The topic areas have been identified by NHS Diabetes staff and the KIR documents will provide readily available information to support and inform Regional Programme Managers and others when attending meetings and other functions. Each KIR topic will include a brief summary introduction to each topic, followed by a short collection of latest key policy papers, National Body statements, clinical or care guidelines and the latest key research and evaluation papers.

## Acknowledgements

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# Emotional and Psychological Support in Diabetes

## Emotional and psychological support and the National Service Frameworks

Emotional and psychological support is a key intervention in implementing standards 3, 5, 10 and 12 of the National Service Framework (NSF) for Diabetes (1), standards 6 and 8 of the Children's NSF (2), standard 7 of the NSF for Older People (3), in addition to addressing aspects of the NSF for long term conditions (4) and NSF for renal services (5).

## Information on emotional and psychological support available from NHS Evidence

Policy guidance and research findings relating to emotional and psychological support in diabetes from the NHS Evidence Diabetes Specialist collection can be accessed from the 'Type1 > Condition Management > Psychosocial Care' and 'Type2 > Condition Management > Psychosocial Care' part of the website and collectively includes: 5 guidelines/pathway documents, 15 evidence papers, 4 reference articles, 2 education/CPD documents, and 2 patient information articles.

## NICE Guidelines

The National Institute for Health and Clinical Excellence (NICE) have published guidelines offering best practice advice on the management and care of people with Type 1 (Clinical Guideline (CG)15) (6) and Type 2 (CG66/CG87) (7,8) diabetes, including emotional and psychological support and care. The psychological care of children and young people is highlighted as one of the key priorities in these guidelines. NICE have also published guidelines for the care of people with 'Depression in adults with chronic physical health problems' (CG91) (9) and 'Neuropath pain' (CG96) (10).

## Other national and international guidelines

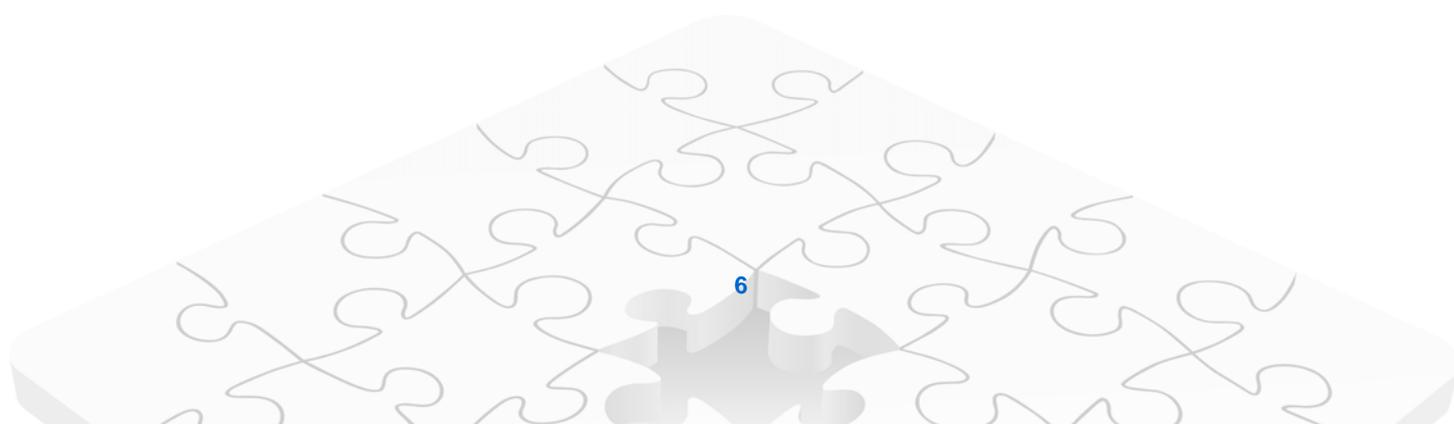
National diabetes guidelines for Scotland (11), Wales (12) and Northern Ireland (13, 14) address some aspects of the emotional and psychological care of people with diabetes. The International Diabetes Federation has published global guidelines for Type 2 diabetes relevant in a worldwide context (15). The guidelines address communication, assessment/awareness, counselling and referral issues surrounding the psychological care of people with diabetes; these recommendations are split into different levels of care depending on the availability of local resources. The International Society for Paediatric and Adolescent Diabetes (ISPAD) clinical practice consensus guidelines address the emotional and psychological needs of children and young people, and include 12 recommendations (16). The evidence used to develop the guidelines relates predominantly to the psychosocial factors in managing Type 1 diabetes, as there is little research regarding psychological factors in Type 2 diabetes.

NHS Diabetes and Diabetes UK have published a report on many aspects of the emotional and psychological support and care in diabetes (17). The report details the need for emotional and psychological support for people with diabetes, and describes the current provision of services. Failings of the current service provision are highlighted and provide recommendations for commissioning and the delivery of future services. Evidence relating to the current provision of emotional/psychological care of adults with diabetes comes predominantly from the '*Minding the Gap*' report published by Diabetes UK (18). The findings from this study suggest that the current provision of psychological support for people with diabetes in the UK are well below expected standards; less than 3% of diabetes services meet all six of the psychologically relevant NSF standards and NICE guidance, and 27% of diabetes services do not meet any of these standards. The vast majority of people with diabetes do not have access to expert psychological services, and skills and services within multidisciplinary diabetes teams vary significantly between locations.

## Evidence for the effectiveness of emotional and psychological support

NHS Evidence and Diabetes UK commissioned a review of the effectiveness of emotional and psychological interventions for people with diabetes (17). The review discusses the benefits of such interventions, and also highlights that much more research is needed to establish the effectiveness of many interventions, particularly in treating people with more severe psychological problems.

A recent randomised control trial (RCT) assessing the effectiveness of Motivational Enhancement Therapy and Cognitive Behavioural Therapy for people with Type 1 diabetes has shown that a combination of these two interventions may be beneficial in controlling blood sugar levels, and may be cost-effective (19). The effectiveness of psychological interventions on glycaemic control in people with Type 2 diabetes has recently been assessed by meta-analysis (20) and has shown that psychological interventions can improve glycaemic control. Both of these studies suggest that diabetes professionals can be trained to deliver effective psychological interventions, thereby making emotional and psychological support and care more widely available.



## 1.0 NICE Guidelines

### 1.1 CG15 Type 1 Diabetes: The management of Type 1 diabetes

Available to download at: [www.nice.org.uk/nicemedia/live/10944/29390/29390.pdf](http://www.nice.org.uk/nicemedia/live/10944/29390/29390.pdf)

#### 1.1.2 Children (younger than 11 years) and young people (11 – 17 years inclusive) with Type 1 diabetes

- One of the key priorities outlined in these guidelines is the psychological care of children and young people, the guidelines state:

‘Children and young people with Type 1 diabetes and their families should be offered timely and ongoing access to mental health professionals because they may experience psychological disturbances (such as anxiety, depression, behavioural and conduct disorders and family conflict) that can impact on the management of diabetes and well-being’.

#### NICE recommendations, in brief;

##### Management of disease (section 1.1.2, pages 11-12)

- All children and young people with Type 1 diabetes should be offered a continual and integrated package of care, delivered by a multidisciplinary paediatric team, including professionals with appropriate training in the mental health aspects of diabetes care for children and young people.
- Initial inpatient management should be offered to children/young people who have social or emotional difficulties.
- Appropriate emotional support following diagnosis should be offered, tailored to emotional and social needs.

##### Monitoring glycaemic control (section 1.2.6, pages 18-19)

- Children/young people with Type 1 diabetes and their families should be informed that blood glucose levels should be interpreted in context of the child as a whole, including the social, emotional and physical environment.

##### Psychological and social issues (section 1.4, pages 29-31)

- Diabetes care teams should be aware that children/young people with Type 1 diabetes are at greater risk of emotional/behavioural problems, depression/anxiety, and eating disorders.
- Screening for anxiety/depression should be offered to those with consistently poor glycaemic control.
- Children/young people with suspected anxiety/depression should be referred to child mental health professionals.
- Children/young people with eating disorders may have associated problems (hyperglycaemia, recurrent hypoglycaemia and/or symptoms associated with gastric paresis).
- Children/young people with eating disorders should be offered joint management involving diabetes care team and child mental health services.
- Parents of pre-school children should be informed of the increased risk in long-term neurocognitive dysfunction associated with persistent hypoglycaemia (particularly in conjunction with associated seizures).
- Children/young people with behavioural/conduct disorders, and their families, should be offered access to mental health professionals.
- Non-adherence therapy should be considered/offered to those with poor glycaemic control and to those who present with diabetic ketoacidosis.

- Young people with 'brittle diabetes' should have their emotional/psychological well-being assessed.
- Non-adherence therapy issues should be raised in a sensitive manner.
- Diabetes care teams should be aware that poor psychosocial support has a negative impact on a variety of outcomes (e.g. glycaemic control & self-esteem).
- Structured behavioural interventions should be offered, especially to those with multiple daily injection regimes – may improve psychological well-being and glycaemic control.
- Young people should be offered specific support strategies (e.g. mentoring, self-monitoring of blood glucose supported by problem-solving) to improve self-esteem and glycaemic control.
- Families of children/young people should be offered specific support strategies (e.g. behavioural family systems therapy) to reduce diabetes-related conflict between family members.
- Children/young people/their families should be offered timely and ongoing access to mental health professionals as they may experience psychological problems that can impact on management of diabetes and well-being.
- Diabetes care teams should have access to mental health professionals to support psychological assessment and delivery of psychosocial support.

#### Future research

- NICE have highlighted 12 key areas of future research; six of which relate to the care of children and young people with Type 1 diabetes. In relation to emotional and psychological support, the recommendations state:

'Evaluation of the effectiveness of behavioural and social interventions for managing anxiety, depression, eating disorders, behavioural and conduct disorders, and non-adherence to therapy in children and young people with newly diagnosed and established Type 1 diabetes, especially young people'.

### 1.1.3 Adults with Type 1 diabetes

#### Dietary management (section 1.8.3)

- Nutritional recommendations (for individuals) should be modified to take into account associated features of diabetes, including eating disorders.

#### Blood glucose control and insulin therapy (section 1.9)

- In adults with erratic/unpredictable blood glucose control, the possibility of psychological/psychosocial difficulties (amongst other things) should be considered.
- Adults with psychological difficulties should be provided with injection devices or needle-free systems.
- When hypoglycaemia becomes unusually problematic or more frequent, a review of possible contributory causes, including psychological problems should be carried out.

#### Management of painful neuropathy (section 1.11.5)

- Professionals should be aware of the psychological consequences of chronic painful neuropathy - appropriate management should be offered if identified.

#### Newly diagnosed adults (section 1.12.1)

- At time of diagnosis diabetes care teams should develop with and explain a plan for their early care – the plan will require (amongst other things) assessment of: emotional state to determine appropriate pace of structured education, psychological well-being, immediate family/social relationships and availability of informal support.

### **Psychological Problems** (section 1.12.5)

- Diabetes care teams should be alert to the development or presence of clinical/sub-clinical depression and/or anxiety, especially if there are self-management problems.
- Members of the diabetes care team should have appropriate skills in detection and basic management of non-severe psychological problems in people from different cultural backgrounds; team members should be familiar with counselling techniques and drug therapies, with timely referral to specialist teams for those with psychological problems that have a significant impact on well-being or diabetes self-management.

### **Eating disorders** (section 1.12.6)

- Diabetes care teams should be alert to eating disorders and insulin dose manipulation in people with: an over-concern with body image/weight, low BMI or poor blood glucose control.

## **1.2 CG87 Type 2 Diabetes: The management of Type 2 diabetes**

Available to at: [www.nice.org.uk/nicemedia/live/12165/44320/44320.pdf](http://www.nice.org.uk/nicemedia/live/12165/44320/44320.pdf)

Full guidelines (CG66) available at: [www.nice.org.uk/nicemedia/live/11983/40803/40803.pdf](http://www.nice.org.uk/nicemedia/live/11983/40803/40803.pdf)

- The full guidelines (CG66) discuss the aims/benefits of structured education and self-management programmes, which include improvements in quality of life and a reduction in depression (section 5.1.1, page 27).
- The importance of psychological health in people with Type 2 diabetes is discussed in the full guidelines but do not provide any specific guidelines relating to emotional/psychological care, (section 6.2.1, page 39), current national guidelines should be followed (e.g. CG91, see section 1.3 of this document).
- Diabetes care teams should be alert to psychological consequences of chronic, painful diabetic neuropathy and offer psychological support according to individual needs (CG87, section 1.14.2.2, page 32).

## **1.3 CG91 Depression in adults with chronic physical health problems**

Available to at: [www.nice.org.uk/nicemedia/live/12327/45909/45909.pdf](http://www.nice.org.uk/nicemedia/live/12327/45909/45909.pdf)

- Guidelines for adults 18 years and older.
- Depression 2-3 times more common in people with a chronic physical health problem.
- Treatment of depression can improve quality of life and increase life expectancy.
- The guidelines set out the principles of caring for people with depression, including:
  - Importance of building trusting relationships with patient, with discussions taking place in appropriate settings to protect privacy, confidentiality and dignity.
  - Awareness of the stigmatisation/discrimination associated with depression and the impact this may have on the patient.
  - Awareness of cultural/ethnic/religious backgrounds.
  - Awareness of any learning/cognitive difficulties.
  - Always directly ask about suicide ideation and intent.
  - Patients posing immediate risk to themselves/others should be urgently referred to specialist mental health services.
  - Effective delivery of interventions is also discussed, including: competency of practitioners, clarification of responsibility for monitoring/treatment where patient's management is shared between primary and secondary care, consideration of alternative interventions when appropriate.

- The 'stepped-care model' is described - a four-step model starting with the least intrusive and most effective treatments, moving step-wise upwards if interventions are not effective, or if the patient declines an intervention, briefly;
- **Step 1: 'recognition, assessment and initial management'** (section 1.3, pages 17-20)
  - Interventions include: support/information and active monitoring.
- **Step 2: 'recognised depression – persistent sub-threshold depressive symptoms or mild to moderate depression'** (section 1.4, pages 20-24)
  - Interventions include: low-intensity psychological/psychosocial (e.g. physical exercise programmes, peer support), possible pharmacological treatment.
- **Step 3: 'recognised depression – persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression'** (section 1.5, pages 25-35)
  - Interventions include: high-intensity psychological (e.g. group/individual CBT, behavioural couple's therapy) and/or pharmacological treatments - collaborative care should be considered for non-responders.
- **Step 4: 'complex and severe depression'** (section 1.6, page 36)
  - Interventions include: medication, high-intensity psychological interventions, electroconvulsive therapy, combined treatments, crisis resolution and home treatment teams, inpatient care.
- Information on the use and delivery of low-intensity psychosocial (section 1.4.2, pages 21-24) and high-intensity psychological (section 1.5.3, pages 33-34) interventions are provided.
- Information on the use of antidepressants (sections 1.4.3 & 1.5.2, pages 24, 26-33), includes:
  - Choice of medication
  - Interactions of SSRIs with other medications
  - Starting, continuing and stopping/reducing antidepressant treatment
  - Failure of treatment
- Future research recommendations are also provided (section 4, 37-44).

### **Economic cost of depression in those with chronic physical health conditions**

Available at: [www.nice.org.uk/nicemedia/live/12327/45913/45913.pdf](http://www.nice.org.uk/nicemedia/live/12327/45913/45913.pdf) (full guidelines)

- The economic cost of depression in those with chronic physical health conditions is assessed (section 2.4, pages 30-31; section 6.3.6, pages 129-133).
- Depression alone has significant economic burden:
  - There are an estimated 1.24 million people in UK with depression, projected to rise to 1.45 million (17%) by 2026.
  - The estimated total cost of services for depression in England in 2007 is £1.7 billion, and is projected to be £3 billion by 2026.
  - Adding the cost of lost employment to these figures, the estimated costs increase to £7.5 billion in 2007 and projected to rise to £12.2 billion by 2026.
- There is little evidence on the combined economic impact of depression in patients with chronic health problems, particularly within the UK.
- Studies from the USA and Canada suggest there is a significant increase in the economic burden on people with chronic health problems, and on society as a whole, and this is likely to continue to rise in future years.
- No (UK) studies assessing the cost-effectiveness of the collaborative care approach in the treatment of depression in people with chronic physical health conditions were found - clinical evidence suggests beneficial outcomes.
- Economic modelling of the cost effectiveness of a collaborative care approach compared with normal care was carried out (section 6.4, pages 134-158).

- Evaluation of the economic costs of psychosocial interventions are also presented (section 7.3, pages 203-210):
  - No evidence of the economic benefits of psychosocial interventions was found from the systematic literature review; therefore, cost analyses were performed to assist in decision making.
  - A review of the cost analysis of CBT and low-intensity psychosocial interventions (physical activity programmes, peer-group support, guided self-help, computerised CBT) is given.

## 1.4 CG96 Neuropathic pain

Available at: [www.nice.org.uk/nicemedia/live/12948/47949/47949.pdf](http://www.nice.org.uk/nicemedia/live/12948/47949/47949.pdf)

(Section 1.1.3, 1.1.4, 1.1.9, pages 12-14)

- Guidelines for the pharmacological treatment of neuropathic pain in non-specialist settings (i.e. primary and secondary care services that do not provide specialist pain services).
- 'Neuropathic pain is an unpleasant sensory and emotional experience that can have a significant impact on a person's quality of life'.
- In addition to pharmacological treatments, the availability of non-pharmacological treatments e.g. psychological therapies should be discussed when agreeing which treatments to use.
- Selection of pharmacological treatment of neuropathic pain should take into account existing mental health problems such as depression and anxiety<sup>1</sup>.
- Regular clinical reviews should be performed, including assessment of mood (in particular, possible depression and/or anxiety)<sup>1</sup>.

## 2.0 Other national and international guidelines

### 2.1 Diabetes Management: A National Clinical Guide. Clinical Guideline 116, Scottish Intercollegiate Guidelines Network (2010)

Available at: [www.sign.ac.uk/pdf/sign116.pdf](http://www.sign.ac.uk/pdf/sign116.pdf)

- Key recommendations for the psychosocial care of people with diabetes are outlined (*section 2.2, page 5*); briefly,
- People with Type 1 diabetes should be regularly assessed for a broad range of psychological and behavioural problems, including:
  - Adults: anxiety, depression, eating disorders.
  - Children: eating disorders, behavioural, emotional and family functioning problems.
- Psychological interventions (e.g. motivational interviewing, cognitive behavioural therapy, goal setting skills) should be offered to children and adults with Type 1 and Type 2 diabetes to help improve glycaemic control.
- Section 4 (pages 25-29) details the evidence used to develop the recommendations.

### 2.2 Diabetes Action Plan 2010: Quality Care for Diabetes in Scotland

Available at: [www.scotland.gov.uk/Resource/Doc/321699/0103402.pdf](http://www.scotland.gov.uk/Resource/Doc/321699/0103402.pdf)

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<sup>1</sup> Referral to 'Depression with a chronic physical health problem' (NICE CG91) and 'Anxiety' (NICE CG22) should be made if necessary.

- Action plan designed to increase access and improve quality of diabetes care in Scotland.
- Two actions to be taken relating to emotional and psychological support (*section 3.9, pages 35-38*) are detailed:
  - 'Ensuring adequate training of staff in psychological skills'
  - 'Develop and share effective national initiatives'

### **2.3 Designed for the Management of Adults with Diabetes Mellitus across Wales: Consensus Guidelines (2008)**

Available at:

[wales.gov.uk/dhss/publications/health/guidance/diabetesconsensus/diabetese.pdf?lang=en](http://wales.gov.uk/dhss/publications/health/guidance/diabetesconsensus/diabetese.pdf?lang=en)

- There is little advice/recommendations relating to the emotional and psychological care of people with diabetes.
- Within the advice on diet and lifestyle management, the guidelines state (*page 15*):
  - 'stress and depression can influence dietary choices and detract from a healthy lifestyle therefore, 'stress and depression should be identified and treatment offered'.
- Care pathways/principles/guidelines are provided relating to the delivery of services for those people with diabetes requiring multi-agency support, ensuring they receive integrated health and social care; thereby satisfying standard 12 of the NSF for diabetes (*pages 119- 127*).

### **2.4 Report of the Northern Ireland Task Force on Diabetes. A Blueprint for Diabetes Care in Northern Ireland in the 21<sup>st</sup> Century. Clinical Resource Efficiency Support Team (CREST) and Diabetes UK, 2003.**

Available at: [www.gain-ni.org/Library/Guidelines/diabetes-cover.pdf](http://www.gain-ni.org/Library/Guidelines/diabetes-cover.pdf)

- The task force highlighted emotional and psychological support as one of eight areas for early action to be taken.

### **2.5 Dr. Foster and Diabetes UK 2005. Your local care: Diabetes services in Northern Ireland.**

Available at: [www.diabetes.org.uk/Guide-to-](http://www.diabetes.org.uk/Guide-to-diabetes/Support_for_managing_your_diabetes/diabetes_care_and_you/Your_local_care/)

[diabetes/Support\\_for\\_managing\\_your\\_diabetes/diabetes\\_care\\_and\\_you/Your\\_local\\_care/](http://www.diabetes.org.uk/Guide-to-diabetes/Support_for_managing_your_diabetes/diabetes_care_and_you/Your_local_care/)

- Three of the four Health and Social Services Boards listed psychological support for people with diabetes as a priority area (this increased to all four by 2006 (Diabetes UK. Diabetes State of the Nations 2006: progress made in delivering the national service frameworks. A report from Diabetes UK. 2007)).

### **2.6 Global Guideline for Type 2 diabetes (2005) Chapter 4: Psychological Care**

Available at: [www.idf.org/webdata/docs/GGT2D%2004%20Psychological%20care.pdf](http://www.idf.org/webdata/docs/GGT2D%2004%20Psychological%20care.pdf)

- These guidelines highlight that published national guidelines are derived from resource-rich countries and are not relevant across the globe.
- These guidelines have been drawn up to be cost-efficient.
- Each recommendation is split into 'Levels of Care'.

- Summary of the Levels of Care structure:
  1. *Standard care*: Evidence-based care, cost-effective in most nations with a well developed service base and with health-care funding systems consuming a significant part of their national wealth.
  2. *Minimal care*: Care that seeks to achieve the major objectives of diabetes management, but is provided in health-care settings with very limited resources – drugs, personnel, technologies and procedures.
  3. *Comprehensive care*: Care with some evidence-base that is provided in health-care settings with considerable resources.
- Recommendations relate to: communication, assessment/awareness, counselling and referral to specialist mental health teams for complex problems.

## 2.7 International Society for Paediatric and Adolescent Diabetes Clinical Practice Consensus Guidelines 2009. Psychological care of children and adolescents with diabetes. *Paediatric Diseases* 2009, 10 (Suppl. 12): 175-184

Available at: [www.ispad.org/FileCenter/ISPAD%20Guidelines%202009%20-%20Education.pdf](http://www.ispad.org/FileCenter/ISPAD%20Guidelines%202009%20-%20Education.pdf)

- The ISPAD Consensus Guidelines 2000 stated: “Psychosocial factors are the most important influences affecting the care and management of diabetes”
- Three general recommendations were made:
  - Social workers and psychologists should be part of a multidisciplinary healthcare team.
  - Overt psychological problems in young persons or family members should receive support from the diabetes care team and expert attention from mental health professionals.
  - The diabetes care team should receive training in the recognition, identification, and provision of information and counselling on psychosocial problems related to diabetes.
- This document is an update of the 2000 Consensus Guidelines and contains a review of the research findings relating to the psychosocial factors in the management of Type 1 diabetes (see section 3.2 of this document), together with recommendations based on the presented evidence.
- No specific recommendations are made on the psychological care of young people with Type 2 diabetes, as there is very little research regarding the psychological care of young people with Type 2 diabetes.
- Based on evidence from the literature, 12 detailed recommendations are specified which build upon the three general recommendations from ISPAD Consensus Guidelines 2000.

## 2.8 Emotional and Psychological Support and Care in Diabetes.

Report from the emotional and psychological support working group of NHS Diabetes and Diabetes UK; Published in March 2010.

Available at: [www.diabetes.nhs.uk/publications\\_and\\_resources/reports\\_and\\_guidance/](http://www.diabetes.nhs.uk/publications_and_resources/reports_and_guidance/)

- A working group report detailing the challenges of emotional and psychological support services together with guidance and recommendations in areas including: commissioning, organisation of care, provision of services, workforce and future research priorities.
- The report highlights the importance of psychological health of people with diabetes, and details the range and complexity of emotional and psychological support needs. ‘The Pyramid of

Psychological Problems' model<sup>2</sup> is illustrated and describes five levels of psychological needs of people with diabetes within a population or, over time, an individual (pages 11-15).

- The pyramid model is derived from the quantitative and qualitative description of the distribution of emotional/psychological problems in diabetes and can serve as framework for commissioning emotional and psychological support services in diabetes.
- In summary:
  - **Level 1:** General difficulties in coping with diagnosis and perceived consequences of living with diabetes and impact on lifestyle.
  - **Level 2:** Greater difficulty with coping, significant anxiety or lower mood, but not meeting criteria for a diagnosable condition. Impaired ability for self-care as a consequence.
  - **Level 3:** Diagnosable/classifiable psychological problems treatable with psychological interventions (e.g. mild depression, anxiety, obsessive/compulsive disorders, disordered eating behaviours).
  - **Level 4:** More severe diagnosable psychological problems requiring biological treatments, medication and/or specialist psychological interventions (major depression, severe anxiety disorder, eating disorders).
  - **Level 5:** Severe and complex mental illness, requiring specialist intervention(s) (including severe depression or eating disorders in addition to severe mental illness e.g. schizophrenia).
- A comprehensive summary of the national policy guidelines/recommendations relating to the emotional and psychological needs of people with diabetes are provided (pages 17-24).
- The report describes the current provision of emotional and psychological support services (pages 26-31), highlighting the major gaps in adult and paediatric services revealed by the *Minding the Gap Survey* and the DEPICTED study (Development and Evaluation of Psychosocial Intervention for Children and Teenagers Experiencing Diabetes); in addition to other key findings from other national surveys and studies.
- Inequalities in emotional and psychological services are discussed (pages 31, 53-56) and focuses on the disparity of healthcare services in Black, Asian and Minority Ethnic communities, people with learning difficulties, gypsies/travellers, people in prison and Polish immigrants (pages 53-56).
- A summary of a specially commissioned literature review of the evidence relating to the effectiveness of psychological interventions is provided (see section 3.1 of this document).
- Chapter 6 (pages 36-39) provides a guide to commissioning emotional and psychological support and care services in diabetes.
- The report makes recommendations on several aspects of psychological services, including: commissioning, service delivery, workforce (including planning, development and review using a competence based approach) and future research.

## 2.9 Minding the Gap: The provision of psychological support and care for people with diabetes in the UK. A report from Diabetes UK (2008).

Available at: [www.diabetes.org.uk/Documents/Reports/Minding\\_the\\_Gap\\_psychological\\_report.pdf](http://www.diabetes.org.uk/Documents/Reports/Minding_the_Gap_psychological_report.pdf)

These findings have also been published in a short report: Nicholson TRJ, Taylor JP, Gosden C, Trigwell P and Ismail K. **National guidelines for psychological care in diabetes: how mindful have we been?** *Diabetes Medicine* 2009; 26:447–450.

- A survey designed to establish the availability of psychological care in diabetes (aged 17 years or older).

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<sup>2</sup> Originally developed for the National Survey of Psychological Services for People with Diabetes commissioned by Diabetes UK.

- Surveyed all 464 diabetes services in the UK by postal questionnaire (58% response rate) and structured telephone interview (response rate 80%).
- The key findings of the survey were, (briefly);
  - Around 85% of people with diabetes have either no defined access to psychological care, or at best only local generic services are offered.
  - Where psychological services are provided, a range of disciplines (57% psychologists, 17% liaison psychiatrists) deliver care but there is no clear plan or rationale for the development of these services – services reflect the interests of the practitioners rather than on need and access to these services is restricted; 28.3% patients seen within one month and 17% of people had to wait greater than 3 months.
  - Diabetes care teams felt they needed help with managing virtually all psychological problems and need expert psychological input.
  - Many diabetes services lack basic elements of care relating to psychological needs (e.g. telephone advice lines, defined screening/assessment tools, no protocols/guidelines for referral to specialists).
  - Only 2.6% of diabetes services meet all six psychologically relevant NSF standards and NICE guidance, and 25.8% do not comply with any of them.
- The guidelines report extensive recommendations, including;
  - Development of services
  - Commissioning services
  - Skills and training
  - Tools and guidelines

## 2.10 DiabetesE 5<sup>th</sup> National Report, Innove.

Available at: [www.diabetes.nhs.uk/document.php?o=1066](http://www.diabetes.nhs.uk/document.php?o=1066)

- 38% of PCTs answered yes to the question, 'Are psychological support services available to people with diabetes at diagnosis and whenever necessary?'

## 3.0 Evidence for the effectiveness of emotional and psychological support in people with diabetes

### 3.1 Emotional and Psychological Support and Care in Diabetes.

Report from the emotional and psychological support working group of NHS Diabetes and Diabetes UK; published in March 2010.

Available at: [www.diabetes.nhs.uk/publications\\_and\\_resources/reports\\_and\\_guidance/](http://www.diabetes.nhs.uk/publications_and_resources/reports_and_guidance/)

- A review of the evidence assessing the use of psychological interventions in supporting and treating people with diabetes with emotional/psychological problems was commissioned by NHS Diabetes and Diabetes UK and carried out by Dr Jackie Sturt and Kathryn Dennick at Warwick Medical School.
- The review is based on systematic reviews, published primary research and examples of best practice published between 1982 and 2008.
- The evidence was mapped to the pyramid model (see section 2.8 of this document), the main findings include:
  - **Level 1:** Most current research relates to interventions at this level - interventions are mainly based on education, self-management and peer support and have been shown to have at least one beneficial outcome.

- **Level 2:** Cognitive behavioural stress management, CBT, SSRI therapy, blood glucose awareness training have been shown to improve various emotional and psychological difficulties depending on severity of problem.
- **Level 3:** Psychotherapy, CBT, integrated inpatient therapy, group blood glucose awareness training, psycho-education have all be shown to have some positive psychological effects.
- **Level 4:** Not much research at this level - antidepressant and CBT *may* be beneficial. Psychodynamic supportive psychotherapy, collaborative/stepped-care depression programmes (antidepressant therapy in conjunction with problem-solving therapies) and integrated psychiatric care interventions have shown to have beneficial outcomes.
- **Level 5:** Very little research conducted within this level.

### 3.2 International Society for Paediatric and Adolescent Diabetes Clinical Practice Consensus Guidelines 2009.

Psychological care of children and adolescents with diabetes. *Paediatric Diseases* 2009; 10 (Suppl.12): 175-184.

Available at:

[www.ispad.org/FileCenter/ISPAD%20Guidelines%202009%20-%20Education.pdf](http://www.ispad.org/FileCenter/ISPAD%20Guidelines%202009%20-%20Education.pdf)

- Research findings relating to psychosocial factors in the management of Type 1 diabetes in children detailed in this document include:
  - Psychological adjustment and psychiatric disorders
    - Increased risk of adjustment difficulties to diagnosis, and psychiatric disorders, including: depression, anxiety, behavioural problems, social difficulties, eating disturbances/disorders, poor self-esteem.
    - Where psychological problems exist, there is evidence of an increased risk of poor diabetes management in adulthood.
  - Neurocognitive and school functioning
    - Increased risk of a variety of learning problems/difficulties, and lower academic achievement and school performance is associated with poor glycaemic control.
  - Family functioning and social support
    - A supportive family environment with agreements in diabetes management is associated with better regime adherence and glycaemic control.
    - Conflicts relating to diabetes management associated with poorer regime adherence and glycaemic control.
    - Parents may also suffer psychological problems after diagnosis of Type 1 diabetes.
  - Stress and coping
    - Children with high levels of life or diabetes-related stress are associated with poor glycaemic control.
    - Poor glycaemic control related to negative coping strategies, compared with good glycaemic control associated with positive coping styles.
  - Quality of life
    - Children with diabetes may experience lower quality of life compared with healthy children, especially if parents rate their child's quality of life.
  - Psychosocial and behavioural interventions
    - Family-based, peer group and individual psychosocial/behavioural interventions may be effective in addressing emotional/psychological problems, in addition to improving metabolic control.

### 3.3 Ismail K, Maissi E, Thomas S, Chalder T, Schmidt U, Bartlett J, Patel A, Dickens C, Creed F, Treasure J. **A randomised controlled trial of cognitive behaviour therapy and motivational interviewing for people with Type 1 diabetes mellitus with persistent**

**sub-optimal glycaemic control: a Diabetes and Psychological Therapies (ADaPT) study.** Health Technology Assessment 2010 May; 14 (22):1-101, iii-iv.

- A randomised control trial (RCT) to assess the effectiveness of Motivational Enhancement Therapy (MET) and Cognitive Behavioural Therapy (CBT) in improving glycaemic control in Type 1 diabetes - the effectiveness of these interventions on secondary outcomes, depression and quality of life, and the cost effectiveness of the treatments were also examined.
- The study was commissioned by NIHR Health Technology Assessment Programme to inform NICE Type 1 diabetes guideline update as there is insufficient evidence from randomised controlled trials that psychological treatments are effective in improving glycaemic control in adults with Type 1 diabetes.
- Adults 18-65 years from diabetes clinics in seven acute trusts in south east London and Manchester with HbA<sub>1c</sub> value of 8.2-15%.
- Outcomes measures: HbA<sub>1c</sub> 12 months from randomisation.
- Secondary outcome measures: self-report psychological measures.
- Economic assessment: 1-year costs measured by: Client Service Report Inventory at 0, 6 and 12 months, quality-adjusted life-years (QALYs) measured by Short Form-36 Health Survey Questionnaire (SF-36) and European Quality of Life-5 Dimensions (EQ-5D) at 0 and 12 months.
- Conclusions from the study:
  - Diabetes professionals can be trained to deliver diabetes-specific MET and CBT (with supervision).
  - Only MET + CBT resulted in a significant improvement in HbA<sub>1c</sub>; therefore, combined MET + CBT may be beneficial to those with continually poor diabetes control.
  - MET alone was less effective than MET + CBT and normal diabetes care.
  - Both interventions were associated with greater health and social care costs.
  - MET + CBT had a high probability of cost-effectiveness based on HbA<sub>1c</sub> improvement, but MET had high probability of cost-effectiveness based on QALY; therefore, 'decisions regarding the provision of such interventions depend on the relative importance of these two outcomes'.
  - In the MET + CBT group, the younger the person with diabetes and the higher the HbA<sub>1c</sub> at baseline, the greater the improvement in glycaemic control.
  - The interventions tested did not appear to improve psychological well-being.

**3.4 Alam R, Sturt J, Lall R, Winkley K. An updated meta-analysis to assess the effectiveness of psychological interventions delivered by psychological specialists and generalist clinicians on glycaemic control and on psychological status. *Patient Educ Couns.* 2009; 75(1):25-36.**

- An updated meta-analysis to establish the effectiveness of psychological interventions on glycaemic control and psychological well-being in Type 2 diabetes – the effectiveness of the delivery of the interventions by generalist clinicians and psychological specialists were compared.
- Primary outcome measure was HbA<sub>1c</sub>.
- 35 trials reviewed, 19 trials included in meta-analysis (n=1431).
- Overall, there was a 0.54% reduction in HbA<sub>1c</sub> after psychological intervention.
- Interventions were delivered by diabetes or general clinicians in nine trials (n=832) – reduction in HbA<sub>1c</sub> by 0.51%.
- Interventions were delivered by psychological specialists in nine trials (n=561) - reduction in HbA<sub>1c</sub> by 0.57%.

- The effectiveness of psychological interventions was similar when delivered by generalist clinicians or psychological specialists; therefore, psychological care could be made more widely available by training generalist clinicians in psychological interventions.
- The effectiveness of psychological treatments was reduced compared with an earlier study.<sup>3</sup>

## 4.0 Current Trials

4.1 McNamara R, Robling M, Hood K, Bennert K, Channon S, Cohen D, Crowne E, Hambly H, Hawthorne K, Longo M, Lowes L, Playle R, Rollnick S, Gregory JW. **Development and Evaluation of a Psychosocial Intervention for Children and Teenagers Experiencing Diabetes (DEPICTED): a protocol for a cluster randomised controlled trial of the effectiveness of a communication skills training programme for healthcare professionals working with young people with Type 1 diabetes.** *BMC Health Services Research* 2010; 10:36

- The main objective of this trial is to assess whether a communication skills training intervention for paediatric diabetes team members can improve clinical and psychological outcomes for children/teenagers with Type 1 diabetes.
- The trial aims to evaluate an intervention that can be delivered by diabetes specialists without the involvement of trained psychologists thereby maximising availability of the intervention.

## 5.0 GP Quality and Outcomes Framework

- GPs are required to ask about depression in everyone with diabetes using two standard questions:
  - During the last month have you often been bothered by feeling down, depressed or helpless?
  - During the last month have you often been bothered by having little interest or pleasure in doing things?
- The first Depression 1 Clinical Indicator (DEP 1) is the % of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions.
- There are two other depression clinical indicators in QoF which are:
  - DEP 2 In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the % of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care.
  - DEP 3 In those patients with a new diagnosis of depression and assessment of severity, recorded between the preceding 1 April to 31 March, the % of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity.
- Both assessments should be completed using an assessment tool validated for use in primary care.

<sup>3</sup>Winkley K, Ismail K, Landau S, Eisler I. Psychological interventions to improve glycaemic control in patients with type 1 diabetes: systematic review and meta-analysis of randomised controlled trials. *BMJ* 2006; 333(7558):65.

## 6.0 Commissioning Resources

- A commissioning guide for Mental Health and Diabetes Services is available from NHS Diabetes.

Available at: [www.diabetes.nhs.uk/commissioning\\_resource/](http://www.diabetes.nhs.uk/commissioning_resource/)

- This commissioning guide has been developed by NHS Diabetes with key stakeholders including clinical and social care professionals, and patient groups represented by Diabetes UK.
- The guide is designed to form the basis of discussions or development mental health and diabetes services between commissioners and providers from which a contract for services can be agreed.
- The guide contains a description of the key features of good mental health and diabetes care, briefly;
  - High quality mental health and diabetes services should have mechanisms for early detection and timely access to treatment for people with diabetes who:
    - have emotional and psychological problems
    - develop eating disorders
    - develop severe mental illness
  - Services should also:
    - ensure that people with severe mental illness who develop diabetes have access to appropriate diabetes care
    - have specific services for children and young people
- Services should be developed in a co-ordinated way, and be commissioned jointly by health and social care services - a holistic approach should be used.
- A high level intervention map describes the key high level clinical and administrative actions or interventions mental health and diabetes services should undertake to provide the most efficient and effective care from admission to discharge (or death) from the service.
- A mental health and diabetes services contracting framework that brings together all the key standards of quality and policy relating to diabetes and mental health care is provided.
- A template service specification for mental health and diabetes services is also provided.

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