DIABETES – PSYCHOLOGICAL ASPECTS

The North West London health and care partnership

OVERVIEW

Approximately 40% of people with Diabetes suffer with poor psychological well-being:

- The rate of depression and anxiety is more than doubled in people with Diabetes
- Other conditions such as diabetes distress, eating disorders, alcohol and substance use and needle phobias are more prevalent in diabetes
- People with poorly controlled diabetes and **vascular changes** in feet, eyes and kidneys have a higher likelihood of such changes **in their brains leading cognitive impairment.**
- People with type 2 diabetes are more likely to have experienced childhood adversity
- People with severe mental illness such as schizophrenia and bipolar affective disorder are at higher risk of developing type 2 diabetes . Atypical antipsychotics increase this risk.

Impact of all these conditions in Diabetes if not addressed is:

- Difficulty with motivation, hope for the future, cognitive function and self-esteem leading to difficulty with self-care

Treatment for psychological conditions has been shown to lead to reduced symptoms and improved glycaemic control, as well as the costs of healthcare.

Person Centred approach

- People with diabetes want to be asked about their psychological wellbeing and how they are managing living with Diabetes .
- People with Diabetes want a menu of choices in terms of interventions, including peer support and self-help including online resources (see below)

CLINICIAN RECOMMENDATIONS

Especially when people have off target HbA1c or are not engaged with treatment, be alert to :

- **Diabetes distress, clinical or subclinical depression, anxiety**. Use the screening tools that are at bottom of this page-DDS2 (In secondary care), PHQ4 (in primary or community care) as a screen and refer to IAPT or other relevant local pathway if +ve. See here for other considerations and options, how to introduce medication etc.
    - For moderate to severe depression, consider an antidepressant in the form of an SSRI, e.g. citalopram (20mg od, titrate up to maximum 40 g od) or sertraline (50mg od, titrate up to maximum of 200mg od). Give them at least 6 weeks at maximum dose before trialling a different antidepressant. **Don't switch from one SSRI to another as they work in the same way**. Try a different agent and/ or refer to mental health trust. **Don't use dosulepin**.
    - **Don't use anxiolytics for anxiety**. This is contraindicated. CBT is **the** NICE treatment of choice- so refer to IAPT
- **Alcohol and drug use**- often used as a coping strategy when people are feeling distressed, anxious, overwhelmed or depressed. Ask about this using the AUDIT tool (see below) and whether they would like referral to local drug and alcohol services
- **Eating disorders** and insulin dose manipulation if there is poor glucose control, low BMI or over concern with body shape and weight. Early, and occasionally urgent, referral to local eating disorder services should be considered. Eating Disorder Resources
- **Cognitive impairment (**delirium or dementia) if they have other complications-even in people as young as 50 and even if they appear to be compos mentis. Use 6 item Cog test (see below) and consider discussion with or referral to dementia services locally. Add in extra support if required e.g. administration of medication
- **Relapsing or new onset of psychosis** may put the person with diabetes at greater risk of poor self-care for their diabetes. Aripiprazole is the recommended anitpsychotic if the person has diabetes. If the person's psychosis is stable, consider titrating the antipsychotic dose down slowly and carefully with close monitoring. Discuss with team psychiatrist if in doubt .

Mental health screening tools and other resources

Screening tools

Alcohol screening tool "AUDIT"
Diabetes Distress scale (DDS2 and DDS longer version)
PHQ4 (depression and anxiety brief screen)
PHQ9(depression)
GAD 7(anxiety)
6 item Cog
Eating Disorder screening for primary care

Resources

***Award winning self-help leaflets** about a number of different mental health issues (available in easy to read, audio available)*
MIND Charity for information and support
Samaritans for support in a crisis

Date of preparation: December 2022. For review: July 2023

TYPE 2 DIABETES – MENTAL CAPACITY ACT (1)

The North West London health and care partnership

Refer to the five principles of the MCA

1. Assume a person has capacity
2. Support the individual to make their own decision
3. Someone may make an unwise decision
4. Always act, or decide, for a person without capacity in their best interests
5. Choose the least restrictive option

The two-stage capacity test

Stage one. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,

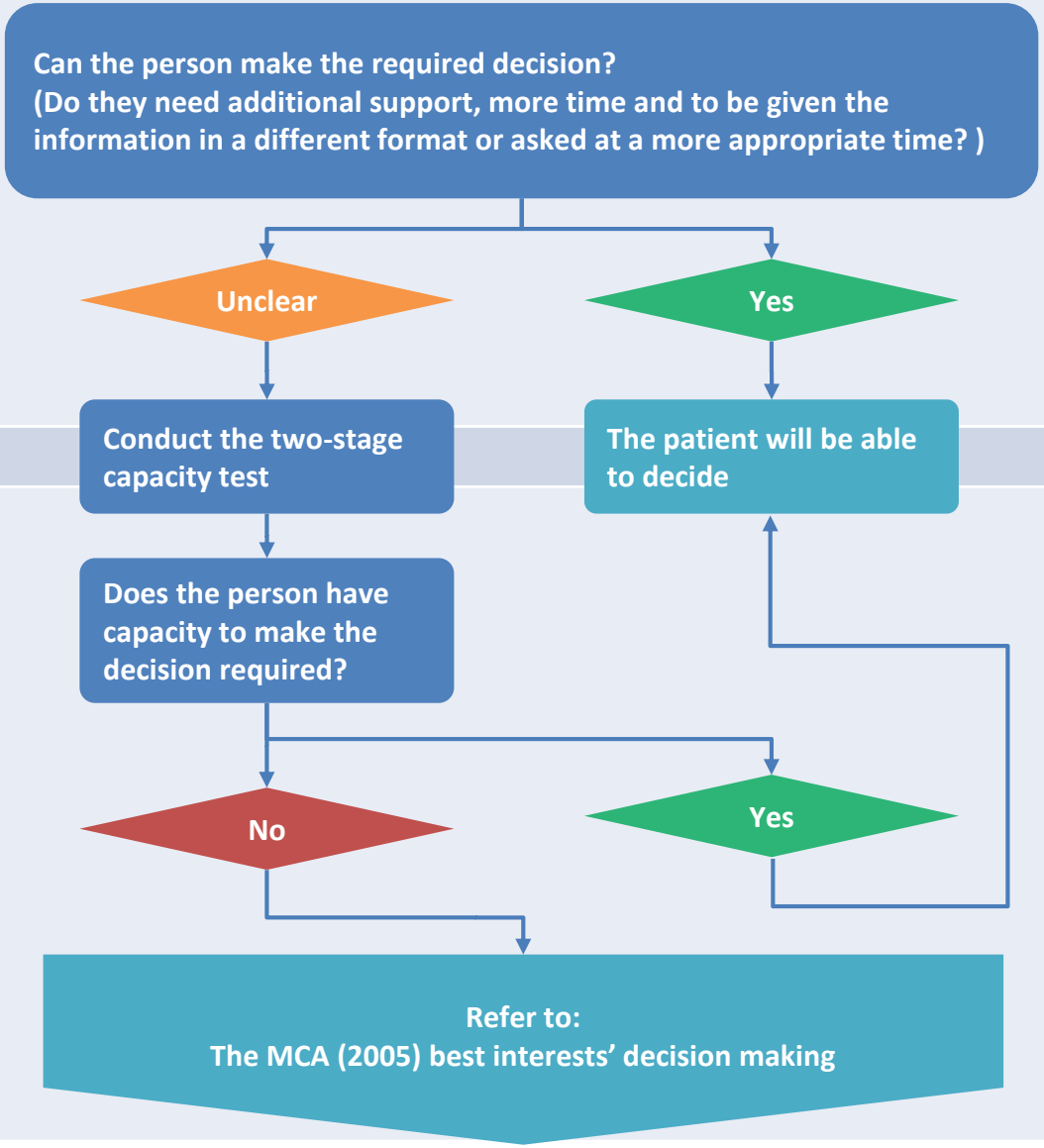
Stage two. Does the impairment or disturbance impede the person's capacity to make the particular decision?
Can the person:

1. **Understand the information relevant to the decision,**
2. **Retain that information, Weigh that information as a part of the process of making a decision**
3. **Communicate their decision (whether by talking, using sign language or any other means)?**

(Person must demonstrate all four functions above to be deemed as having capacity for the required decision-making)
Record this!

MCA (2005) Decision Making Flowchart

All adults should be presumed to have capacity unless an assessment of capacity has proved otherwise. If the patient is capable, consent must be obtained by the person undertaking the procedure.



TYPE 2 DIABETES – MENTAL CAPACITY ACT (2)

The North West London health and care partnership

Refer to the five principles of the MCA

- Must ensure that the proposed action/treatment is in the best interests of the person.
- The decision maker needs to check if there is an Advance Decision (AD), Lasting Power of Attorney [LPA] or Deputy covering health and welfare or if there is a friend/carer of person nominated by the person to consult.
- Advance Decision must be relevant to this decision.

The best-interest checklist

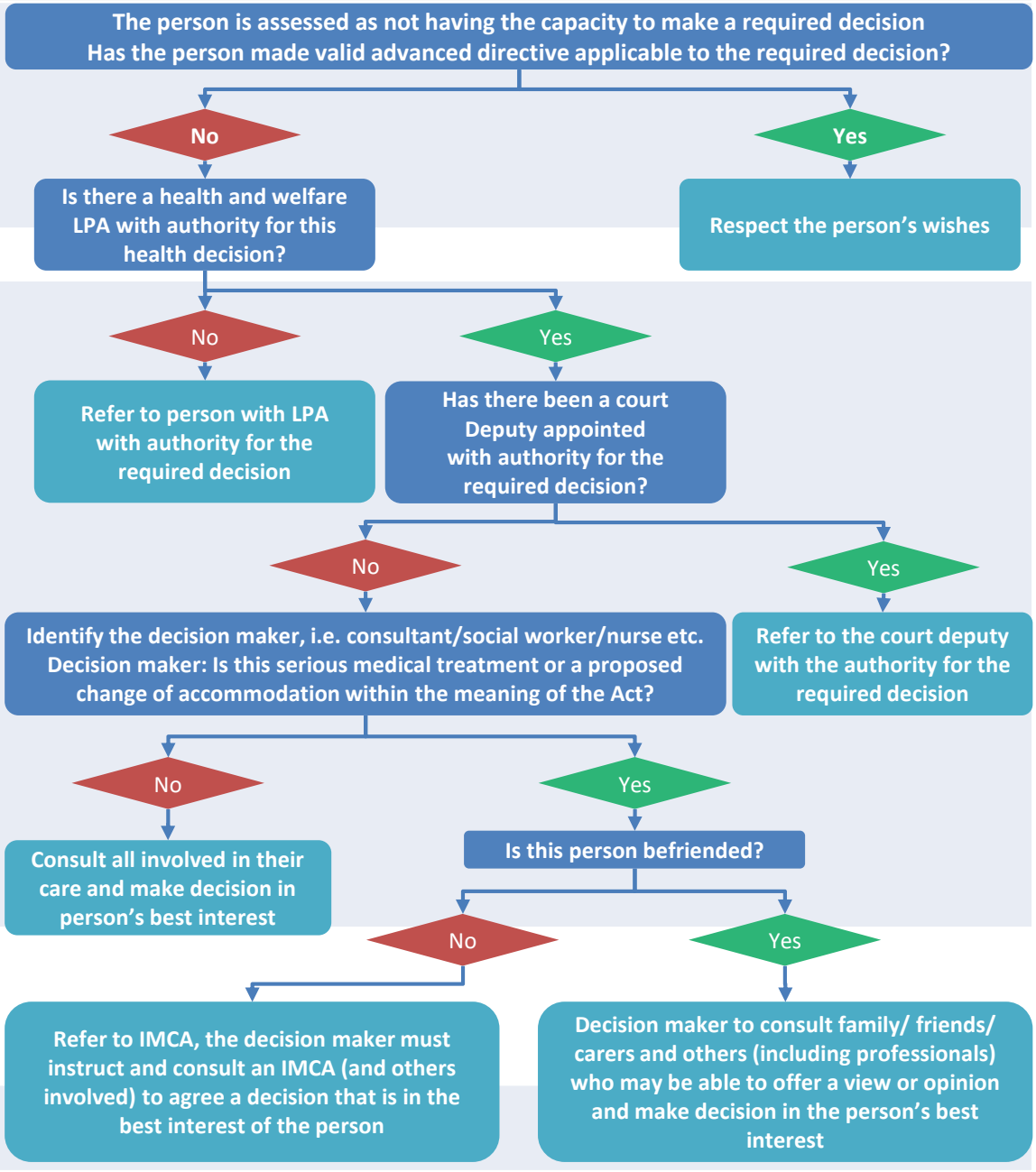
When making a decision in someone's best interests one must:

- Involve the person as much as possible
- Find out the person's wishes and feelings
- Consult people who know the person well
- Consider all relevant information in time
- Avoid making the decision if it is likely that the person might regain capacity
- Think about what would be the least restrictive option and not:
- Make assumptions based on the person's age, appearance, condition or behaviour
- Make a decision involving life-sustaining treatment that is motivated by a desire to end the person's life.
- Consult with all relevant others, i.e. the person, medic/GP, carers, Allied Health Professionals, social care staff, Advocate/IMCA, or people who know the person well, i.e. LPA or Deputy or Enduring Power of Attorneys
- Consider all the relevant circumstances relating to the decision in question
- Be able to justify and evidence their decision making
- Ensure that other least restrictive options are always explored (complete best interests decision record).

A formal best interests meeting is not always needed. It is important that consultation has taken place and the decision maker follows the guidance above with all relevant others and this is documented on the agreed paperwork.

Record keeping: it is important that you accurately record and evidence any decisions made with regards to best interests.

MCA (2005) Best Interests Decision Making



Date of preparation: December 2022. For review: July 2023