

Debate & Analysis

Diabetes care:

closing the gap between mental and physical health in primary care

THE RELATIONSHIP BETWEEN DIABETES AND MENTAL HEALTH

People with diabetes are vulnerable to comorbid mental illness. The burdens and worries of accepting the diagnosis, living with diabetes, adherence to treatment, fear of complications, and fear of hypoglycaemia can result in considerable distress, making diabetes difficult to self-manage.¹ As a result, rates of depression and anxiety are higher.^{2,3} Other mental health problems linked to diabetes include delirium, substance use disorders, psychotic disorders, and eating disorders.⁴ Comorbidity of diabetes and mental illness is complex and can present as:

- co-occurring independent conditions with no apparent direct connection;
- diabetes being a risk factor for development of mental illness;
- mental illness and its treatment being a risk factor for development of diabetes;
- overlapping clinical presentation of diabetes and mental illness;
- interaction of medications; and
- treatment non-adherence.⁴

COMPREHENSIVE DIABETES CARE IN PRIMARY CARE

The combination of mental illness and diabetes is related to worse health outcomes.¹⁻⁴ Caring for patients with diabetes requires considering emotional and psychological needs together with physical health needs. Management of mental health should be a regular part of diabetes care and be delivered with the same commitment as attending to blood glucose values. Early identification of potential risks and subclinical distress is preferable to waiting for a patient's mental health or physical health (due to poor mental health) to deteriorate before action is taken.

On the other hand, caring for patients with psychosocial issues requires addressing their physical health. A major problem in looking after people with mental illness and diabetes is the difficulty in prioritising the metabolic control and monitoring when there are complex psychosocial issues that need addressing first. The pressing needs of the short-term mental health problem often means that there is not enough time to focus on the longer-term physical health problems.

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COLLABORATIVE APPROACH IN CARE OF PEOPLE WITH DIABETES AND MENTAL HEALTH PROBLEMS

In a collaborative approach, primary care providers and specialists work together to provide care and monitor patients' progress. Using Hickman *et al's* taxonomy of shared care,⁵ we propose a model of liaison meetings between specialists and primary care team members for discussion and planning of ongoing management of prespecified chronic disease. Whether this model is clinically- and cost-effective has not been determined yet because of variations in the model, but there is some evidence that embedding treatment interventions in a collaborative framework has a positive impact. In the TEAMcare⁶ and COINCIDE⁷ models, case-managing practice nurses provided individualised management plans/targets and support for self-managements (TEAMcare) and low-intensity psychological therapy (COINCIDE). They received supervision from a psychologist and/or psychiatrist. Improvements in composite outcome of glycaemic control, blood pressure, lipids, and depression scores (TEAMcare) and in self-management and depression scores (COINCIDE) were seen. However, the cost-effectiveness of this intervention remains uncertain (COINCIDE).⁸ These promising results in the management of diabetes comorbid with depression support our approach to including a psychological service into the regular care management of patients with diabetes. This approach is in contrast to simple educational strategies that focus on education of practitioners and guideline implementation, which are largely ineffective when compared with more complex interventions that combine practitioner education, case management, and a greater degree of integration between primary and secondary care (consultation-liaison models).⁹

PRIMARY CARE AT THE CENTRE OF DIABETES CARE

Primary care is at the centre of every patient's care, including their diabetes and mental

health. However, with the increasing workload in primary care and the multiple demands on time, there are concerns about the capacity of primary care to deliver 'parity of esteem' in diabetes. *The Five-Year Forward View for Mental Health*¹⁰ points at underdeveloped models of primary mental health care, lack of comprehensive standards, and lack of evidence for effective interventions. As a result, people with comorbid mental health illness are not always well supported with only 15% of people with diabetes having access to psychological help.¹⁰ Collaborative care arrangements, better integration of mental health support with primary care, and chronic disease management programmes can improve outcomes of care.¹¹ The 2022 GP vision¹² made primary care responsible for making these arrangements.

DELIVERING PARITY OF ESTEEM

A new approach to commissioning, workforce planning, service delivery, and research is needed to recognise and treat psychological needs. This is essential to the wellbeing of people with long-term physical health and vital to their self-management.¹³ The specifics of the recommended approach are being left to the care providers. The NICE guidelines are still underdeveloped in supporting delivery of parity of esteem, but at least recognise some mental health issues linked with type 1 diabetes¹⁴ and depression in long-term conditions.¹⁵

MOVING FROM A REFERRAL MODEL TO A COLLABORATIVE MODEL

As primary and secondary healthcare professionals, we have long experienced frustrations over doing all we could for our patients with diabetes but not achieving desired outcomes. We adjust treatment and, as a last resort, we often refer patients to mental health services with various degrees of responsiveness. As general and specialist healthcare practitioners, we have been trained to a lesser or greater degree in mental health awareness and equipped with skills to address patients' needs. However,

the increasing demand and complexity of caring for people with diabetes and working in primary–secondary care silos leads to a predominantly medical model of illness within a fragmented healthcare system. Traditionally we have been practising a multidisciplinary approach, approaching mental health specialists when we think they are needed, but it is time to move towards an interdisciplinary approach, embedding mental health workers in the teams, collaboratively setting treatment goals, and jointly carrying out the treatment plans.¹⁶ We see the latter as a more effective integrated healthcare system spanning physical and mental health.

We are moving towards an integrated diabetes service with embedded mental health care, shared outcomes (across physical and mental health as well as across primary–community and secondary services), and a joint decision-making body delivering care to the whole population with diabetes. Building on the widely accepted model of collaboration through virtual clinics, with healthcare professionals discussing preselected patient cases, the team meets in a primary care setting and has input from practice nurses, GPs, and consultants in diabetes and psychiatry (psychological medicine). The biggest difference compared with the traditional referral model is in the role of mental health workers and for the effect that this has on the primary care and diabetes team. Psychiatric input is delivered proactively, not just when all other options have been exhausted and it is felt that the mental health issue needs addressing. It is welcomed when all preselected cases are discussed, whether or not there was initially thought to be a psychological component to the patient's condition. As a result, conditions and diagnoses such as cognitive impairment, medically unexplained symptom patterns, learning disabilities, and personality traits have all been identified and addressed as factors contributing to poor outcomes.

The major benefit of a mental health specialist working with the team is not to see the patients directly (only in rare occasions) but support, advise, and train the usual team with a much larger cohort. The advantage of this is that it breaks down the physical–mental health silos, preserves continuity of the patient–primary healthcare provider relationship, and adds essential skills to the non-specialist team. Crucially, in the light of increasing prevalence of diabetes and mental health, it is also likely to be more sustainable and 'future proofed'.

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The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

DOI: <https://doi.org/10.3399/bjgp17X692993>

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