

# Why should we have diabetes psychologists in the multidisciplinary team?

It has been said that supporting people with diabetes to take adequate responsibility in diabetes self-management is “the utopian state dreamt of by all diabetologists [and diabetes healthcare professionals]!” (Kalra et al, 2018). If this is the case, where are all the psychologists in diabetes care? If we know that evidence-based psychological interventions can positively impact diabetes self-management, and impact both soft (e.g. quality of life) and hard (micro- and macrovascular complications) outcomes, then why do diabetes services not all have embedded, functionally integrated diabetes psychologists as part of the multidisciplinary team (MDT)?

This is an important question and, I believe, one that commissioners of diabetes services should all be asking themselves. Is there not a moral imperative to ensure access to evidence-based “treatments” that improve outcomes for patients and families? We know that optimising psychological well-being for people with diabetes is positively correlated with improved medical outcomes, including better blood glucose management and even lower mortality (Massey et al, 2019).

What is the rationale for not providing a powerfully effective and evidence-based “treatment”? Is there a cost–benefit ratio consideration here that tips the scales away from psychology as a fundamental component of the diabetes MDT? There is no evidence to suggest this; in fact, the opposite. We know that 1 in 4 people with type 1 diabetes and 1 in 5 people with insulin-treated type 2 diabetes experience severe distress (Diabetes UK, 2019). According to Diabetes UK, there are almost 5 million people currently living with diabetes in the UK. If we only look at the 8% of people with type 1 diabetes, for the sake of simplicity, this means that approximately 400 000 people are currently struggling with the burden of living with the condition and its associated emotional and psychological impact. And it is

important to note here, that the 1 in 4 figures mentioned earlier only relates to those living with severe distress. What about all the other people who don’t necessarily trip the criteria for “severe distress”, but who may be struggling with the ability and motivation to self-manage, and the associated impact on health outcomes, not to mention reduced quality of life?

## “But there’s no money/we can’t afford a diabetes psychologist”

This is a weak and unsubstantiated excuse in the context of the healthcare economic data. According to The King’s Fund, long-term condition and mental ill-health comorbidity increases total healthcare costs by at least 45% per person, with overall costs of up to £14bn each year in England alone, and the cost of treating complications comprising the largest proportion of this total spend (Naylor et al, 2012). Diabetes UK’s latest figures show that the cost of diabetes to the NHS is more than £1.5m an hour, which equates to 10% of the total budget for England and Wales. If we know that embedded, functionally integrated psychology within the diabetes MDT impacts “hard” and “soft” outcomes, and, in this regard, plays a key role in reducing risk of complications, what is the rationale for *not* having a UK-wide directive to commission and recruit diabetes psychologists, if for no other reason than as a “transformational” cost-saving measure? Based on the data, the argument must be “we can’t afford to *not* have psychology in the diabetes MDT.”

I do not think anyone would argue that inequitable access is not a major challenge for health and social care. The necessity of addressing health inequalities is, therefore, a clear priority in the design and delivery of services. On this basis, again, psychology must become an established, routinely commissioned part of the diabetes MDT. We know that people with long-



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***“Functionally integrated and embedded psychology also supports the normalisation of psychological distress associated with diagnosis and condition burden.”***

term conditions (such as diabetes) and comorbid psychological distress and/or mental ill-health are more likely to live in areas of social deprivation, and that social deprivation negatively influences outcomes for people with diabetes (Kilvert and Fox, 2023). Furthermore, this relationship is bi-directional – social deprivation is associated with poor quality diet, being less active, experiencing increased levels of stress and trauma, and increased risk of developing type 2 diabetes (Agardh et al, 2011). People living in poverty are more at risk of depression, and it has long been known that depression is an independent risk factor for cardiovascular disease and diabetes (Knol et al, 2006). We also know that people with type 1 or type 2 diabetes are at higher risk of developing depression, based on both behavioural/lifestyle risk factors and via emerging pathophysiological mechanisms. In these people, quality of life is reduced and blood glucose self-management is more of a challenge, leading to worse glycaemic control and increased risk of complications (Nouwen et al, 2010).

There have been recent initiatives in England to increase physical health screening of people with severe mental illnesses (SMIs); that is, people with diagnoses such as schizophrenia or bipolar disorder. This was driven by findings from the 2018 National Diabetes Audit that showed that people with SMIs die 10–20 years earlier than people without, and that long-term conditions (most specifically, type 2 diabetes) are what accounts for this mortality gap (Ashworth et al, 2017). People with an SMI are at twice the risk of developing type 2 diabetes, and there is a complex interplay between anti-psychotic-induced obesity, insulin resistance and thrombosis (Smith et al, 2008). Furthermore, they are much more likely to struggle (or even be averse) to accessing services, and can often fall between the arbitrary gap between mental and physical health services. For example, people with an SMI and type 2 diabetes are significantly less likely to access the eight diabetes care processes (Cohen et al, 2018). So, what difference can psychology within the diabetes MDT make to this population, whose needs are complex and who are often already under the care of mental health and/or liaison psychiatry services?

I would argue that this is a naïve question – just because a person has an SMI diagnosis, *they still have diabetes self-management needs*. They can also still benefit from evidence-based interventions that can enhance coping, reduce distress and promote lifestyle/behavioural changes. It would *not* be the remit of the diabetes psychologist to treat or manage the person’s SMI diagnosis; however, it would be their remit to advocate for their complex needs, liaise with mental health services and colleagues, and support the MDT in making necessary and reasonable adaptations to potentiate the likelihood of them attending clinic, undergoing care processes and, ultimately, benefiting from good diabetes MDT care.

**The rationale is clear; how can we access a diabetes psychologist in our MDT?**

If we accept that, based on the huge weight of clinical, equity and healthcare economic evidence, routinely commissioned, functionally integrated psychology should be part of the diabetes MDT establishment, how do we go about accessing it? This is where confusion can lie, as there is a wide continuum of psychological need for people with diabetes. This ranges from challenges related to acceptance of diagnosis, coping or motivation, to supported self-management, diabetes distress and the more severe and debilitating “mental health” end of the continuum. This more nuanced understanding of the range of psychological need for people with diabetes is important to enable us to be clear about what psychology could be commissioned and from where.

The more eagle-eyed amongst you will have noticed that I have repeatedly used the terms “functionally integrated” and “embedded” psychology, as this describes having a psychologist as part of the MDT and working across the continuum of need. Functionally integrated and embedded psychology also supports the normalisation of psychological distress associated with diagnosis and condition burden. We want to avoid a model of service delivery where the “problem” patients are referred for “mental health treatments” and, instead, support patients and families to optimise their diabetes self-management. Of course, where a person has primary needs related to a diagnosis

of a mental health condition – and their needs are related to that condition and not management of diabetes – then appropriate mental health services can be accessed by onward referral, as we would do for any patient.

What we want to avoid, however, is assuming that mental health services are the “right” place to access diabetes psychological care – they are not. This is not being disrespectful to the abilities or skills of the range of psychology practitioner colleagues who work within mental health services and undertake great work – rather, it is a clear directive to not pathologise the need for holistic care. Our current Secretary of State for Health and Social Care, Steve Barclay, has recently stated that “our health and care system has been built in silos, often focused on specific diseases... our workforce model needs to adapt... we need to support clinical professionals to heal with whole-person care” (Barclay, 2023). The assumption that pre-existing mental health services – whether community or secondary care – can address the psychology gap in service provision for people with diabetes is erroneous.

The route to accessing the appropriate (evidence-based) diabetes psychology expertise and workforce is going to vary according to geography. Where I work in the North of England, there are well-established psychology services that are embedded across the regional group of acute trusts. Each of these services either provides – or is working to provide – integrated diabetes psychology across the lifespan and ability range. So, finding out and contacting your local and/or regional clinical health psychology service(s) is an excellent first step. From this, conversations can be had related to the art of the possible. Can you refer patients to their service?; if not, what (locally relevant) business planning can occur? Who might be able to help with this? Who are the long-term condition leads and/or diabetes clinical leads in place who can help support the inclusion of psychology within future commissioning strategy?

If you are a non-psychology healthcare professional colleague reading this, don't underestimate the power that your voice can add to the argument for realisation of diabetes psychology business cases – it is one thing for psychologists to be making the case for commissioning of

psychology, and quite another for our medical, nursing and therapies colleagues also to be doing so. The UK-wide [Diabetes Psychology Network](#) is a wonderful group of highly motivated and supportive folk who can help to access examples of business cases that can be adapted, and can support by providing evidence, routes to data and, of course, mentorship. Whenever I speak with colleagues across the country, I ask, “Do you have a psychologist in your team?” The answer is invariably, “No, but we would love to have one.”

Can we harness that desire and change it into action? To lobby for inclusion of psychology within every diabetes MDT up and down the country? I would like to think that we can, that in understanding the value psychology can bring to the table (in addition to the impact on outcomes, equity and healthcare economics), the utopian dream of “optimal self-management of blood glucose” – and, of course, whole-person care – can be achieved. ■

**“Don't underestimate the power that your voice can add to the argument for realisation of diabetes psychology business cases.”**

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