Screening for depression – what happens next?

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Depression in people with diabetes is a major health problem, with up to 30% of people with diabetes affected (Katon et al, 2004). Considering the impact of untreated depression on wellbeing, family relationships and motivation to self-manage diabetes, it is not surprising that research indicates that people who have both diabetes and depression have poorer glycaemic control than those with diabetes who do not have a low mood disorder (Lustman and Clouse, 2005). A vicious circle occurs as adherence to medication and dietary regimens is more difficult for people with depression, which leads to poor glycaemic control, intensifying symptoms of low mood. If depression is addressed, glycaemic control is enhanced and mood and quality of life is significantly improved (Lustman and Clouse, 2005).

Screening for depression

In 2009, NICE guidance was published to support healthcare professionals (HCPs) to recognise and treat depression in diabetes. Furthermore, as part of the primary care Quality and Outcomes Framework (QOF), people with diabetes were to be asked two validated screening questions for depression.

Despite the mammoth problem, NICE (2012) has recently recommended that the DEP1 indicator, which encouraged primary care to screen all individuals with diabetes for depression, should be scrapped. So, what is going on? It would seem that, although screening does produce some positive results, the number of positive cases was so small that the value of screening was called to account (Burton et al, 2013). The question is, if depression is really so prevalent in people with diabetes as the research suggests, why did the DEP1 indicator for depression in those with a chronic illness fail so spectacularly that it has actually been taken out of QOF in 2013/14?

There could be a number of plausible explanations, starting with the obvious danger of transferring research findings directly into clinical practice, without testing it with a pilot study first. In the context of a complex chronic disease appointment, depression screening questions may actually seem out of context to the patient, who may feel very uncomfortable giving a positive answer, especially if the screening questions are delivered in an automated fashion as part of a tick-box exercise. If the patient gives a positive response, the healthcare professional then needs the skills to filter out false-positive results. Also many HCPs are wary of discussing depression due to time constraints of a routine appointment. Even once identified, review and intensification of treatment for depression is often inadequate.

Common-sense approach

So, where do we go from here? Perhaps we merely need to apply a common-sense approach to the issue and start to practice what we preach: holistic, individualised care. Use of depression tools can compromise the relationship between the person with diabetes and HCP, threatening holistic practice and intuition. Nonetheless, all HCPs working in diabetes need to be vigilant for signs of low mood and depression. We need to feel confident exploring how low mood impacts on an individual's life and diabetes self-management and we should all have the skills to recognise and discuss this in routine consultations. It is essential that low mood is put in such a way that the person with diabetes is comfortable seeking help. Let us not forget that life for those affected with depression is miserable enough, without the added burden of poorly controlled diabetes. ■

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