Changing diabetes®

The Diabetes Wellbeing Service: The impact of psychological therapy on HbA_{1c} in people with diabetes

Dr Jen Nash, Clinical Psychologist, Central & North West London NHS Trust and Director of Positive Diabetes; Dr Simon Dupont, Consultant Clinical Psychologist, Central & North West London NHS Trust

The Diabetes Wellbeing Service was established at the Hillingdon Hospital as an "Innovation Fund Partnership" between Hillingdon Clinical Commissioning Group and the Central and North West London NHS Trust. The partnership was awarded funds in recognition that psychological and social factors can interfere with the individual's ability to prioritise their diabetes self-care in those with both type 1 and type 2 diabetes.

Diabetes is one of the most demanding of the chronic health conditions, presenting significant ongoing physical, psychological, emotional and lifestyle challenges. The individual with diabetes is two-to-three times more likely to be diagnosed with depression than the person without diabetes (Barnard et al, 2006).

This article reports on the outcome of additional clinical psychology support, which is given alongside routine clinical care. The "Diabetes Wellbeing Service" is a short-term psychological intervention, designed specifically for people with poorly controlled type 1 and type 2 diabetes (HbA_{1c} >75 mmol/mol [9%]). The intervention aims to:

- Improve diabetes control and reduce complications by reducing HbA_{1c}.
- Improve the psychological wellbeing of the individual with diabetes.
- Decrease the use of unscheduled care, both in primary and emergency care.

Method

Referral criteria for this intervention were people with poorly controlled type 1 or type 2 diabetes. Referrals were accepted from GPs in primary care and all multidisciplinary clinicians in secondary care. The service deliberately used the term "wellbeing" in place of "psychology" or "mental health" and this was due to the stigma that these terms can attract. People referred to this service may be cautious or hesitant to attend if these terms are used.

Following NICE guidelines (NICE, 2009) the structure of the therapeutic intervention was based on cognitive behavioural therapy (CBT). Retrospectively, however, it was felt that a number of people simply benefitted from space to engage in the practical problem solving of prioritising self-care tasks in the context of the other demands in life. This extra time allowed them time to concentrate on their diabetes care, which is something that is not possible in "routine care" appointments. These interventions often took a motivational interviewing and solution-focused approach, which encouraged the individuals to proactively think of ways to manage their diabetes. Some of the common issues dealt with were:

This extra time allowed them to focus on overcoming the obstacles to implementing their medical advice, which is something that is not always possible in "routine care" appointments.

- Low mood, depression and anxiety affecting diabetes self-care.
- Eating issues, including emotional eating and binge eating.
- Assertiveness skills (for example, setting appropriate boundaries with others to enable health needs to be prioritised).
- Grief reactions affecting diabetes self-care.
- Working through difficulties relating to healthcare professionals.
- Education or "myth-busting" (including confusion about differences between type 1 and type 2 diabetes).
- Unhelpful narratives regarding diabetes (for example, "It's not that serious", or "My dad died of diabetes so what's the point in trying?").

Sessions were 60 minutes and were scheduled according to the frequency and duration that suited the individual. The number of interventions per person ranged from 1–16 sessions, with a mean of 8 sessions per person.

The clinical psychologist also provided education to primary care professionals about the psychological issues in people with diabetes and how these issues can be addressed

in primary care. These education sessions took place during local GP-led multidisciplinary team meetings.

Results

There were 50 appropriate referrals accepted into the service between April 2013 and January 2014. The mean age of patient was 43 years (range 18–70) and 38% of referrals were male. A total of 46% had type 1 diabetes. The mean baseline HbA_{1c} was 95 mmol/mol (10.8%). Data collection is ongoing.

To date, we have found that the intervention resulted in a statistically significant mean reduction in HbA_{1c} of 12 mmol/mol (1.2%, n=40). The reduction in HbA_{1c} ranged between 1–51 mmol/mol.

Significant reductions were also achieved in depression scores on the Patient Health Questionnaire (PHQ-9; Kroenke et al, 2001). Pre-intervention PHQ-9 mean scores were: 12.3 (standard deviation [SD]=7.68), and post-intervention PHQ-9 mean scores were 7.6 (SD=6.39).

Anxiety scores were also lower post-intervention and this was assessed using the GAD-7 Anxiety Questionnaire (Spitzer et al, 2006). Mean anxiety scores pre-intervention were: 8.9 (SD=6.98) and post-intervention mean scores were 5.2 (SD=4.24).

Discussion

People with poorly controlled diabetes can often be labelled as "disengaged" by healthcare professionals. These results tentatively suggest that it may be the medical focus itself that "disengages" the individual.

People who attended this service benefitted from a psychologically informed "space" to engage in the practical problem solving of prioritising self-care tasks in the context of the other demands in life. It is possible that, prior to the intervention, the individual did not have the time or opportunity to engage with prioritising their diabetes, nor have the skill-set to facilitate any change; and this is something that is not always possible to provide in the medical setting.

These results demonstrate that if additional services and interventions can provide a psychological space in which the individual can be encouraged to think about diabetes from a non-medical perspective, excellent clinical outcomes can be achieved.

The input of a clinical psychologist, and the role they can play in assisting people to achieve improved HbA_{1c}, contributes to a truly multidisciplinary approach to the care of the person with diabetes. Furthermore, the clinical psychologist has an important role to play in training other diabetes professionals about the psychological impact of diabetes and can share some simple techniques that healthcare professionals can use to help people with poorly controlled diabetes achieve the best possible clinical outcomes.

It is important to recognise that some people with diabetes may require extra support to truly "engage" with their diabetes self-care.

The service was "commended" in the "Best CCG Initiative" category in the Quality in Care Awards, 2014. Readers interested in finding more about the service or about how it could be adapted locally, are invited to contact the author at: drjen@positivediabetes.com ■

Read more about the service and case study examples in the document: *London's care pathway for diabetes: Commissioning recommendations for psychological support.* Available at: http://bit.ly/1pbCFFS

Barnard K, Skinner T, Pevelar R (2006) The prevalence of co-morbid depression in adults with type 1 diabetes: Systematic literature review. *Diabet Med* **23**: 445–8

Kroenke K, Spitzer RL, Williams JB (2001) The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med* **16**: 606–13

NICE (2009) Depression in adults with a chronic physical health problem: Treatment and management. CG91. NICE, London. Available at: http://www.nice.org.uk/guidance/cg91 (accessed 04.11.14)

Spitzer RL, Kroenke K, Williams JB, Löwe B (2006) A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med* **166**: 1093–7