Diabetes, depression and dementia: The forgotten people

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As healthcare professionals working wholly in diabetes, we would perhaps be considered as expert leaders in our field; however, in recent times it has become apparent that we need to broaden our field of vision to encompass other aspects of care that influence diabetes management. Mental health issues, such as depression and dementia, are frequently discussed in the media, but little attention has been paid to these complex conditions in the diabetes nursing world.

The impact of mental health conditions on the management of diabetes is challenging to address, so requires cross-speciality working to care for these people and new skill sets that we, as specialist nurses, need to embrace.

Depression and diabetes

Depression in people with diabetes is common. It is estimated that the incidence of depression is two-to-three times higher in those with diabetes than in those without, and that it occurs in about 20% of people with a chronic physical condition. Depression can present in many forms, including low mood and episodes of anxiety. The impact of depression on the management of diabetes is manifold, potentially leading to poor glycaemic control, an inability to self-care and self-manage diabetes, and loss of confidence. This can result in lost productivity, an increased risk of developing cardiovascular disease and increased mortality (Diabetes UK, 2008).

Existing evidence suggests that appropriate treatment of depression can improve glycaemic control (Anderson et al, 2001; NICE, 2009), so effective screening for depression is essential. However, Diabetes UK (2008) reports that depression in people with diabetes is often undetected and is missed in 30% to 50% of cases, in both primary and secondary care settings.

Dementia and diabetes

Dementia care has frequently been in the headlines since Jeremy Hunt, the Secretary of State for Health, made Dementia one of his top NHS priorities. The Prime Minister, David Cameron, spoke about dementia at the Alzheimer's Society Conference in 2012:

> *"One of the greatest challenges of our time is what I'd call the quiet crisis, one that steals lives and tears at the hearts of families, but that, relative to its impact, is hardly acknowledged."*

Two-thirds of people with dementia are women, 2–5% are under 65 years of age, and it is estimated that one in three people over the age of 65 will develop dementia in the future (Alzheimer's Society, 2013).

The relationship between type 2 diabetes and cognitive function has long been recognised; however, it is only recently that published evidence has clearly established an association between type 2 diabetes and the development of dementia (Crane et al, 2013). Both conditions are progressive and affect mainly older people, and individuals with type 2 diabetes may have double the risk of developing dementia compared with those without diabetes (Crane et al, 2013).

The number of people with diabetes in the UK has reached over 3 million and is expected to reach 5 million by 2025 (Diabetes UK, 2012). The number of people with dementia in the UK has increased to over 850 000, and it is estimated this will rise to over 1 million by 2021 (Alzheimer's Society, 2012). Therefore, we could be seeing more individuals with both diabetes and dementia in the future, so it is important to recognise the signs.

Impact on the individual

A secondary diagnosis of diabetes or dementia when an individual also has a pre-existing diagnosis of

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one of these long-term conditions can have a huge impact on self-management and long-term care. For example, there will be inherent practical difficulties when a dementia diagnosis is made in an individual already diagnosed with diabetes. Equally, a new diagnosis of diabetes in a person with dementia will add to the confusion experienced by that individual. Hypoglycaemia is a real risk in individuals with both conditions as the signs and symptoms may be mistaken for signs of worsening confusion. There are also the additional safety risks associated with poor medication compliance and polypharmacy, as well as more practical issues, such as blood glucose monitoring, insulin devices or changes in dietary habits.

Screening for dementia in individuals with diabetes is, therefore, important and there are simple tools that can be used, such as the Mini Cog tool (Institute of Diabetes for Older People [IDOP] and TREND-UK, 2013). If a positive diagnosis of dementia is made, it may lead to additional financial or social support for the individual and their family. For example, in end-of-life care, it may be that an independent advocate would need to be appointed to work on behalf of the individual with both conditions.

Conclusion

It is clear that diabetes combined with either depression or dementia, or both, and the rapidly increasing prevalence of diabetes and dementia will significantly impact on our way of working in the future. There needs to be greater awareness and understanding of how each condition impacts on the other if we are going to improve quality of life and minimise the risk of short- and long-term complications. All healthcare professionals need to be more aware of how to manage diabetes in these individuals, as the usual glycaemic targets and intensive treatment regimens may no longer be appropriate. Nurses working in diabetes care and management need to learn from mental health colleagues to ensure a combined approach for the care of these, our most vulnerable, patients.

Further information

Improved knowledge and competency assessment for all staff is essential and recent publications and leaflets commissioned by the IDOP and produced by TREND-UK, as well as the TREND-UK *Career and Competency Framework* (2011) may be of help. ■

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