No health without mental health? The costs of not attending to the mind

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Earlier this year, Diabetes UK published the findings of an online survey on emotional support for people with diabetes. The survey concluded that more specialist emotional support is needed, as more than two thirds of people who needed professional psychological support had not received it (Diabetes UK, 2015).

This is especially concerning as rates of depression, anxiety and eating disorders are high in people with diabetes, compared with the general population. The King's Fund has calculated that comorbidity increases the average cost from £3910 to £5670 per annum for each person with a long-term condition (Naylor et al, 2012). In diabetes, comorbid mental health problems are associated with poorer glycaemic control, complications, and increased hospital admissions and GP consultations (Das-Munshi et al, 2007), all of which increase the cost to the NHS significantly. It has been suggested, however, that the provision of psychological therapy would reduce these costs by 20% per annum (Chiles et al, 1999). Holmes (1994) has said that it is "too expensive not to treat people with psychotherapy, if they need it".

Overestimating diabetes education and technology

Not providing specialist psychological intervention also incurs additional costs, although these are harder to calculate. These involve the use of diabetes education in lieu of psychological provision, where individuals are referred time and again for "education". This has been referred to as the "unproductive overuse of diabetes education" (Fosbury et al, 1996). Although diabetes education in all its forms is most certainly the cornerstone of diabetes care, it is ineffective when psychological problems are present. Additionally, many poorly controlled individuals can be very knowledgeable about their condition and how to control it, and will be persuasive in their desire to use the most recent technology, such as continuous subcutaneous insulin infusion (CSII) and continuous glucose monitoring.

Without psychological service provision, clinicians are usually at a loss as to where to send their distressed and poorly controlled patients for help. Often individuals are referred back to their practice nurse, specialist nurse or dietitian, with a view to commencing CSII therapy.

Underestimating psychological issues

When psychological problems are discussed in diabetes they are often presented as an effect of the condition. However, research has shown that pre-diabetes depression can lead to over-eating and the subsequent development of type 2 diabetes. It is suggested, therefore, that depression is bi-directional (Holt et al, 2014). Emotional factors, such as shame and sigma, are also often neglected (Archer, 2014) and these can lead to denial of the condition, poor self-care and the development of complications. Erectile dysfunction is also higher amongst males with diabetes than any other medical condition (Rosen et al, 2004), with causes being multi-factorial (neuropathy, depression, anti-depressant medication and anxiety). Furthermore, sexual health problems among women with diabetes are more prevalent compared to controls and encompass a whole range of difficulties caused by hyperglycaemia, including reduced vaginal lubrication, dyspareunia and self-image problems (Meeking et al, 2013). Finally, although diabetes does not cause eating disorders, it is a major risk factor for developing eating disorders.

This is a glimpse of how complex and interconnected psychological issues can be in an individual with diabetes. Thus, problems are usually heterogeneous and configure around pre- and post-diagnosis difficulties and the challenges of living with diabetes.

Underestimating treatment

If people with diabetes are lucky enough to receive psychological help, they usually receive cognitive

"If people with diabetes are lucky enough to receive psychological help, they usually receive cognitive behavioural therapy."

behavioural therapy (CBT). The restructuring of mental health trusts to improve access to CBT began in 2009 with the IAPT (Improving Access to Psychological Therapies) programme, a government initiative aimed at reducing depression levels among the general population, in particular the unemployed. Reducing the number of people receiving incapacity benefit and getting people back to work would ease exchequer costs by £1.4 billion a year (Layard et al, 2007). As a result, CBT became the first port of call for all psychological difficulties and although recommended by NICE, a recent parliamentary debate outlined challenges of the "squeezing out" of other forms of therapy in favour of CBT.

A critique of CBT is that it is designed for homogeneous difficulties and is, therefore, less applicable to complex problems (Fosbury, 2012; Pilgrim, 2013). As a psychotherapy, it is based on "learning theory", which, via psychological teaching methods, expects the rational cooperation of the individual in the treatment process. This means that the individual is required to be cooperative (motivated). Many of our poorly controlled patients, however, are unable or unwilling to respond to the demands of their condition. They behave in ways that are central to their problems, and the understanding and treatment of this difficulty is based on psychoanalysis. The difficulty is known as "resistance". In 2006, an article in *The Guardian* stated that an individual can also be refused CBT because they have "too many intertwining problems" and it is therefore only effective for people with "simple, uncomplicated depression" (Pidd, 2006).

Clinical commissioning groups

Although most of us agree that there is "no health without mental health", funding psychological care in diabetes is often bypassed. The Best Practice Tariff Working Group reported that:

> *"The inclusion of specialist psychological intervention provided a step too far. The challenges to inclusion seemed insurmountable."* (Price et al, 2013)

Without a redesign of payment mechanisms, it is likely that these barriers will continue and this is a challenge to clinical commissioning groups (CCGs).

Diabetes UK is calling for all CCGs to make sure they are commissioning appropriate psychological services. This requires CCGs to have knowledge about the psychological aspects of diabetes and robust treatment approaches for both type 1 and type 2 diabetes, as outlined above. If services are commissioned, they are usually established outside of the diabetes clinic via the local mental health trust and the model of treatment is often CBT.

This signposting away from diabetes clinics prevents "integrated care" as it separates the physical from the emotional. A diabetes psychotherapy service should be *in situ* to diabetes clinics, spanning secondary, community and primary care for multidisciplinary working. Enhanced psychological skills training should be made available for diabetes staff working with less complex individuals (Fosbury and Nash, 2014), but psychotherapists should be able to work with a range of psychological and emotional problems with specialist knowledge of diabetes in both a type 1 and type 2 population. This is reflected in the *Best Practice Commissioning Diabetes* document, an integrated care framework that states that the nature of diabetes requires areas of care and multidisciplinary teams that are wider reaching than for any other long-term condition (Diabetes UK, 2013).

In terms of costs to health and wellbeing, it is not best practice to exclude diabetes psychotherapy from the people that need it. ■

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