

Diabetes and depression in general practice:

meeting the challenge of managing comorbidity

BACKGROUND

One of the greatest challenges facing medicine in the 21st century is comorbidity, where two or more diseases occur together in the same individual. The World Health Organization estimates that two-thirds of people >55 years of age with a chronic disorder have more than one illness at the same time. Comorbidity of depression and anxiety disorders with physical illness is particularly frequent. Lifetime prevalence of depression is between 2% and 15%, and growing; and people with chronic physical illness or long-term conditions (LTCs) are two to three times more likely to suffer from depression than people without physical health problems. This leads to significantly greater reductions in health status.¹ In addition, people are likely to have multimorbidity, with several LTCs, which increases complexity of management.²

There are numerous interactions between depression and LTCs (Box 1). It is suggested that up to 30% of patients with diabetes also have depression, with over half of these patients reaching diagnostic criteria for major depression.

COMPLEX INTERACTIONS

The relationship between diabetes and depression is complex. Current research suggests that each disease is a risk factor for developing the other, that the two disorders may share similar pathogenetic mechanisms, and that the presence of depression may be an indicator of particularly severe diabetes. Depression in people with

Box 1. Possible interactions between depression and long-term conditions

People with physical illness:

- are at high risk for depressive disorders; and
- may have symptoms of depression or anxiety.

Depressive disorders may:

- be a risk factor for physical illness;
- amplify the symptoms of physical illness; and
- adversely affect the trajectory of physical illness or increase the probability of complications of physical illnesses.

Patients with depression may present with a variety of symptoms, for which current medicine finds no organic cause. The more numerous such symptoms, the more probable is the diagnosis of depression.

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diabetes may lead to poorer concordance with medical management, to reduced motivation for self-management activity, greater severity of the physical illness, higher mortality, and higher healthcare costs.³

Self-management, defined as 'the care taken by individuals towards their own health and wellbeing', concerns a healthy lifestyle, the satisfaction of social and emotional needs, managing the condition, and prevention activities. Depression can reduce motivation and capacity for self-management, and poor outcomes in people with comorbid depression and diabetes may reflect poor self-management. Patients with depression may have feelings of hopelessness (which may influence their judgements about the effectiveness of treatment), may be more likely to be socially isolated and lack support, and may struggle with limited concentration and energy. Sometimes the management of one condition actively conflicts with the management of another. For example, improving mood in a patient with diabetes and depression may also lead to improved appetite, with potentially negative effects on diet and diabetes control.

IDENTIFYING COMORBID DEPRESSION

In patients with an LTC such as diabetes, under-detection of a comorbid depression is common; patients tend to use normalising attributional styles that see depression as a normal consequence of ill health. This, along with professionals' conceptualisations

of depression as 'justifiable' or difficult to manage, especially in older adults, lead to under-detection of depression and problems initiating treatment of depression in primary care.^{4,5} Such barriers can partly be explained by the time-constrained nature of the primary care consultation, where clinical decision making is centred around prioritising competing patient demands. This is especially true in health settings like the NHS where the management of LTCs is driven by guidelines and treatment algorithms that focus on single diseases. In these highly structured environments, competing demands on health professionals' time often lead to prioritisation of physical health problems, and patients are similarly predisposed to focus on physical rather than mental health problems. Review consultations in primary care, which focus on the biomedical agenda set by the Quality and Outcomes Framework (QOF), emphasise this, and may make patients become passive subjects of 'surveillance'. Patient needs, including problems with mood, outside the narrow protocol are made invisible by the process of review.⁶

There appears to be a lack of congruence between patients' and professionals' conceptual language about depression. This, along with deficits in communication skills on the part of both patients and professionals, can lead to uncertainty about the nature of the problem and reduce opportunities to develop appropriate treatment strategies.⁵

"... the requirement to ask these case-finding questions ... as part of the QOF has now been retired: will this lead to depression continuing to be under-diagnosed in patients with diabetes?"

Box 2. Case-finding questions

- During the past month, have you often been bothered by feeling down, depressed, or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?
- A 'yes' to either question is an indication that a depressive disorder may be present. A 'no' response to both questions makes depression highly unlikely.

The use of case-finding questions (Box 2) should be part of usual practice for GPs in consultations with people with LTCs such as diabetes.

Since 2013, the requirement to ask these case-finding questions to patients with diabetes and heart disease as part of the QOF has now been retired: will this lead to depression continuing to be underdiagnosed in patients with diabetes?

THE NEED FOR GUIDELINES TO RECOGNISE COMORBIDITIES

Guidelines have the potential to improve the care of people with LTCs but seldom provide specific instruction for the action in the treatment of people with several conditions. This reflects the way in which clinical evidence is created (in randomised controlled trials of a single intervention for a single disease) but does not match everyday practice, where multimorbidity is common.² Combining recommendations for patients with multimorbidity can result in burdensome or even harmful treatment regimens. The National Institute for Health and Care Excellence (NICE) guideline for the management of depression in adults with a chronic physical health problem does attempt to recognise the complexity of comorbidity.⁷ There is a need to develop clinical guidelines that are relevant to a patient with a number of different LTCs, rather than to single conditions.

Recent work has focused on the role of educational and organisational interventions to overcome barriers to managing depression in primary care, either alone, or when comorbid with physical conditions. Simple educational strategies that focus on education of practitioners and guideline implementation are largely ineffective when compared with more complex interventions that combine practitioner education with enhanced roles for non-medical specialists (case management), and a greater degree of integration between primary and secondary care (consultation-liaison models).⁸ Such

a collaborative care intervention has been shown to be effective in improving outcomes of both diabetes and depression,⁹ and is included in the NICE guideline for depression with chronic physical health problems. GPs should reflect on whether such models of care are being commissioned in their locality.

The effective management of comorbid mental and physical illnesses requires a change in the way modern medicine is taught and practised; there is a need for a better understanding of the nature and consequences of comorbidity. Physical illness and mental illness are currently taught separately in medical and nursing schools with scant attention to the ways in which these affect each other. Medicine is becoming increasingly specialised at a time when comorbidity is rapidly becoming more frequent and a greater collaboration between general health and mental health services is essential.

AN INTERNATIONAL INITIATIVE

It was against this background that the Dialogue on Diabetes and Depression, (DDD),¹⁰ was established as an international collaboration with the aim of addressing the challenges of comorbid diabetes and depression. The goals of DDD have been endorsed by a number of international and national non-governmental organisations, and its activities include the coordination of research, the development of training materials, the organisation of symposia and training courses, the production of reviews of knowledge and the evidence-base, as well as the facilitation of collaboration around the prevention or reduction of problems of comorbid diabetes and depression among countries, organisations, and experts. This is valuable work: will the Royal College of General Practitioners respond to the challenge of managing people with diabetes and depression, and endorse the DDD?

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Provenance

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