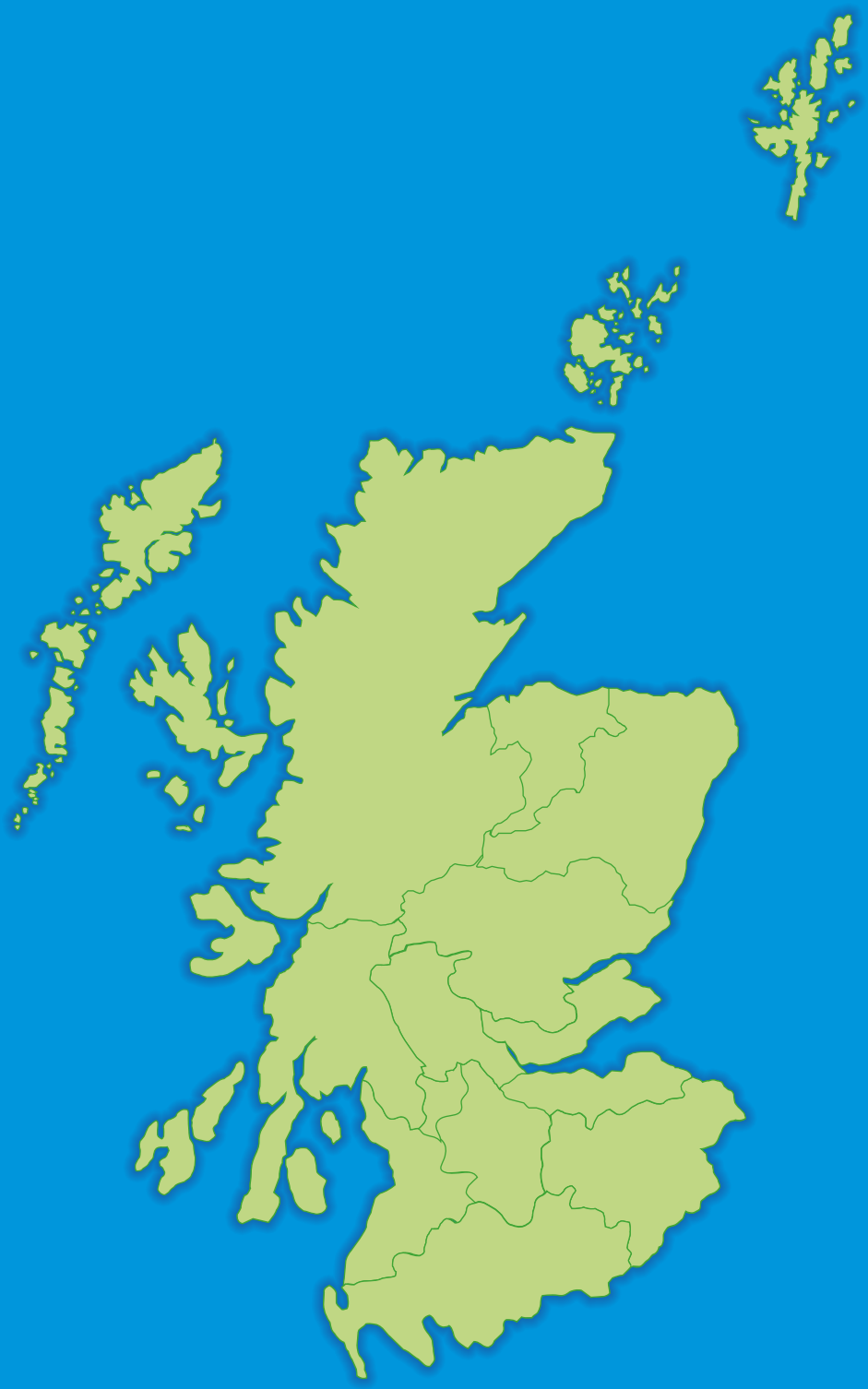
NHS SCOTLAND

Scottish Diabetes Group

# Short Life Working Group on Mental Health Screening in Diabetes



*'We will work with NHS Boards, clinicians and third sector to promote good practice and reduce variation in access to mental health support across the country, so that everyone has the opportunity to live well with diabetes'.*

**Diabetes Improvement Plan 2021-2026**

# Executive Summary

- People with Type 1 diabetes must carry out complex and relentless self-management regimens in order to keep blood glucose levels within certain limits, and avoid shorter- and longer-term health complications.
- Managing Type 2 diabetes is similarly difficult. While a range of medications are available, lifestyle changes are equally important in managing blood glucose levels.
- Identifying mental health problems in people with diabetes is important because they are associated with poorer quality of life, increased self-management difficulties, elevated HbA1c levels, and poorer health outcomes.
- Mental health problems are more common in people with diabetes than the general population, and it is clearly important that they receive the care they need.
- Systematically identifying mental health problems such as anxiety and depression in people with diabetes presents a significant challenge. It can be difficult for health and social care professionals to recognise the symptoms of anxiety and depression during routine consultations; this is in part due to the overlap between the somatic symptoms of common mental health problems and diabetes. Screening questionnaires can be helpful for improving the recognition of anxiety and depression in people with diabetes.
- Increasing the awareness of co-existing mental health difficulties provides an opportunity for people with diabetes and health and social care professionals to better understand any self-management challenges and agree achievable, realistic treatment goals.
- The Scottish Diabetes Group formed a Short Life Working Group (SLWG) to identify screening questionnaires for anxiety and depression and make recommendations on best practice.
- The SLWG recommend annual screening of anxiety using the GAD7, GAD2 or HADS, and of depression using the PHQ9, PHQ2 or HADS. Formal screening of diabetes distress is not recommended, however, the importance of asking specific open-ended questions about diabetes-related distress is highlighted.
- Questionnaires can be administered face-to-face, or using other methods such as asynchronous consulting technology, video or telephone consultations.
- It is imperative that services that choose to implement mental health screening co-develop and design agreed care pathways for people with diabetes that reflect the availability of local mental health provision.
- The SLWG recommends national monitoring of the screening for anxiety and depression using SCI-Diabetes.
- All health boards should have dedicated psychological/psychiatric resource for people with diabetes. Diabetes services should use the breadth of psychologists' knowledge, skills and competencies, including training and supervising colleagues.
- Awareness raising and training to both deliver the screening and ensure successful implementation of optimal referral pathways for health and social care professionals working across all levels in diabetes care would be helpful.
- All diabetes professionals should be aware of the role of anxiety and depression in diabetes self-management, as well as being able to have skilful conversations to help people access the support they need.
- These recommendations may be an appropriate approach to mental health screening and associated care pathways for a range of long-term conditions.

# 1.0 What is the Problem?

- People with diabetes are more likely to experience mental health difficulties than people without diabetes, and those with pre-existing mental health problems can find managing diabetes an additional emotional burden.
- Anxiety and depression are common mental health problems that can make diabetes self-management more challenging[1,2]. This is partly because they reduce energy levels and motivation; thereby increasing the gap between actual and best possible self-management behaviours, and resulting in poorer diabetes control[2, 3].
- People with diabetes are almost entirely responsible for the daily management of their condition, and poorer diabetes control leads to the earlier onset of secondary complications, including macrovascular and microvascular complications, disability, and premature death.
- Diabetes costs NHS Scotland around £1 billion each year, of which approximately 80% is spent treating potentially avoidable complications. Furthermore, around 12% of the total inpatient budget in Scotland is spent on treating diabetes and its related complications[4].
- Identifying common mental health problems in people with diabetes presents a significant challenge. This is partly because the symptoms of anxiety and depression are often similar to those of chronic diseases, and only a minority (less than 2 in 5) of people with anxiety and depression seek treatment[5].
- The size of the population diagnosed with diabetes also presents a substantial challenge. At the end of 2020, nearly 320,000 people in Scotland had a diagnosis of diabetes (5.8% of the population); an increase of 22.5% over the past decade[6]. Around 20% of people with diabetes experience mental health problems at any one time, substantially more than people without a diagnosis of diabetes.
- Diabetes distress is usually defined as the emotional burden associated with the relentless daily self-management of diabetes, and the prospect of developing long-term complications.
- Living with diabetes can be challenging and diabetes distress fluctuates. Distress may increase shortly after diagnosis, during major changes in treatment, following the diagnosis or development/ worsening of long-term complications, or simply due to the impact of other general life events and transitions. If untreated, diabetes distress can develop into mental health difficulties. Diabetes distress is also associated with poorer glycaemic control[7].
- Diabetes distress can increase during periods of stress. The prevalence of distress during the pandemic and impact of both COVID-19 and mental health problems has fallen disproportionally on those from our most deprived communities and those with pre-existing long term conditions[8]. Evidence relating to the impact of COVID-19 on people with diabetes is limited but continuing to emerge. People with both Type 1 and Type 2 diabetes were at an increased risk of developing severe illness from COVID-19 and were shielding during the peak of the pandemic.

- COVID-19 has led to postponement and delays in scheduled diabetes clinic appointments, as well as delays in the diagnosis and treatment of diabetes itself and secondary complications[8].
- The pandemic has also been associated with a substantial rise in symptoms of mental health problems[9], and people with diabetes have reported significant diabetes distress exacerbated by COVID-19[10]. Furthermore, many of the ways in which people with diabetes maintain positive wellbeing and alleviate anxiety and depression, such as being physically active (a prescribed behaviour change intervention for many with Type 2 diabetes), socialising and participating in enjoyable pastimes, have been significantly limited by COVID-19 preventive measures.

**SPOTLIGHT: TYPE 1 DIABETES**

- People with Type 1 diabetes must carry out complex and relentless self-management regimens in order to keep blood glucose levels within certain limits, and avoid shorter- and longer-term health complications.
- Approximately two fifths (41.3%) of people with Type 1 diabetes experience elevated anxiety symptoms, with generalised anxiety prevalence around 14%[11].
- Depression is more than three times as common in adults with Type 1 diabetes (12%) [12].
- Around 20–40% of people with type 1 diabetes experience elevated or severe diabetes distress [13].

**SPOTLIGHT: TYPE 2 DIABETES**

- Managing Type 2 diabetes is similarly difficult. While a range of hypoglycaemic medications are available, lifestyle changes (including eating and physical activity) are equally important in managing blood glucose levels. This is particularly pertinent given the majority of people with Type 2 diabetes in Scotland (87.4% in 2020) are overweight or obese[14].
- Similarly, over two fifths (42.2%) of people with Type 2 diabetes experience elevated anxiety symptoms, with generalised anxiety prevalence around 14%[11].
- Prevalence is approximately 19% for depression[13].
- Over a third (36%) experience significant diabetes distress[15, 16].

Figure 1: Spotlight on Type 1 and Type 2 Diabetes

# 2.0 Identifying Mental Health Needs and a Generic Care Pathway

- The Scottish Diabetes Group (SDG) formed a multi-disciplinary Short Life Working Group (SLWG) to establish how best to ensure that the mental health needs of people with diabetes are addressed (membership is detailed in appendix 1).
- In particular, the SLWG was tasked with establishing:

  1. An efficient way of identifying mental health needs in people with diabetes that could be incorporated into routine primary and secondary care practice.

  2. A generic care pathway that could be aligned with any identified needs of varying complexity.

- The SLWG drew heavily on the existing empirical literature, clinical guidelines and clinical expertise of the group to establish recommendations. An outline of the process is detailed in Figure 2 below.
- The consensus of the group was that all people with diabetes should be screened annually for anxiety and depression regardless of where care is provided (see Figure 2). The group further recommended that diabetes distress is explored through thoughtful, open-ended questions (for example, "how are you coping with diabetes at the moment?"). The recommendations are outlined in appendices 2, 3 and 4.

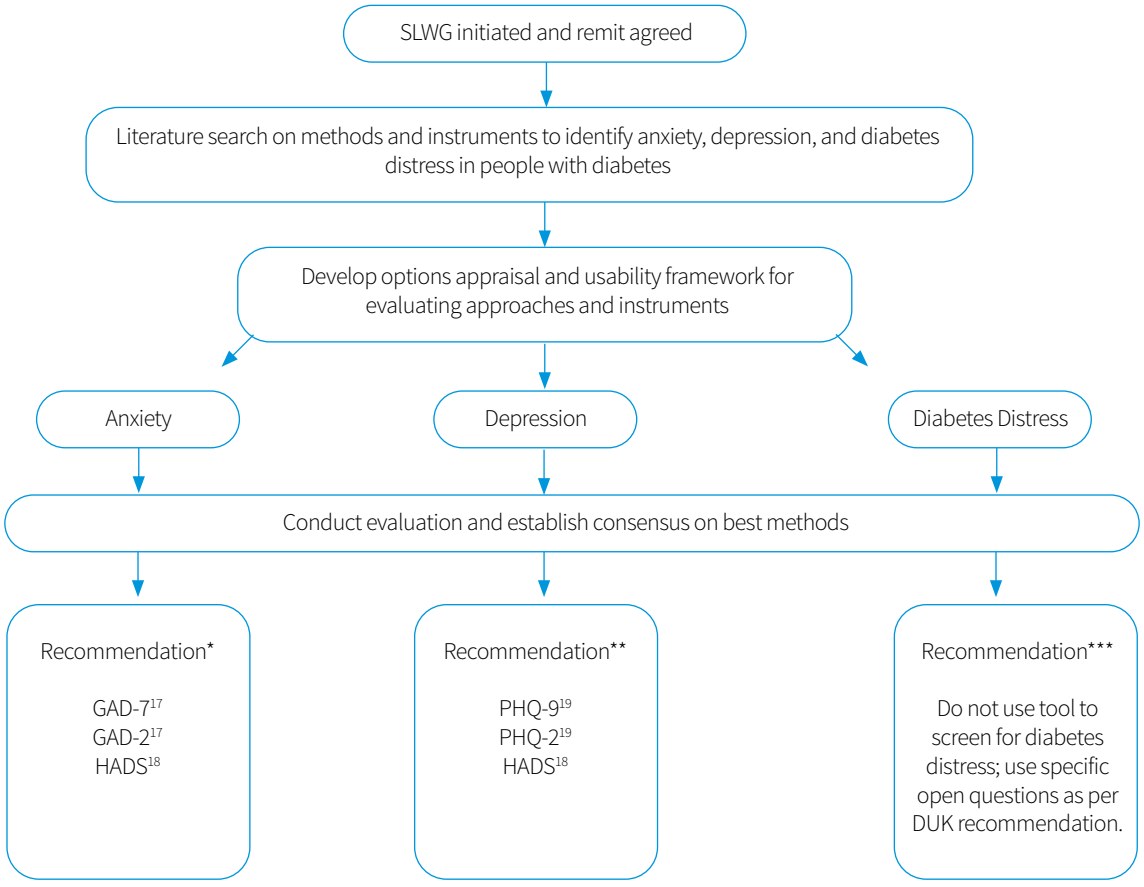



Figure 2 The process and outputs of phase 1, focused on recommending the best way to identify anxiety, depression and diabetes distress. For further clinical information to help inform screening measure choice/questions (including additional option for those with additional needs) and clinical cut-offs for anxiety & depression, see *appendix 2, **appendix 3, and ***appendix 4.

It is important that services measuring or screening for anxiety and/or depression have clearly defined pathways for all potential outcomes. An example of a referral pathway to be used after screening is illustrated in Figure 3. An example of good practice is illustrated in Figure 4 (the NHS Grampian Diabetes Psychology Pathway). These pathways will need to be co-developed and designed based on the availability and structure of each local health board's mental health/psychological services.

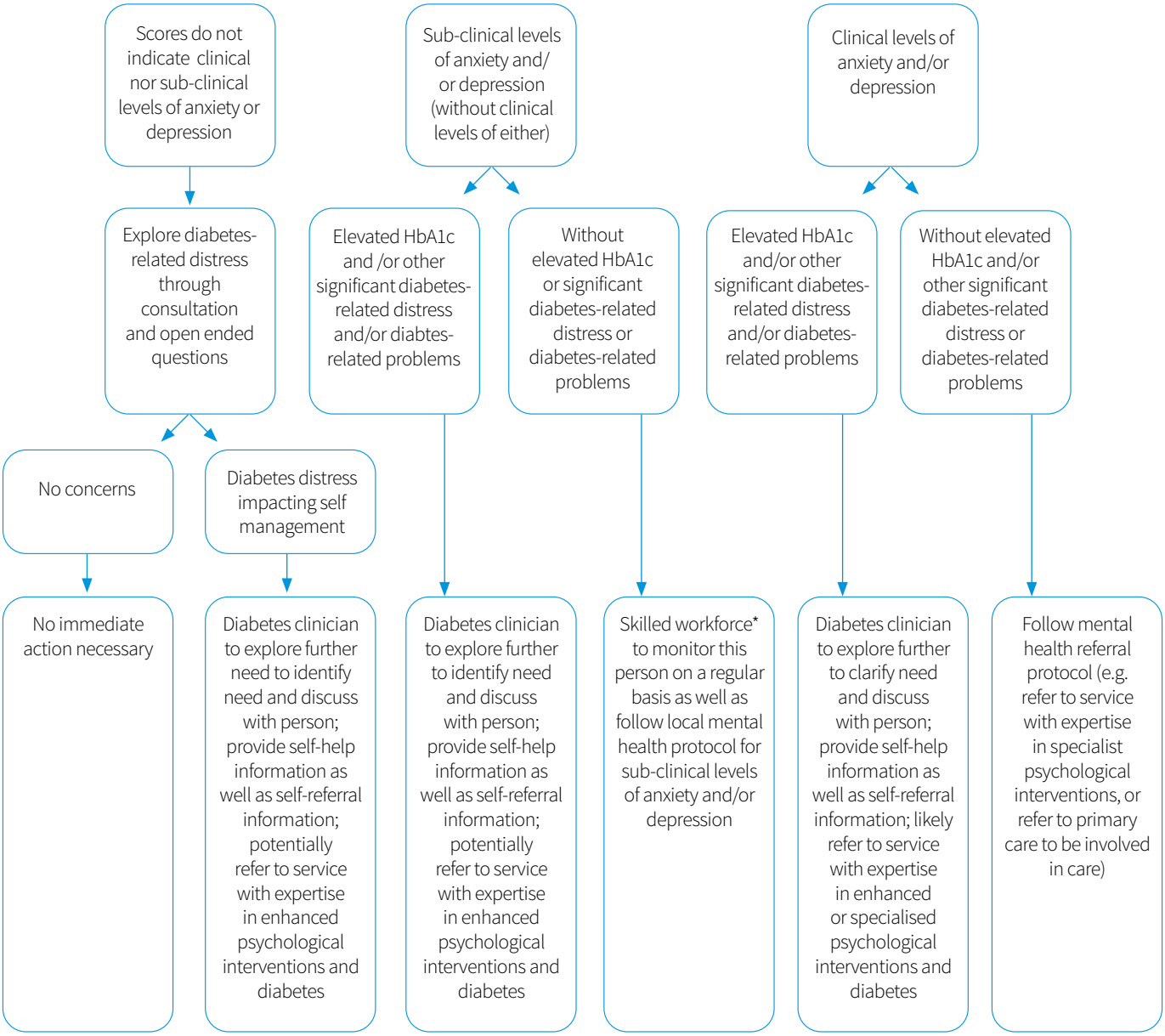



Figure 3. An example of best practice referral pathway to high and low intensity psychological intervention services for people scoring at sub-clinical and clinical levels of anxiety and/or depression, with and without elevated HbA1c, and with and without diabetes-related distress. For *skilled workforce, see appendices 5 & 6.

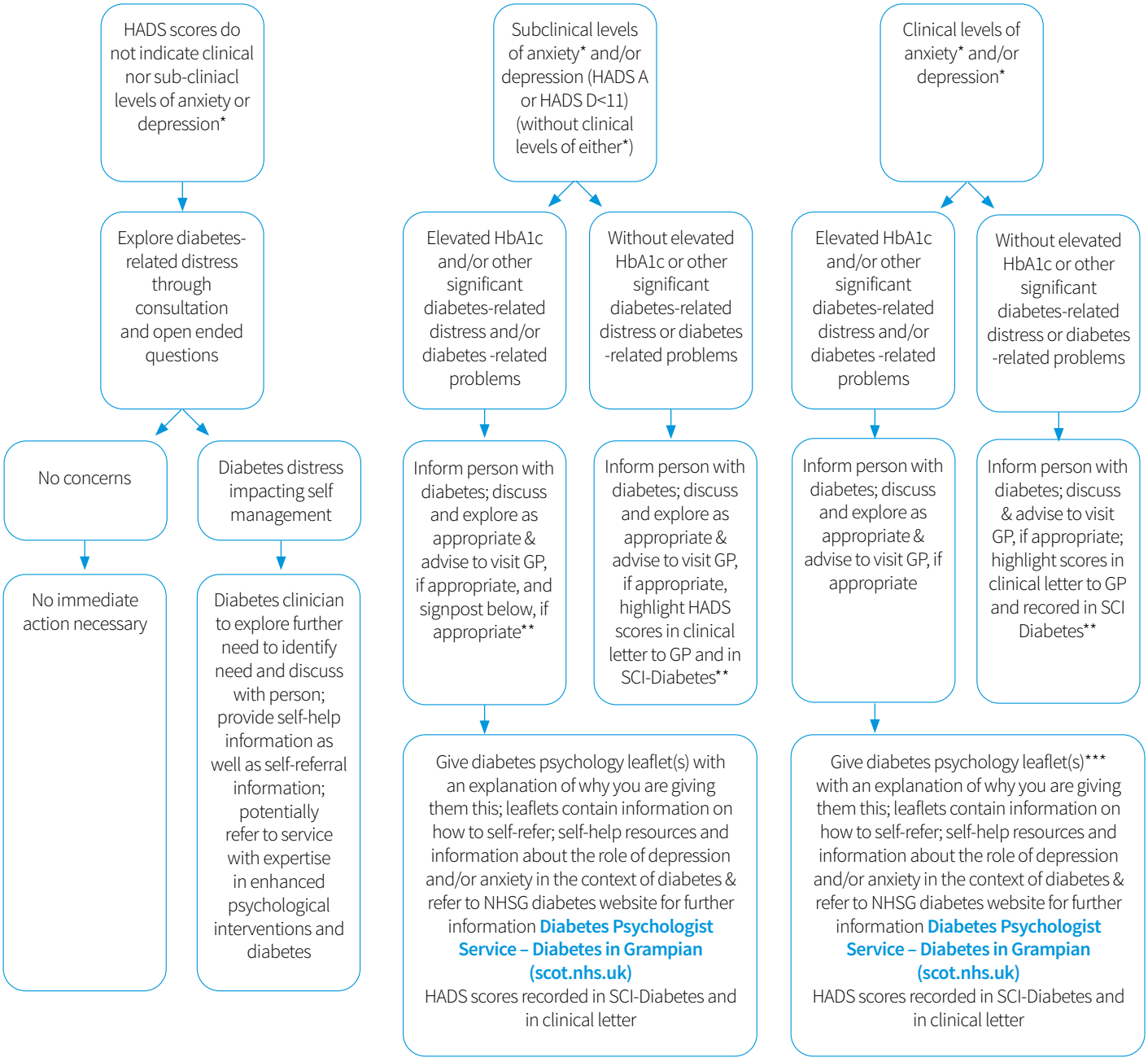



Figure 4. A good practice example: The NHS Grampian Diabetes Emotional Wellbeing Screening Protocol
*Anxiety score is general anxiety, so specific anxiety e.g. hypo fear may not be picked-up.
**If immediate risk highlighted in consultation, would instead contact GP immediately and follow local risk protocol.
***If patient scores 11 or over on BOTH depression and anxiety, then hand out both anxiety and depression leaflets.

Below are some important considerations for screening and associated pathways:

- If adults with diabetes have elevated HbA1c or other significant diabetes-related problems in addition to clinical levels of anxiety and/or depression, they should ideally receive psychological treatments from practitioners who also have significant expertise in diabetes. This is because these professionals can alleviate mental health problems, whilst simultaneously supporting individuals to manage their diabetes-related challenges (including improving glycaemic control, where necessary). It is also important to note that the main focus of the intervention may be providing skills to cope with a diabetes specific self-management issue that is causing or exacerbating a mental health problem. However, we appreciate that there are few staff in Scotland who have expertise in both psychological therapies and diabetes. Where that is the case, we recommend making use of existing psychological/ mental health/psychiatric services to treat anxiety and/or depression, whilst specialist services are developed.
- For people who have elevated HbA1c or other significant diabetes-related problems (such as specific anxieties, including needle phobia) in addition to scoring at sub-clinical levels, it is the responsibility of the diabetes practitioner to further explore how this impacts the individual's life and ability to self-manage diabetes. It may be appropriate for that person to receive psychological treatments from practitioners who also have knowledge of diabetes.
- For people with diabetes who have sub-clinical or clinical levels of anxiety and/ or depression in the absence of diabetes-related problems (including elevated HbA1c and diabetes-related distress), the standard, local mental health care pathways for treatment as usual should be followed.
- People with diabetes who have severe and enduring mental health problems, such as psychosis, personality disorders, severe depression and eating disorders, will typically require the help of multi-disciplinary mental health teams in collaboration with the diabetes specialist team20 (see appendices 5 and 6).
- Additionally, in the case of those who present with significant risk of suicidal ideation (such as those struggling during admission for recurrent admission for diabetic ketoacidosis), the involvement of mental health services, including psychiatry, is essential.
- People who do not meet thresholds for clinical/sub-clinical levels of anxiety or depression may still benefit from psychological support during routine appointments. General consulting skills form the basis of this and there are widely available courses delivered by NHS Education for Scotland (NES) to support and upskill staff to embed psychological skills into routine practice (see appendices 5 and 6).
- Examples of psychologically- informed approaches across the four levels of the psychological matrix for adults with Type 1 diabetes, adults with Type 2 diabetes and Health and Social Care Professionals are detailed in appendix 7.
- It is widely recognised that it is better to have psychologists and other mental health professionals working within and alongside the multi-disciplinary teams delivering diabetes care; this facilitates collaborative working and support, and cross-pollination of knowledge and skills, and helps to ensure all are working toward shared goals.

| Specialist and Enhanced Psychological Practice | Skilled Psychological Practice |
|---|---|
| This could include moderate to severe levels of anxiety and/or depression impacting on diabetes self-management; significant adjustment difficulties; fear of hypoglycaemia; anxiety about starting insulin; fear of diabetes-related complications; and some eating disorders.<br><br>Dependent on the persons need, specialist psychological therapies (i.e. based on an individualised formulation and using evidence-based, tailored therapy) would be delivered by those working at specialist level. This includes clinical, health or counselling psychologists with specialist knowledge of diabetes, or psychologists with additional training and expertise in diabetes (typically embedded in secondary diabetes teams).<br><br>Enhanced-level interventions are generally suitable for people with mild to moderate difficulties. These are low-intensity therapies delivered in protected time and to a specific protocol by staff who have been trained in the intervention and have access to regular supervision. This might include professionals with expertise in delivering brief psychological interventions (ideally with an understanding of diabetes or supported by staff with this expertise).<br><br>For people with complex situations, intervention by a multi-disciplinary specialist mental health team (including psychiatrists) with specialist knowledge of diabetes and with significant support from the secondary care diabetes team is required. | This might include general distress impacting on diabetes self-management, or specific distress (e.g. needle phobia, diabetes distress) with sub-clinical levels of anxiety and/or depression.<br><br>Integrating a range of psychological skills, such as Motivational Interviewing, into usual practice can enhance engagement and effectiveness of diabetes self-management behaviours.<br><br>Health and social care professionals may also be well placed to oversee and monitor computerised treatments and self-help. The delivery of combined educational courses, and physical activity interventions requires knowledge and skills in both psychological interventions and diabetes. These may be typically delivered in primary care or community mental health teams. |

Figure 5: Explanation of enhanced and specialist interventions, and skilled psychological practice mentioned in Figure 3.

# 3.0 Recommendations

- All health boards should have dedicated psychological and psychiatric resource for people with diabetes. For specialist and enhanced input, a combination of psychology/mental health, including psychiatry, is best practice. Diabetes services should use the breadth of psychologists' knowledge, skills and competencies, including training and supervising colleagues.
- For all adults living with Type 1 and Type 2 diabetes, annual screening for anxiety and depression using the previously outlined validated measures, and an exploration of diabetes-related distress is recommended. This should occur across both primary and secondary care services.
- There is no 'right way' to carry out screening; services should be flexible in using asynchronous and other digital options, as well as face-to-face, to fit the needs of the service and service users.
- In so far as possible, appropriate referral pathways should be developed to ensure needs identified at screening are met and adopted across primary and secondary care on a NHS board basis.
- To monitor best practice and progress, the SDG should introduce a figure on the SCI-Diabetes dashboard indicating the percentage (%) of people within board areas who have completed annual mental health screening questionnaires.
- It might be helpful to collaborate with NHS Education Scotland to develop a National Training Programme for diabetes psychological care for health and social care professionals. This could include training for staff to utilise screening effectively and ensure successful implementation of optimal referral pathways.

# 4.0 How to achieve these?

- Dedicated resource at local and national level is required to lead the implementation of the above recommendations, and to liaise with various work streams, including the Scottish Government, the Scottish Diabetes Group, and each respective health board.
- The creation of an implementation sub-group would be required to develop the necessary infrastructure and processes to enable screening of people with diabetes to occur. This could include driving forward the following aims:
  - ▷ Developing a national directory of services available to complement the aforementioned care pathways.
  - ▷ Identification and implementation of asynchronous and digital screening capture into patient electronic paper records across primary and secondary care.
  - ▷ Exploring options to get mental health screening data from MyDiabetesMyWay from people with diabetes.
  - ▷ Ensuring licensing is supported by the SDG for any screening measures that require it.
  - ▷ Working with SCI-Diabetes to record all screening measures, highlight clinical cut-offs and local care pathways.
  - ▷ Working with primary and secondary care to explore options to record screening measures, e.g. EMIS, Vision.
  - ▷ Developing a national diabetes training programme for health and social care professionals, including a national resource for professionals working at levels 1 and 2 (i.e. psychologically informed or skilled (see appendix 5 and 6 ) .

# Appendix 1: Core Membership and Advisory Group of Short Life Working Group

### Core Membership of Short Life Working Group

| | |
|---|---|
| Dr Mary Cawley | Consultant Clinical Psychologist, NHS Greater Glasgow & Clyde |
| Laurie Eyles | Professional Advisor, Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes |
| Christopher Galloway | Policy Officer, Clinical Priorities Unit, Scottish Government |
| Dr Ann Gold | Consultant Diabetologist, NHS Grampian |
| Dr Catriona Howes | Consultant Psychiatrist, NHS Lothian |
| Dr Kirsty MacLennan (Chair) | Clinical Psychologist, NHS Grampian |
| Angela Mitchell | National Director, Diabetes Scotland |
| Emma Nieminen | Lived Experience of Type 1 diabetes |
| Euan Ramsay | Policy Officer, Clinical Priorities Unit, Scottish Government |
| Dr Vivien Swanson | Health Psychologist, Programme Lead, NHS Education for Scotland; Reader, University of Stirling |
| Dr Neil Wilson | General Practitioner, NHS Forth Valley |
| Mr Keith Walker | Lived Experience Type 2 Diabetes |

### Advisory Group to Short Life Working Group

| | |
|---|---|
| Dr Sandra Ferguson | Associate Director of Psychology, NHS Education for Scotland |
| Prof Brian Kennon | Chair of the Scottish Diabetes Group, Scottish Government |
| Dr Andrew Keen | Consultant Health Psychologist, NHS Grampian |
| Valerie Laszlo | Diabetes Improvement Lead, Scottish Government |
| Bryony Murray | Senior Policy Manager, Respiratory Conditions & Diabetes |
| Dr Leeanne Nicklas | Head of Programme: Psychology Specialist Practice, NHS Education for Scotland |
| Prof Sam Philip | SCI-Diabetes Clinical Lead, Scottish Diabetes Group |
| Chris Wright | National Advisor for Digital Mental Health, Scottish Government |

### With thanks to

| | |
|---|---|
| Dr Emily Moffat | Health Psychologist, NHS Grampian |
| Christina Ellwood | Health Psychologist, NHS Grampian |

# Appendix 2: Table of recommended anxiety screening measures with additional clinical information to help inform screening measure choice

The following measures were agreed in the group as recommended screening measures for use in clinical practice. It is important to note that the cut-offs described below are for 'clinical caseness'; however, these scores should not be taken in isolation as they do not map directly on to a diagnosis. Instead they offer some information that warrants further exploration, in a careful and sensitive manner, in clinical consultation.

| Measure | Item no. | Clinical cut-offs (range) | Pros and cons |
|---|---|---|---|
| HADS[18] (anxiety sub-scale) | 7 | 0-7 none<br>8-10 mild<br>11-14 moderate<br>15-21 severe | Good measure for generalised anxiety in adult diabetes; recommended by SIGN and NICE guidelines; focuses on non-physical symptoms; specifically designed for people with physical conditions, and so does not overlap with somatic symptomology; primary care familiar with measure; well validated; available in many languages; can be administered multiple times to monitor progression or improvement; some issues with wording. Attention to be paid to the licensing. |
| GAD2[17] | 2 | ≥3**(0-6) | Very brief and simplified screening measure; NICE recommended for diagnostic measure then ask additional 5 questions in GAD7. However, contains items that are also indicative of the somatic symptoms of high and low blood glucose, and therefore often found to overestimate the likelihood of these conditions in people with diabetes. |
| GAD7[17] | 7 | 0-4 none<br>5-9 mild<br>10-14 moderate<br>15-21 severe | Recommended by NICE if suspected anxiety; has best performance characteristics for identifying generalised anxiety in comparison to other measures; GAD-7 is reliable, valid measure to quickly screen; can be administered multiple times to monitor progression or improvement. |
| Distress Thermometer* | 1 | | Recommended measure for people with significant communication or language difficulties. |

*For people with significant language or communication difficulties, consider using the **Distress Thermometer** (a single-item question screen to identify distress, asking the person to mark on a scale of 0 to 10 how distressed they have been during the past week) and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further.

**The GAD2 is deemed a screening measure whereas the GAD7 is a diagnostic measure. For more comprehensive information on how to use these measures, see **https://www.nice.org.uk/guidance/cg123/resources/common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173** (pages 8, 16 and 32).

# Appendix 3: Table of recommended depression screening measures with additional clinical information to help inform screening measure choice

The following measures were agreed in the group as recommended screening measures for use in clinical practice. It is important to note that the cut-offs described below are for 'clinical caseness'; however, these scores should not be taken in isolation as they do not map directly on to a diagnosis. Instead they offer some information that warrants further exploration, in a careful and sensitive manner, in clinical consultation.

| Measure | Item no. | Clinical cut-offs (range) | Pros and cons |
|---|---|---|---|
| HADS[18] (depression subscale) | 7 | 0-7 none;<br>8-10 mild;<br>11-14 moderate;<br>15-21 severe | Good measure for depression in adult diabetes; recommended by SIGN and NICE guidelines; focuses on non-physical symptoms; specifically designed for people with physical conditions, and so does not have as much overlap with somatic symptomology as some other measures; primary care familiar with measure; well validated; can be administered multiple times to monitor progression or improvement; available in many languages; some issues with wording. Attention to be paid to the licensing. |
| PHQ2[19] | 2 items** | ≥3**(0-6) | Very brief and simplified screening measure; NICE recommended for diagnostic measure then ask additional questions in PHQ9; contains items that are also indicative of the somatic symptoms of high and low blood glucose and therefore have often been found to overestimate the likelihood of depression. |
| PHQ9[18] | 9 items | 0–4 none;<br>5–9 mild;<br>10–14 moderate<br>15–19 moderately-severe<br>20–27 severe | Can be administered multiple times to monitor progression or improvement; contains items that are also indicative of the somatic symptoms of high and low blood glucose and therefore have often been found to overestimate the likelihood of these conditions in people with diabetes. |
| Distress Thermometer* | 1 | | Recommended as best measure for people with significant communication or language difficulties |

*For people with significant language or communication difficulties, consider using the **Distress Thermometer** (a single-item question screen to identify distress, asking the person to mark on a scale of 0 to 10 how distressed they have been during the past week) and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further.

**The PHQ2 is deemed a screening measure, whereas the PHQ9 is a diagnostic measure. For more comprehensive information on how to use these measures, see **https://www.nice.org.uk/guidance/cg123/resources/common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173** (pages 8, 16 and 32).

# Appendix 4: How to explore diabetes-related distress in clinical consultations

Following extensive discussion and review of the options appraisal, the SLWG agreed that none of the brief diabetes-related distress measures were uniformly clinically viable. Although a range of diabetes-distress scales were considered, they lacked usability as a screening measure in clinical practice.

Instead, it was agreed that open-ended questions would be more appropriate to identify how people with diabetes are impacted by their diabetes self-management efforts.

The following examples have been taken from: **https://www.diabetes.org.uk/professionals/resources/shared-practice/psychological-care/emotional-health-professionals-guide/chapter-3-diabetes-distress**

"There are many ways you can ask about diabetes distress; choose an approach that you find most comfortable and one that best suits the person with diabetes. Here are some examples of open-ended questions you could use:

- 'What is the most difficult part of living with diabetes for you?'
- 'What are your greatest concerns about your diabetes?'
- 'How is your diabetes getting in the way of other things in your life right now?'

These questions offer the person an opportunity to:

- raise any difficulties (emotional, behavioural or social) that they are facing
- express how particular diabetes-related issues are causing them distress and interfering with their self-care and/or their life in general.

One example of how to follow up the conversation could be: 'It sounds like you're having a difficult time with your diabetes. The problems you describe are quite common. And, as you also said, they often have a big impact on how you feel and how you take care of your diabetes. If you like, we could take some time to talk about what you and I can do to reduce your distress. What do you think?'"

# Appendix 5: Levels of Psychological Intervention or Different Practice Types for Adults with Type 1 Diabetes

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 1: Informed | Mental health and diabetes awareness/ promotion. | Managed Clinical Networks; local diabetes leads; national leads; Scottish Diabetes Group; Diabetes Scotland; public health; all health and social care professionals in contact with adults with diabetes. | Training for all health and social care professionals working with people with diabetes re: importance of screening and links between mental health and self-management in diabetes. |
| 2: Skilled | Minimum annual screening within primary and secondary care services; and, early presentations of distress impacting diabetes self-management (e.g. adjusting to diagnosis around time of diagnosis), usually with sub-clinical levels of anxiety and depression. | Primary and secondary care professionals providing care to people with diabetes. (Each board to identify responsibility for screening and pathways on a local level). | Identification of emotional problems and their impact, if any, on diabetes self-management (screening & consultation skills).<br>Education, including signposting to national and local resources.<br>Psychoeducation and self-management.<br>Brief motivational interviewing carried out by staff.<br>Basic psychosocial support delivered as part of routine care (including all barriers impacting ability to self-manage, so may mean social prescribing) & signposting (e.g. housing, financial).<br>'Watchful Waiting' (i.e. closely watching a person's condition/presentation but not providing treatment unless symptoms emerge or change). |

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 3: Enhanced | Distress that impacts diabetes self-management that has not responded to level 2 approaches or specific distress (e.g. needle phobia) with sub-clinical levels of anxiety and/or depression. | Professionals with expertise in delivering brief psychological interventions (ideally with an understanding of diabetes or supported by staff with this expertise) are required to deliver therapies; practitioners with psychological intervention training working in primary care staff may be well placed to oversee and monitor computerised treatments and self-help, delivery of combined educational courses requires knowledge and skills in both psychological interventions and diabetes. Enhanced psychological practice is underpinned by regular clinical supervision of the psychological intervention. | Training for all health and social care professionals working with people with diabetes re: importance of screening and links between mental health and self-management in diabetes. |

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 4: Specialist | **Multi-disciplinary specialist mental health team required for complex range**<br><br>Complex, long-term severe mental health problems impacting diabetes self-management (e.g. repeated diabetic ketoacidosis, severe Type 1 Diabetes with eating disorders, self-harm/ suicidal intent, diabulimia), and including difficulties that have not responded to individual formulation approaches<br><br>**Individual formulation level**<br><br>Mild to moderate levels of anxiety and/or depression impacting diabetes self-management and/ or aspects such as significant adjustment difficulties, fear of hypoglycaemia, recurrent diabetic ketoacidosis, insulin omission/ diabulimia and difficulties that have not responded to level 3 approaches. | Multi-disciplinary specialist mental health team (including psychiatry) with specialist knowledge of diabetes; with significant support from the secondary care diabetes team; often inpatient and crisis teams.<br><br>Psychological professionals with additional training and expertise in diabetes, delivering tailored psychological therapies (typically embedded in secondary care diabetes teams). | Complex, longer-term therapies generally as part of a multi-modal approach often including medications and long-term psychological therapy.<br><br>At this level, the psychological problems will almost certainly impact on diabetes self-management and specialist input from secondary care diabetes professionals will be required to offer their expertise to inform ongoing care plans.<br><br>For eating disorders in Type 1 please see specific guidance in SIGN Eating Disorders 2021.<br><br>Specialist psychological therapies tailored to individual needs typically over more than 8 appointments. Therapies targeted to improve both emotional difficulties and diabetes self-management. |

# Appendix 6: Levels of Psychological Intervention or Different Practice Types for Adults with Type 2 Diabetes

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 1: Informed | Mental health and diabetes awareness/ promotion. | Managed Clinical Networks; local diabetes leads; national leads; Scottish Diabetes Group; Diabetes Scotland; public health; all health and social care professionals in contact with adults with diabetes. | Teaching and training to all HCPs working with people with diabetes of importance of screening and links between mental health and self-management in diabetes. |
| 2: Skilled | Early presentations of distress impacting diabetes self-management (e.g. unplanned/mindless eating, adjusting to diagnosis around time of diagnosis), usually with low levels of anxiety and depression, or minimum annual screening within primary and secondary care services. | Primary and secondary care professionals providing care to people with diabetes. (Each board to identify responsibility for screening and pathways on a local level) | Identification of emotional problems and their impact if any on diabetes self-management through screening.<br><br>Education including signposting to national and local resources.<br><br>Basic psychosocial support delivered as part of routine care (including all barriers impacting ability to self-manage such as physical activity and eating habits) & signposting (e.g. housing, financial).<br><br>'Watchful Waiting' (i.e. closely watching a person's condition/presentation but not providing treatment unless symptoms emerge or change).<br><br>Brief behaviour change interventions. |

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 3: Enhanced | Distress impacting diabetes self-management that has not responded to level 2 approaches, sub-clinical levels of anxiety and/or depression. | Professionals with expertise in delivering brief psychological interventions (ideally with an understanding of diabetes or supported by staff with this expertise) are required to deliver the low intensity therapies, primary care staff may be well placed to oversee and monitor computerised treatments and self-help, delivery of combined educational courses requires knowledge and skills in both psychological interventions and diabetes, as does delivery of physical activity treatments. | Enhanced psychological interventions (usually manualised therapy i.e. interventions that are performed according to specific guidelines for administration, maximizing the probability of therapy being conducted consistently across settings, therapists, and clients).<br>Guided self-help.<br>Computerised psychological therapy.<br>Psycho-educational groups that includes mental health AND diabetes components.<br>Behavioral activation interventions. |

| Level | Psychological Problems | Performed by | Psychological Approaches |
|---|---|---|---|
| 4: Specialist | Multi-disciplinary specialist mental health team required for complex range<br>Complex, long-term severe mental health problems impacting diabetes self-management such as certain eating disorders, including binge eating disorder and difficulties that have not responded to level 4 individual formulation level therapies.<br>Individual Formulation Level<br>Mild to moderate levels of anxiety and/or depression impacting diabetes self-management, and/or aspects such as significant adjustment difficulties; anxiety around starting insulin, fear of diabetes-related complications; lower level disordered eating; and difficulties that have not responded to level 3. | Multi-disciplinary specialist mental health team (including psychiatry) with specialist knowledge of diabetes; often inpatient and crisis teams.<br>Professionals with expertise in delivering tailored psychological therapies and knowledge of diabetes, currently usually located in diabetes secondary care. | Specialist psychological therapies requiring complex, longer-term therapies generally as part of a multi-modal approach often including medications.<br>At this level, the psychological problems will almost certainly impact on diabetes self-management and JOINT WORKING diabetes professionals will often be required to offer their expertise to inform ongoing care plans.<br>Specialist psychological therapies tailored to individual needs typically over more than 8 appointments. Interventions improve both emotional difficulties and diabetes self-management. |

# Appendix 7: Examples of Psychologically Informed Approaches across the four levels

| Level | Type 1 Diabetes | Type 1 Diabetes | For HCPs |
|---|---|---|---|
| 1: Informed | Diabetes Scotland Peer Support (an option albeit not psychologically informed).<br>**Local groups - Diabetes Scotland \| Diabetes UK** (an option albeit not psychologically informed). | Diabetes Scotland Peer Support (an option albeit not psychologically informed).<br>**Local groups - Diabetes Scotland \| Diabetes UK** (an option albeit not psychologically informed). | NES Training<br>**Behaviour change for health \| NHS Education for Scotland**<br>DUK Training:<br>**Emotional Wellbeing \| Diabetes UK CPD**<br>7 As Model<br>**https://www.diabetes.org.uk/professionals/resources/shared-practice/psychological-care/emotional-health-professionals-guide/7as** |
| 2: Skilled | Peer Support (an option albeit not psychologically informed).<br>**Local groups - Diabetes Scotland \| Diabetes UK** (an option albeit not psychologically informed).<br>Psychoeducation and self-management groups<br>Silvercloud computerised CBT for anxiety and/or depression and diabetes self-management<br>**Get help with your mental wellbeing \| NHS inform** | Peer Support (an option albeit not psychologically informed).<br>**Local groups - Diabetes Scotland \| Diabetes UK** (an option albeit not psychologically informed).<br>Silvercloud computerised CBT for anxiety and/or depression<br>And diabetes self-management<br>**Get help with your mental wellbeing \| NHS inform**<br>Physical Activity Interventions[20,21,22] | Mental Health Screening Protocol (NHS Grampian HADS protocol example – see Figure 4)<br>Pre-Consultation Checklist (example in appendix 7A)<br>NES Training<br>**MAP of health behaviour change : helping people to make and maintain behaviour change \| Turas \| Learn (nhs.scot)**<br>Developing Practice: **nesd1078psychologicalskills-physicalhealthcare-20-1-20.pdf (scot.nhs.uk)**<br>**Opening Doors: Trauma Informed Practice for the Workforce on Vimeo**<br>Psychoeducation and self-management groups such as EXPERT and reclaim your life |

| Level | Type 1 Diabetes | Type 1 Diabetes | For HCPs |
|---|---|---|---|
| 3. Enhanced | 1:1 Supported Self-Management Interventions<br>**https://care.diabetesjournals.org/content/39/11/1963.short**<br>Silvercloud computerised CBT for anxiety and/or depression and diabetes self-management<br>Get help with your mental wellbeing \| NHS inform | ACT Now!<br>**act-now-diabetes-shtg-imto-review-008-17-endocrinology-and-diab.pdf**<br>Silvercloud computerised CBT for anxiety and/or depression and diabetes self-management<br>**Get help with your mental wellbeing \| NHS inform** | NES Training<br>ADAPT: Accessible depression and anxiety psychological therapy for Long Term Conditions<br>**nesd1078psychologicalskills-physicalhealthcare-20-1-20.pdf (scot.nhs.uk)**<br>Case Management discussions with Diabetes Professionals e.g. Diabetes Specialist Nurses |
| 4. Specialist | Secondary Care Diabetes Psychology and psychiatry and mental health nursing<br>Examples:<br>Group Mindfulness Based Cognitive Therapy<br>Medication | Secondary Care Diabetes Psychology and psychiatry and mental health nursing<br>Examples:<br>Group Mindfulness Based Cognitive Therapy<br>Medication | Diabetic Ketoacidosis (DKA) Protocol (NHS Grampian example Appendix 7B)<br>NES Training<br>Developing Practice: Train the Trainers<br>**nesd1078psychologicalskills-physicalhealthcare-20-1-20.pdf (scot.nhs.uk)**<br>AsSET: Train the Trainers **nesd1078psychologicalskills-physicalhealthcare-20-1-20.pdf (scot.nhs.uk)**<br>Collaborative working between mental health and diabetes professionals<br>Specialist assessment measures **http://www.psad-easd.eu/psychosocial-outcomes-measures/** |

# Appendix 7A: NHS Grampian Pre-Consultation Checklist (Copyright of NHS Grampian Diabetes Psychology Service)

**What would you like to talk about today?**

This checklist was designed to help us make sure we discuss the issues most important to you.

Please place a tick in the box beside the topics you wish to discuss today. Of course, the below is simply a guide so **please feel free to add anything else in the space at the bottom of this sheet.**

**Name** .....

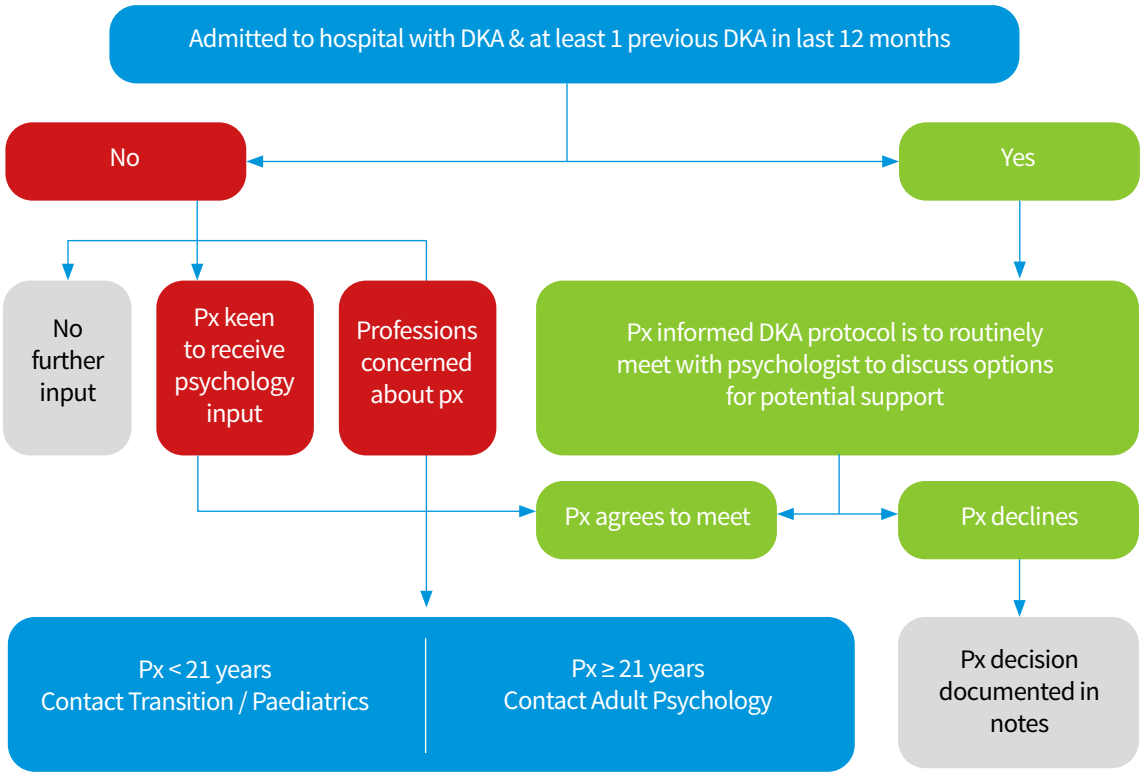
**Date of Birth** ..... **Clinic Date** .....

| Lifestyle | |
|---|---|
| Diabetes and exercise/ physical activity | |
| Diabetes and study/ work | |
| Diabetes and driving | |
| Diabetes and travel, holidays | |
| Diabetes and alcohol/ drugs (recreational, legal highs) | |
| Diabetes and smoking | |
| Diabetes and sexual activity | |
| Diabetes and pregnancy | |
| **Managing your diabetes** | |
| Current insulin doses and adjusting my insulin | |
| Current diabetes tablets and how they work | |
| Managing and avoiding hypos | |
| Blood glucose levels from meter/ diary since last visit | |
| New/recap information about food and counting carbohydrates | |
| Managing diabetes when unwell | |
| Managing high blood glucose levels | |
| Injection sites | |
| Other medicines/ tablets | |
| Equipment e.g. pens, meters, pumps, apps | |
| Other topics e.g. new research in diabetes | |
| HbA1c (results, what it means, why we measure?) | |
| Making sense of and/or discussing screening test results e.g. retinopathy (eyes), nephropathy (kidneys), podiatry (feet), cholesterol, hypertension (blood pressure) | |

| Other forms of support with your diabetes- would you like to see/ access? | |
|---|---|
| Dietitian (for help with learning about carbohydrate and how what you eat affects your control) | |
| Diabetes Specialist Nurse (for diabetes support between visits) | |
| Psychologist (for emotional support and/or to provide support with aspects of diabetes management that are difficult to change) | |
| Sources of information about diabetes e.g. on the internet, leaflets, mydiabetesmyway, support groups e.g. Diabetes UK | |
| Other things important to you: | |

# Appendix 7B: NHS Grampian DKA Protocol (Copyright of NHS Grampian Diabetes Psychology Service)

**DKA psychology Protocol**



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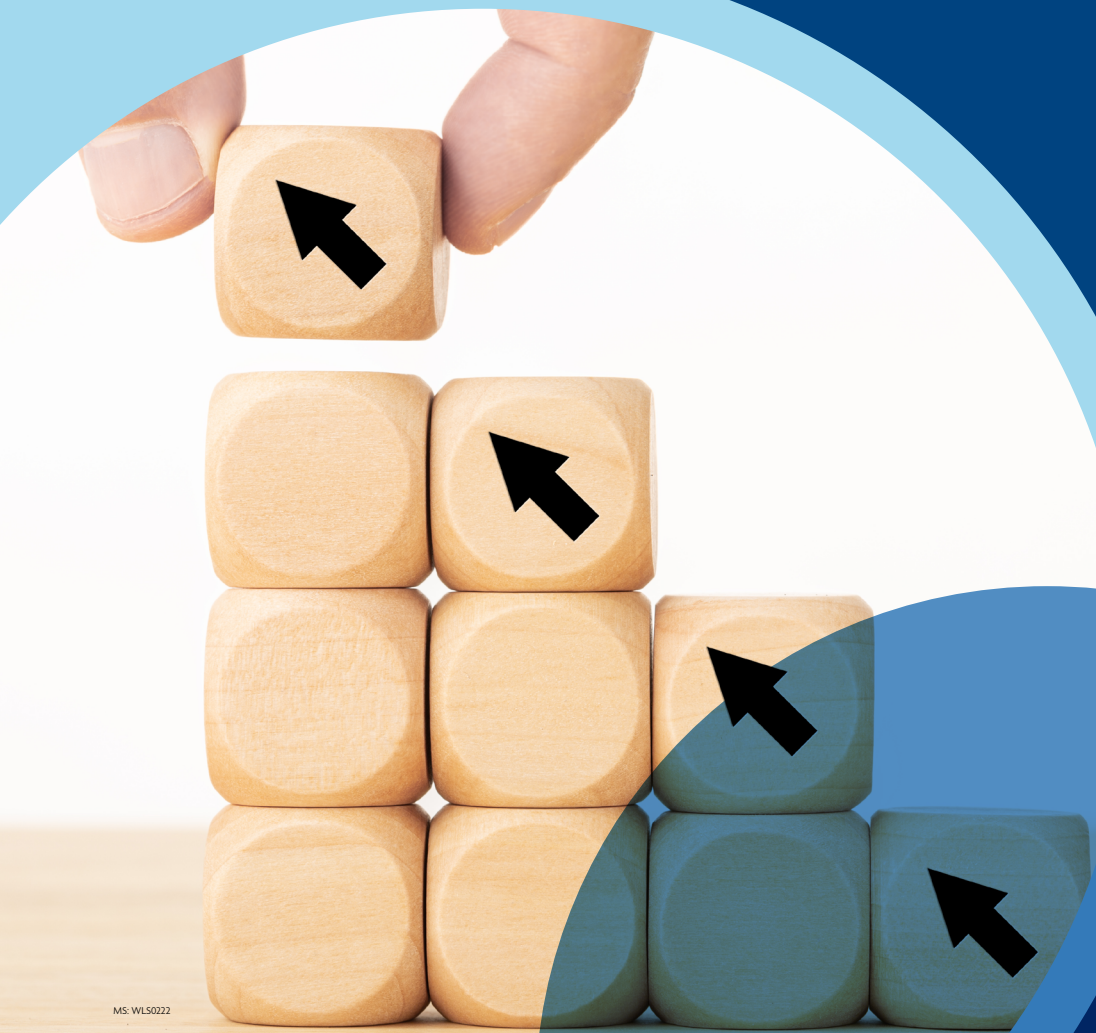

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