

# 06

## Effects of diabetes on CYP mental health and diabetes transition clinic training

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**Institute of  
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**at The Maudsley**

**KING'S  
College  
LONDON**



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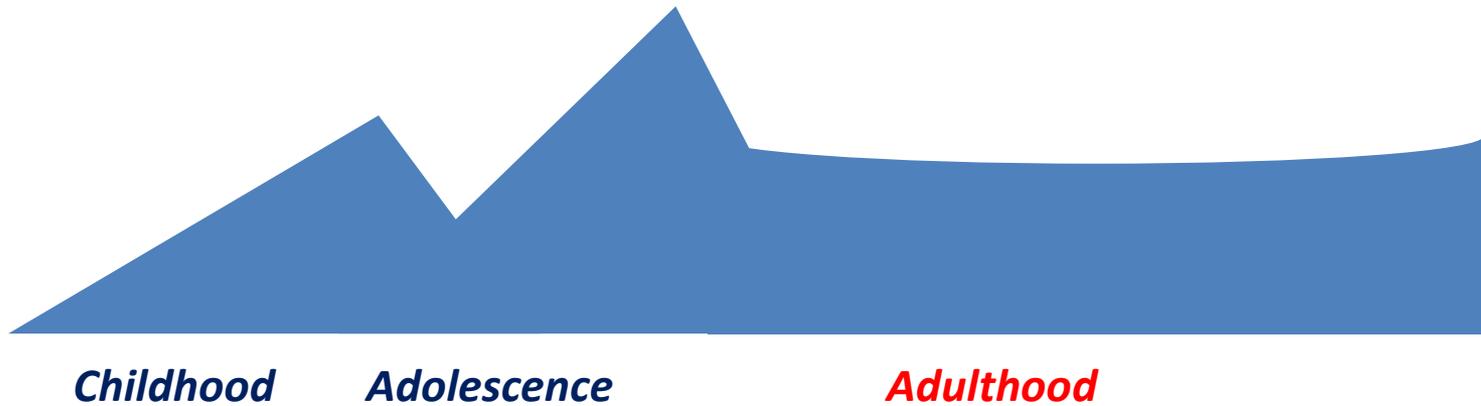
# Overview – (~15 mins of me talking, ~10 mins of discussion)

1. Brief reminder on T1D and connections with MH
2. Aims of course
3. Content of course
4. Rating of course
5. Feedback from course 4 months on
6. Conclusions
7. Discussion

# About T1D & Why do a course on MH and diabetes transition?

- Type 1 diabetes – autoimmune disorder of complete insulin insufficiency presenting with weight loss, polydipsia, polyuria. Hyperglycaemia.
- Complications include –
  1. Life expectancy reduced ~ 10-15 years (1/3 attributed to CVD). Under 50s main cause of death - DKA
  2. End stage renal disease ~ 7% at 30 years duration
  3. Leading cause of acquired blindness in developed world

# Incidence



References (Hodgson S et al 2012), (Svensson J et al, 2008), (Molbak AG et al. 1994), (Thurnander M et al. 2008); (Ostman, 2008); (Tuomilehto, 2013)

## Number of children and young people with diabetes

	Age Bands			
	0-4	5-9	10-14	15-17
<b>England - Number</b>	858	3,960	8,957	7,361
<b>England - Prevalence per 100,000 people</b>	27.4	139.0	293.2	372.7

Source: RCPCH \*, 2009 & ONS mid year population estimates, 2008

Provider	Number of children treated by trust:	
	0-9 Years	10-17 Years
King's College Hospital NHS Trust	34	80

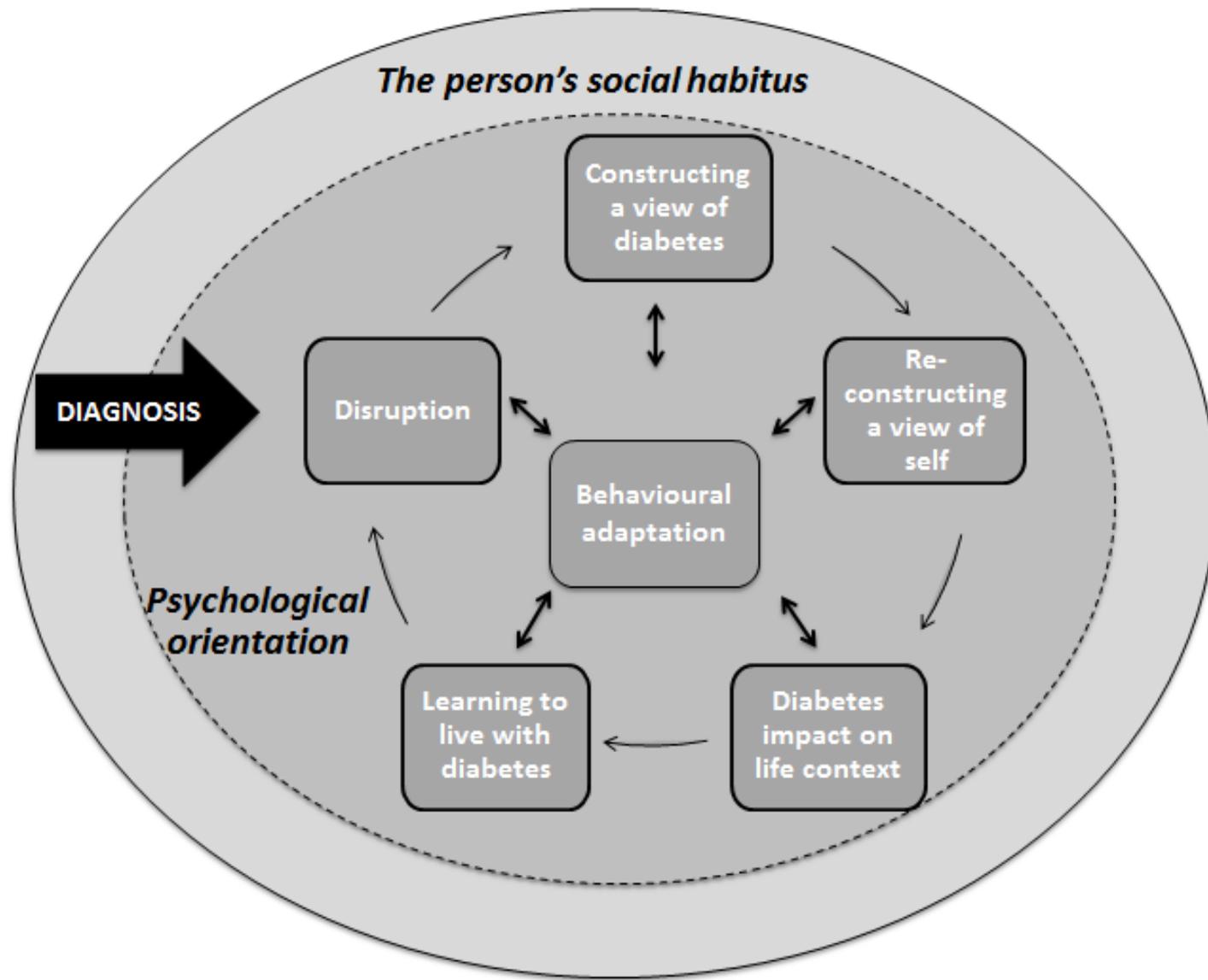
- Treatment with good outcomes involves daily (life-long) subcutaneous insulin administration and adherence to a pretty strict dietary plan.
- Poor outcomes associated with mental health problems, insulin omission, non-adherence to dietary advice and under use of insulin.
- 20% of patients are severely non-compliant [HbA1c>10.0%, 85mmol/mol] (NDA, 2013). Greater in adolescent age group.

# Epidemiology of diabetes and depression

- Depression in diabetes population - 23.8% females, 12.8% males [Ali et al, 2006]
- Depression is associated with non-adherence [Gonzalez et al, 2008] and hyperglycaemia [Lustman, 2000]
- Diabetes and depression leads to greater risk of complications (nephropathy, neuropathy, retinopathy) [Anderson, 2001]. HR of all cause mortality of patients with diabetes and co-morbid depression is 1.5 (1.35-1.66) [Park et al, 2013]

# Epidemiology of diabetes and eating disorders

- Bulimia Nervosa more common in T1DM vs control group (1.73 vs 0.69), AN no significant difference vs control group [Mannucci, 2005]
- T1DM associated with raised BMI, particularly in young females [Lawrence, 2008]
- Patients with T1DM and ED more likely to drop out of treatment and have worse outcomes than patients with ED alone [Custal, 2014]
- T1DM with ED have greater mean HbA1c, more episodes of DKA and BN associated with greater rates of retinopathy [Scheuing, 2014]
- Insulin omission (frequently seen in ED) in females associated with earlier death (45 years vs 58 years) [Goebel-Fabbri, 2008]



# **Young minds and diabetes:**

## **Advanced psychological skills in the transition clinic**

**King's College London,  
Strand Campus Room S-1.22**

**7 – 8th July 2015**

# Aims of the course-

- Increase awareness of psychological and psychiatric disorders in transition services
- Overview of CBT and motivational interviewing and use in approach to engaging with psychological difficulties.
- Assessment of depression and use of psychological scales
- Introduce attachment theory and explain clinical relevance in transition services

# Attendees – Course 1. (17/18)

Profession / Specialty	No.s	NHS Trust
Paediatric Diabetes Specialist Nurse	2	Oxleas, Kingston
Diabetes Specialist Nurse	9	St Mary's St Helier's, UCLH, St Mary's, GSTT x3, Moorfields, Basildon
Consultant in Diabetes and Endocrinology	1	UCLH
Diabetes Dieticians	2	GSTT x2
Psychotherapist	2	GSTT ,Charing Cross
Paediatric Psychiatric nurse	1	ELFT

# Attendees – Course 2. (7/9)

<b>Profession / Specialty</b>	<b>No.s</b>	<b>Site</b>
Consultant Diabetes	1	Chase Farm
Diabetes Specialist Nurse	2	Royal Free
Consultant paediatrician lead in diabetes	1	Royal Free
Paediatric Diabetes Specialist Nurse	1	Royal Free
Clinical psychologist	1	Royal Free
Diabetes dietician	1	Chase farm

# Lecture / session ratings

	<b>Lecture / session</b>	<b>Average rating n/10</b>
Day 1.	<i>Introduction and small group discussion</i>	8.2
	<i>ED case presentation</i>	8.5
	<i>Adolescence and mental health</i>	8.7
	<i>Psychological scales</i>	8.4
	<i>Motivational interviews</i>	8.7
	<i>Motivational interview role play</i>	8.1
Day 2.	<i>Attachment and transition clinic</i>	9.6
	<i>Group discussion on attachment</i>	9.4
	<i>CBT</i>	7.7
	<i>CBT role play and formulation</i>	7.8
	<i>Depression assessment and communication skills</i>	8.6
	<b>Overall</b>	<b>8.5</b>

# Feedback 4 months on – (10/24)

- *Has the course changed your practice?*
- *Has the course changed your confidence in discussing psychological issues?*
- *Is there anything you would want us to do differently?*
- *Out of 10 (with 10 being very likely and 0 being not likely at all), how likely would you be to recommend the course to a colleague?*

# ***Has the course changed your practice?***

- “Yes, It has increased my awareness of psychological issues, encouraged me to explore them more than I did before and provided me with some tools to do so”
- “probably not”
- “I took home from the course [to consider] high HbA1C as a psychological event .... as a team we agreed to refer all our children who were high to our family therapist”
- “The course didn’t particularly change my practice although it has made me more aware of psychological aspects of issues such as non engagement related to attachment”

# ***Has the course changed your confidence in discussing psychological issues?***

- “Definitely, it has given me a better framework and certainly improved my confidence in this area. But it is still early days and I think further training and discussion would be valuable, as follow up from the previous course”
- “Yes, vastly improved it”
- “Yes although this can always be improved, I do try to be relentlessly positive”

# ***Is there anything you would want us to do differently?***

- “Delivering to teams as was discussed, I believe would be beneficial as all would have knowledge of caseloads and realistic/workable practice could be discussed. Was difficult for me to come back full of ideas and share- mainly due to time constraints and difficulties getting everyone together”
- “..we do not have a psychologist as part of our team and it is very difficult to implement many of the principles acquired on the course without this in house support..”
- “I think the skills and understanding from the course are the same as those required for adults with type 1 diabetes and therefore all hcp working in adult diabetes should attend something like this”

# Conclusions (1)

- Course was well received, rated highly, recommended to colleagues.
- Feedback indicates that course has increased awareness of psychological issues, particularly around considering chronic poor glycaemic control as a possible sign of psychological morbidity.
- Was there a selection bias-preaching to the converted?

# Conclusions (2)

- Awareness was generally positive, some clinicians pointed out that this lead to frustration that psychological issues could not be addressed because a mental health professional was not working within MDT.
- Improvements for course included delivering to a whole transition clinic so that strategies of approaches within a clinic could be found.
- Although a 2 day course can deliver a curriculum that increases awareness of psychological problems and engagement with the issues, it is not sufficiently long enough to up-skill clinicians in specific modalities eg CBT, MI.

# What's next for YMaD?

- Role out programme to all clinicians?
- How can learning be maintained and enhanced? Should there be a follow-up?
- Psychologists as part of all T1D MDTs?  
Complexity? Social dimension?
- Psych supervision or within multi-disciplinary team meeting? Maintains thinking. Increases confidence in clinicians.