Psychosocial Care for People with Diabetes

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American Diabetes Association®

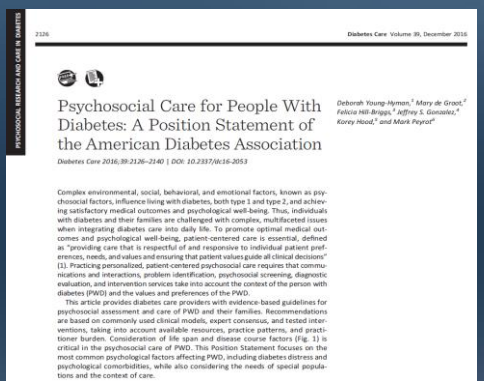
Disclosures

No conflicts of interest to disclose.

Learning Objectives

- Describe psychosocial issues associated with diabetes, which range from normative diabetes-related distress to diagnosable mental health disorders.
- Identify paradigms for implementing psychosocial services into team-based care.
- List screening tools for assessing symptoms of psychosocial issues within routine care.
- Indicate appropriate referral and treatment options for people impacted by both sub-clinical and clinical psychological distress.

ADA Position Statement



PSYCHOSOCIAL RESEARCH AND CARE IN DIABETES

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association

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Complex environmental, social, behavioral, and emotional factors, known as psychosocial factors, influence living with diabetes, both type 1 and type 2, and achieving satisfactory medical outcomes and psychological well-being. Thus, individuals with diabetes and their families are challenged with complex, multifaceted issues when integrating diabetes care into daily life. To promote optimal medical outcomes and psychological well-being, patient-centered care is essential, defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (1). Practicing personalized, patient-centered psychosocial care requires that communications and interactions, problem identification, psychosocial screening, diagnostic evaluation, and intervention services take into account the context of the person with diabetes (PWD) and the values and preferences of the PWD.

This article provides diabetes care providers with evidence-based guidelines for psychosocial assessment and care of PWD and their families. Recommendations are based on commonly used clinical models, expert consensus, and tested interventions, taking into account available resources, practice patterns, and practitioner burden. Consideration of life span and disease course factors (Fig. 1) is critical in the psychosocial care of PWD. This Position Statement focuses on the most common psychological factors affecting PWD, including diabetes distress and psychological comorbidities, while also considering the needs of special populations and the context of care.

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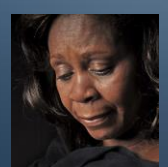
Case Study

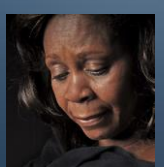


Introduction

- Mrs. R is a 66-year-old librarian.
- She was diagnosed 8 years ago.
- Over the past 2 years A1Cs ~ 9-10.5%.
- She notes feeling powerless to achieve better blood sugar values. She has been missing her medication doses, and she has now stopped monitoring her blood glucose altogether.
- She also has hypertension, hypercholesterolemia.

Continued...

Case Study (Cont'd)



What could you screen for in this person?

A. Diabetes distress, depression, anxiety
B. Disordered eating
C. Depression and cognitive impairment
D. Cognitive Impairment
E. All of the Above

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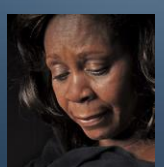
Case Study (Cont'd)



What could you screen for in this person?

A. Diabetes distress, depression, anxiety
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E. All of the Above

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Screening Recommendations



1. Include routine psychosocial assessment as part of ongoing diabetes care using a collaborative, person-centered approach.
2. Psychosocial issues should be understood through a life-course lens, understanding that life circumstances and therefore the needs of the person with diabetes, will change over time.
3. Screening and follow-up should include attitudes, expectations, mood, general and diabetes-related quality of life, resources, and psychiatric history.

Continued...

Standards of Medical Care in Diabetes. *Diabetes Care* 2015; 38 (Suppl. 1): S1-S93

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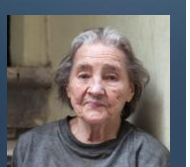
Screening Recommendations (Cont'd)

4. Upon screening, symptoms that reach the level of clinical significance require referral to appropriate care providers.
5. Routinely screen for diabetes-related distress, depression, anxiety, and disordered eating behaviors.
6. Older adults should be considered a high priority population for screening & treatment.



Standards of Medical Care in Diabetes. *Diabetes Care* 2015; 38 (Suppl. 1): S1-S93

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When to Screen



- At diagnosis
- Regularly scheduled visits
- Changes in medical status
- During hospitalization(s)
- When new-onset complications occur
- Whenever problems are identified with:
  - Glucose control
  - Self-management
  - Quality of life

Standards of Medical Care in Diabetes. *Diabetes Care* 2017; 40 (Suppl. 1): S39-40

Person -Centered Care Challenge

- What information or clinical observations would prompt you to refer Mrs. R to a mental health provider?

When to Refer to a Mental Health Provider

- Self-care impaired after tailored diabetes education to ensure knowledge, skill, and resources to perform self-care
- Evidence of persistent diabetes distress on observation or through discussion during clinical encounter
- Positive screen on a validated screening tool (for depression, anxiety)
- Symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating specific to the care regimen
- Intentional omission of insulin or oral medication to cause weight loss

Continued…

When to Refer (cont'd)



- Serious mental illness is previously documented or suspected
- Youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- Screen positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery for 1yr

Common Psychosocial Issues

- Diabetes distress
- Mental health disorders
  - Depression
  - Anxiety
  - Disordered eating

Diabetes Distress

Diabetes Distress



- Significant negative emotional reaction
  - Diagnosis of diabetes
  - Worry and fear regarding health, longevity, complications
  - Financial and behavioral burden of living with diabetes
  - Onset of complications
  - Impact on lifestyle of self-management demands
  - Lack of social support or resources for managing diabetes

Gonzales et al. *Diabetes Care* 2011; 34:2222–2227

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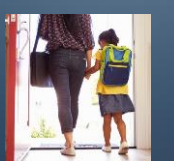
Diabetes Distress: Prevalence and Impact



- 18-45% with an incidence of 38-48% over 18 months
- High levels of diabetes distress significantly impact medication-taking behaviors
- Linked to higher A1C, lower self-efficacy, poorer dietary and exercise behaviors
- One-third of adolescents with diabetes develop diabetes distress (associated with declines in self-management behaviors and suboptimal blood glucose levels)
- Parents of children with type 1 diabetes prone to diabetes distress, which impacts their ability to provide support for their child

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Diabetes Distress: Survey Instruments

- Problem Areas In Diabetes (PAID)
- Diabetes Distress Scale (DSS)
- PAID-Peds
- PAID-Teen Version
- PAID-Parent Revised Version


PROBLEM AREAS IN DIABETES (PAID) QUESTIONNAIRE

INSTRUCTIONS: Which of the following diabetes issues are currently a problem for you? Circle the number that gives the best answer for you. Please provide an answer for each question.

	Not a problem	Minor problem	Moderate problem	Somewhat serious problem	Serious problem
1. Not having clear and concrete goals for your diabetes care?	0	1	2	3	4
2. Feeling discouraged with your diabetes treatment plan?	0	1	2	3	4
3. Feeling scared when you think about living with diabetes?	0	1	2	3	4
4. Uncomfortable social situations related to your diabetes care (e.g., people telling you what to eat)?	0	1	2	3	4
5. Feelings of deprivation regarding food and meals?	0	1	2	3	4
6. Feeling depressed when you think about living with diabetes?	0	1	2	3	4
7. Not knowing if your mood or feelings are related to your diabetes?	0	1	2	3	4
8. Feeling overwhelmed by your diabetes?	0	1	2	3	4
9. Worrying about low blood sugar reactions?	0	1	2	3	4
10. Feeling angry when you think about living with diabetes?	0	1	2	3	4
11. Feeling constantly concerned about food and eating?	0	1	2	3	4
12. Worrying about the future and the possibility of serious complications?	0	1	2	3	4
13. Feelings of guilt or anxiety when you get off track with your diabetes management?	0	1	2	3	4
14. Not "accepting" your diabetes?	0	1	2	3	4
15. Feeling unsatisfied with your diabetes physician?	0	1	2	3	4
16. Feeling that diabetes is taking up too much of your mental and physical energy every day?	0	1	2	3	4
17. Feeling alone with your diabetes?	0	1	2	3	4
18. Feeling that your friends and family are not supportive of your diabetes management efforts?	0	1	2	3	4
19. Coping with complications of diabetes?	0	1	2	3	4
20. Feeling "burned out" by the constant effort needed to manage diabetes?	0	1	2	3	4

PARENT LEVEL

Sample

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Diabetes Distress: Treatment

- Develop a step-by-step action plan to address key concerns
- Provide continuing emotional and instrumental support: reduce burden of care whenever possible through shared responsibility taking
- Follow up with feedback about health status and constructive feasible strategies to improve outcomes
- If setting goals, make sure they are "SMART:"
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time-limited in duration

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Depression

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Depression Impact

- Affects one in four people with type 1 or type 2 diabetes
- Associated with poorer self-care and medication adherence
- Associated with diabetes complications
- Increases risk for obesity, sedentary lifestyle, smoking
- Increases health care service utilization and costs
- Increases risk for type 2 diabetes

Ciechanowski PS, et al. *Arch Intern Med* 2000; 160:3278–3285
Lin EHB, et al. *Diabetes Care* 2004; 27:2154–2160

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Association of Depression with Diabetes Self-Care

Self-Care Activities (Past 7 Days)	Major Depression (%)	No Major Depression (%)	Odds Ratio	95% CI
Healthy eating ≤ 1x week	17.2	8.8	2.1	1.59-2.72
5 servings of fruits & vegetables ≤ 1x week	32.4	21.1	1.8	1.43-2.17
High-fat foods 6x week	15.5	11.9	1.3	1.01-1.73
Physical activity (30 min) ≤ 1x week	44.1	27.3	1.9	1.53-2.27
Specific exercise session ≤ 1x week	62.1	45.8	1.7	1.43-2.12
Smoking: yes	16.1	7.7	1.9	1.42-2.51

Egede LE, Ellis C. *Diabetes Res Clin Pract* 2010;87:302-12

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Association with Diabetes Complications

Depression is associated with:

- Retinopathy (.17)*
- Nephropathy (.25)*
- Neuropathy (.28)*
- Sexual dysfunction (.32)*
- Macrovascular complications (.20)*

(* Weighted R values)

de Groot et al., *Psychosom Med* 2001; 63: 619-630

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Major Depressive Disorder (MDD)

- Either depressed mood or loss of interest/pleasure for 2 week period, AND at least five (5) additional symptoms:
  - Depressed mood --Insomnia or hypersomnia
  - Diminished interest/pleasure --Feelings of worthlessness/excessive guilt
  - Lack of energy --Thoughts of death/suicide
  - Concentration difficulties --Significant weight loss/gain, appetite change
  - Psychomotor retardation/agitation
- Clinically significant impairment in social, occupational, or other important areas of functioning; Represents a marked change in functioning
- Not attributable to the physiological effects of a substance or to another medical condition

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5

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Depressive Symptomatology

- Symptoms, but not meeting criteria for Major Depressive Disorder (MDD)
  - Depressed mood --Changes in sleep
  - Diminished interest --Feelings of worthlessness/excessive guilt
  - Lack of energy --Thoughts of death
  - Concentration difficulties --Changes in appetite/weight
  - Psychomotor retardation/agitation
- Common among people with diabetes
- Associated with poor self-care, complications, and mortality

Gonzales et al. *Diabetes Care* 2011; 34: 236-239

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Depression: Who to Screen

Routine screening recommended for persons with:

- Prediabetes (particularly overweight patients)
- Type 1 and Type 2 diabetes
- Gestational diabetes
- Postpartum diabetes






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Person-Centered Care Challenge

- List validated survey instruments that can be used to screen for depression.
- Identify recommended psychotherapy people with depression could receive.

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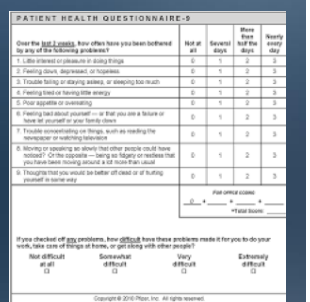
Depression: Survey Instruments

- Patient Health Questionnaire (PHQ-2, PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Child Depression Inventory (CDI-2) in ages 7-17 years
- Geriatric Depression Scale (GDS) ages 55-85 years



PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so figgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING: 0 + ____ + ____ + ____ = ____ *Total Score

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ | Somewhat difficult ☐ | Very difficult ☐ | Extremely difficult ☐

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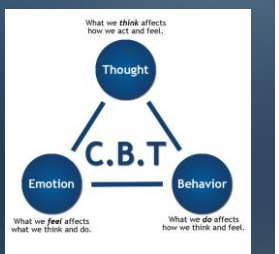
Depression: Referral

Referrals for treatment of depression should be made to mental health providers with experience in:

- Cognitive behavioral therapy (CBT)
- Problem-solving therapy

Pharmacotherapy should also be considered if symptoms interfere with effective self-care behaviors. Referral to a psychiatrist familiar with diabetes is preferred.



Anxiety

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Anxiety: Common Disorders



- Generalized anxiety disorder (GAD)
- Body dysmorphic disorder
- Obsessive compulsive disorder (OCD)
- Specific phobias, particularly needle phobia and fear of hypoglycemia
- Posttraumatic stress disorder (PTSD)

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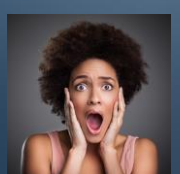
Anxiety: Prevalence and Impact



- Lifetime prevalence of GAD to be 19.5% in people with either type 1 or type 2 diabetes
- Common diabetes-specific anxiety:
  - Fears related to hyperglycemia
  - Not meeting blood glucose targets
  - Insulin injections
  - Fear of hypoglycemia (FoH)
- General anxiety is a predictor of injection-related anxiety and FoH

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Anxiety: Who to Screen



- Exhibiting anxiety or worries that interferes with self-management behaviors regarding:
  - Diabetes complications
  - Insulin injections or infusion
  - Taking medications
  - Hypoglycemia
- Express fear, dread, or irrational thoughts and/or show anxiety symptoms:
  - Avoidance behaviors (including medical care)
  - Excessive repetitive behaviors
  - Social withdrawal

Continued...

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Anxiety: Who to Screen (Cont'd)

- Preoccupation with an imagined defect in appearance that interferes with social, occupational, or other areas of function - body dysmorphic disorder
- Exhibits excessive diabetes self-management behaviors to achieve glycemic targets, reports repetitive negative thoughts about inability to prevent poor health outcomes, and/or has related thoughts and behaviors that interfere with daily living – OCD
- Severe hypoglycemia - PTSD and PTSD-like and panic disorder symptoms

Anxiety: Survey Instruments

- State-Trait Anxiety Inventory (STAI) and for Children (STAIC)
- Beck Anxiety Inventory (BAI)
- Hypoglycemia Fear Survey – II (HFS-II)
- Children's Hypoglycemia Index (CHI)



Anxiety: Referral and Treatment

- In hypoglycemia unawareness (can co-occur with fear of hypoglycemia)
  - Treat using Blood Glucose Awareness Training (BGAT) to help re-establish awareness and reduce fear
- In OCD
  - Referral to a mental health professional familiar with OCD treatment should be considered if diabetes re-education is not effective in reducing obsessive thoughts, behaviors, or feelings of general anxiety

Anxiety: Referral and Treatment (cont'd)

- FoH without symptoms of hypoglycemia
  - A structured program (Blood Glucose Awareness Training) should be delivered in routine clinical practice to improve A1C, reduce the rate of severe hypoglycemia and restore hypoglycemia awareness

Disordered Eating Behavior

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Disordered Eating: Behaviors and Impact



- In type 1 diabetes, insulin omission causing glycosuria in order to lose weight is the most commonly reported disordered eating behavior. People with type 2 diabetes treated with insulin, also frequently report intentional omission.
- In type 2 diabetes, bingeing (excessive food intake with an accompanying sense of loss of control) is most commonly reported.
- Persons with disordered eating, disrupted eating patterns, and eating disorders have higher rates of diabetes distress and FoH than those without these symptoms

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Disordered Eating: Who to Screen

- Unexplained hyperglycemia and weight loss, despite self-report of adherence to medical regimen including medication dosing and meal plan
- Self-report of excessive caloric restriction and/or excessive physical activity.
- Expression of significant dissatisfaction with body size, shape or weight.
- Report of loss of control over eating.
- Repeated unsuccessful dieting attempts.



Disordered Eating: Survey Instruments

- Eating Disorders Inventory-3 (EDI-3)
- Diabetes Eating Problems Survey (DEPS-R)
- Diabetes Treatment and Satiety Scale (DTSS-20)

Disordered Eating: Screening Considerations

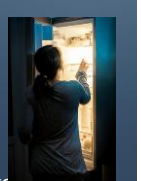
- Potential confounders to the identification of symptoms are:
  - Behaviors prescribed as part of treatment (carbohydrate counting, calorie restriction)
  - Behaviors or effects e.g., loss of control over satiety regulation
  - Adverse effects of treatment, such as excessive hunger secondary to hypoglycemia

Disordered Eating: Screening Considerations (Cont'd)

- When evaluating symptoms, etiology and motivation for the behavior should be considered
  - Missed insulin injections due to suboptimal self-management differ significantly from intentional medication omission to produce weight loss
- Assessment and screening requires methods that account for:
  - Treatment prescription, regimen behaviors and diabetes-specific eating problems

Disordered Eating: Referral and Treatment

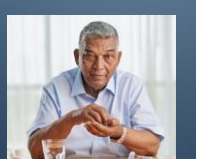
- Review of the medical regimen is recommended to identify potential treatment-related effects on hunger/caloric intake
- If night eating syndrome (recurrent eating at night) is diagnosed, changes to the medication regimen are required until maladaptive eating patterns are modified
- Adjunctive medication such as glucagon-like peptide 1 receptor agonists may help
  - Meet glycemic targets
  - Regulate hunger and food intake
  - Potential to reduce uncontrollable hunger



Disordered Eating: Referral and Treatment

- Bulimia, the most commonly reported symptom in persons with diabetes, should be evaluated in the context of treatment, especially insulin dose.
- If a diagnosis of Bulumia Nervosa is established via clinical interview by a qualified professional, use of anti-depressant and anti-anxiety medications is often effective when accompanied by psychotherapy.
- In severe cases of Bulimia or Anorexia, hospitalization may be necessary to stabilize diabetes and mental health.

Older Adults



- Older adults with diabetes:
  - 73% increased risk of all types of dementia
  - 56% increased risk of Alzheimer's dementia
  - 127% increased risk of vascular dementia
- People ≥65 years of age should receive screening annually for mild cognitive impairment or dementia

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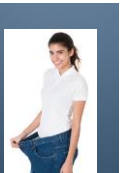
Bariatric Surgery



- Increased risk of:
  - Depression and other major psychiatric disorders
  - Body image disorders, sexual dysfunction and suicidal behavior
- People presenting for bariatric surgery should be assessed by a professional familiar with weight-loss interventions and post-bariatric surgery behavioral requirements
- If psychopathology is evident (particularly suicidal ideation and/or significant depression), postponement of surgery should be considered until psychosocial issues are resolved or stabilized
- Consider ongoing mental health services to help patients adjust post-surgery

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Implementing Team-Based Psychosocial Care

Collaborative Care Model (CCM)	Embedded Behavioral Specialist	Referral to Behavioral Provider
• In primary care • Integrated behavioral care carried out by behavioral health Care Manager, with Psychiatrist consultant • Weekly team meetings include PCP, CM, psychiatrist consultant • Use of a dashboard and metrics for individual patient progress monitoring	• In primary care and diabetes specialty clinics • Behavioral care carried out by a psychologist or clinical social worker embedded within the clinical practice site • Behavioral specialist participates as consultant and/or engages with practice as member of interdisciplinary team	• Referral outside of the medical practice • Concurrent, non-integrated behavioral care provided by behavioral specialist or mental health practice • Arrangement of formal methods of communication (e.g. medical records sharing, formal methods for behavioral provider ongoing progress feedback to referring physician)

**Billing codes available under CMS as of 2017*

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2016-11-02 **Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention**

CMS.gov
Centers for Medicare & Medicaid Services

Mental and Behavioral Health: CMS is finalizing payments for codes that describe specific behavioral health services furnished using the psychiatric **Collaborative Care Model**, which has demonstrated benefits in a variety of settings. In this model, patients are cared for through a team approach, involving a **primary care practitioner, behavioral health care manager, and psychiatric consultant**. CMS is also finalizing payment for a new code that broadly describes behavioral health integration services, including payments for other approaches and for practices that are not yet prepared to implement the Collaborative Care Model.

Cognitive Impairment Care Assessment and Planning: CMS finalizes payment to physicians to perform cognitive and functional assessment and care planning for patients with cognitive impairment (e.g., for patients with Alzheimer's). This is a major step forward for care planning for these populations.

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Helpful Resources

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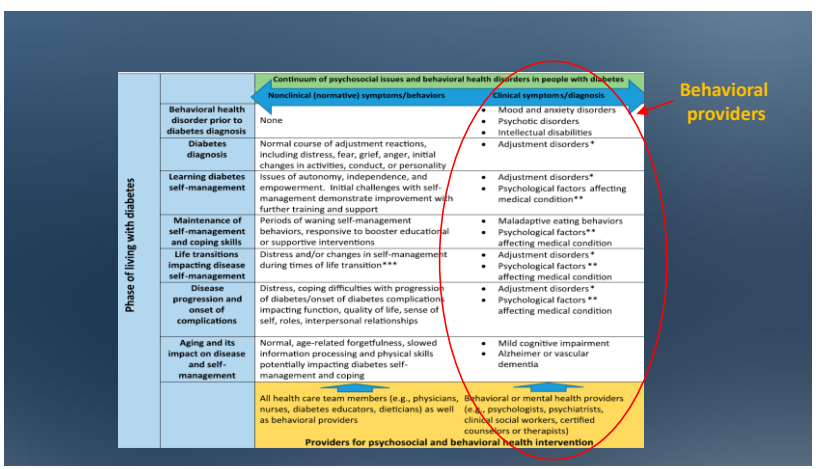
Psychosocial Care: Life Course and Continuum of Care





Psychosocial Care: Life Course and Continuum of Care

Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	Clinical symptoms/diagnosis
Behavioral health disorder prior to diabetes diagnosis	None	• Mood and anxiety disorders • Psychotic disorders • Intellectual disabilities
Diabetes diagnosis	Normal course of adjustment reactions, including distress, fear, grief, anger, initial changes in activities, conduct or personality	• Adjustment disorders*
Learning diabetes self-management	Issues of autonomy, independence, and empowerment. Initial challenges with self-management demonstrate improvement with further training and support	• Adjustment disorders* • Psychological factors** affecting medical condition
Maintenance of self-management and coping skills	Periods of waning self-management behaviors, responsive to booster educational or supportive interventions	• Maladaptive eating behaviors • Psychological factors** affecting medical condition
Life transitions impacting disease self-management	Distress and/or changes in self-management during times of life transition***	• Adjustment disorders* • Psychological factors** affecting medical condition

*With depressed mood, anxiety, or emotion and conduct disturbance. **Personality traits, coping style, maladaptive health behaviors, or stress-related physiological response. ***Examples include changing schools, moving, job/occupational changes, marriage or divorce, or experiencing loss.

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(continued)

Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	Clinical symptoms/diagnosis
Disease Progression and onset of complications	Distress, coping difficulties with progression of diabetes/onset of diabetes complications impacting function, quality of life, sense of self, roles, interpersonal relationships	• Adjustment disorders* • Psychological factors** affecting medical condition
Aging and its impact on disease and self-management	Normal age-related forgetfulness, slowed information processing and physical skills potentially impacting diabetes self-management and coping	• Mild cognitive impairment • Alzheimer's or vascular dementia
	All healthcare team members (e.g., physicians, nurses, diabetes educators, dieticians) as well as behavioral providers	Behavioral or mental health providers (e.g., psychologists, psychiatrists, clinical social workers, certified counselors or therapists)
	Providers for psychosocial and behavioral health intervention	

American Diabetes Association.

Diabetes Mental Health Provider Education Program

American Diabetes Association. | American Psychological Association

Mental Health Provider Diabetes Education Program

ADA and American Psychological Association (APA) partnered to create the first ever, diabetes-focused, continuing education (CE) program for licensed mental health providers.

Upon successful completion of the Continuing Education program, the provider can:

- Become an ADA member at the Associate level
- Receive 12 CE credits from the APA
- Become eligible for inclusion on the Mental Health Provider Referral Directory
- Access the ADA's new listserv for behavioral health and psychosocial topics
- Access monthly "mentoring" calls with experts in the field

ADA's Online Mental Health Provider Referral Directory

Mental Health Provider Diabetes Education Program

Living with diabetes is exhausting. People need support and empowerment to live their best life.

ADA is pleased to announce the launch of the new Mental Health Provider Referral Directory, which can help you locate mental health professionals in your area with demonstrated expertise in diabetes care.

https://professional.diabetes.org/ada-mental-health-provider-directory

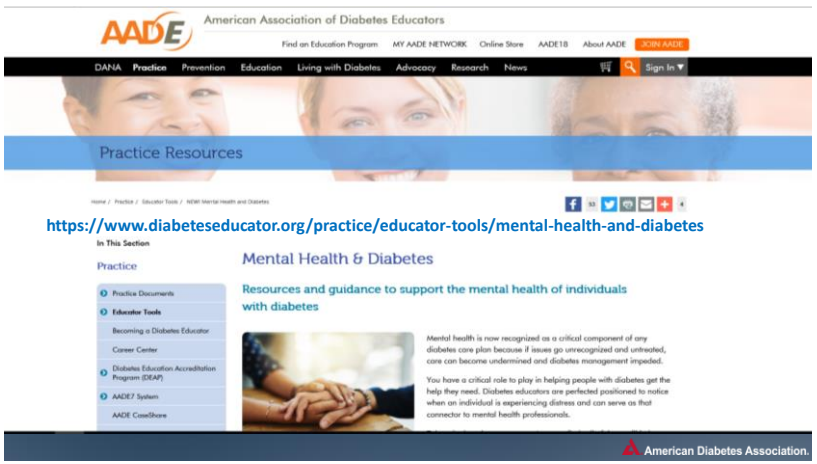
American Association of Diabetes Educators (AADE)

Mental Health and Diabetes Website

- Mental Health and Diabetes Practice Paper
- How-To Resources
- Patient education materials
- Videos

https://www.diabeteseducator.org/practice/educator-tools/mental-health-and-diabetes

American Diabetes Association.



Diabetes Self-Management Education

- Find a recognized Diabetes Self-Management and Support program
- Become a recognized provider of DSME/S
- Tools and resources for DSME/S
- Online education documentation tools



Professional.Diabetes.org/ERP

American Diabetes Association.

Training Resources for Primary Care Providers

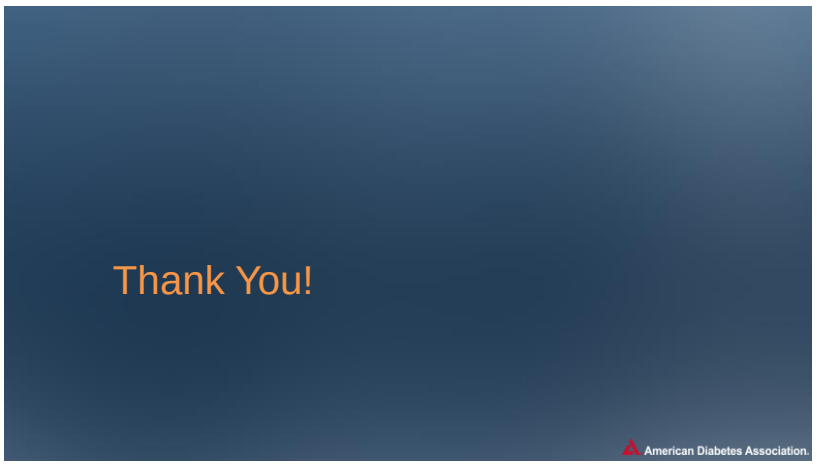
- American Academy on Communication in Healthcare (DocCom Online CME modules http://www.doccom.org/Content

  Ex: The therapeutic relationship in medical encounters, Exploring difficult topics (emotions, sexual activity), Encountering behavioral health issues (anxiety, panic), Shared decision-making

- Motivational Interviewing Training Programs http://www.motivationalinterviewing.org/
- Conducting the Cognitive Screening Assessment During the Medicare Annual Wellness Visit (PCP Instructional videos and assessment tools) http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp

Summary

- Described psychosocial issues that are common in people with diabetes, ranging from normative diabetes specific distress to diagnosable mental health disorders.
- Reviewed screening recommendations and tools for use within routine care.
- Described appropriate referral and treatment recommendations for people impacted by both sub-clinical and clinical psychosocial distress.
- Presented implementation models and resources for integrating psychosocial services into team-based care.


Thank You!
American Diabetes Association.