COMMENT ON POWERS ET AL.

Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Care 2015;38: 1372–1382

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The recently published joint position statement authored by Powers et al. (1) defines when, what, and how diabetes self-management education and support should be provided for adults with type 2 diabetes, with aims to improve patient experience and care and to reduce diabetes-associated health care costs. We applaud the position statement's emphasis on mental health assessment as a core component of diabetes care but are concerned and disappointed that referral to a mental health professional is recommended only on an "if needed" basis in their algorithm of care. Mental health care warrants equal priority in the interdisciplinary care of patients with diabetes, and we believe the American Diabetes Association (ADA) should underscore this by supporting the position that referrals be mandatory at the diagnosis of diabetes.

People with diabetes exhibit twofold higher rates of depressive symptoms and overt depression compared with the general population (2). Among individuals with diabetes, those with depression generate health care expenditures that are 4.5 times higher than those without (3), as depression is associated with worse glycemic control and increased risk of complications (4). The meaningful relationship between mental health and diabetes outcomes has been documented for decades; however, appropriate emphasis of psychological well-being during routine care of patients with diabetes has yet to be enforced with the same fervor as medical therapies.

Referring patients to mental health providers on an "if needed" basis only works if depression is consistently detected by the care team. In reality, less than 50% of these patients are recognized as having depressive symptoms (2), meaning the position statement's algorithm may miss a substantial number of patients who warrant mental health referral. More so, late referrals to the mental health professional require reversal energy for embedded shame, denial, depression, anxiety, and fears of complications rather than successful adjustment and the creation and maintenance of mindful habits from the start (5). Although their skills are overlapping, physicians, nurses, and nutritionists cannot always meet these needs in the same specific and specialized manner as mental health professionals who are trained in targeting the adjustment of patients and their families by minimizing trauma, shaping an adaptive first impression, and instilling adaptive behaviors and thought patterns.

In his plans for his term as the ADA President of Health Care & Education, Dr. David Marrero champions the need for more scholarly and clinical attention toward mental health related to diabetes care. In the "President, Health Care & Education Address—Diabetes Care and Research—What Is the Next Frontier?" during the 75th Scientific Sessions, he announced the recent partnership between the ADA and the American Psychological Association in the development of programs to train and certify psychologists to best help patients adapt to life with diabetes.

The landscape of mental health care among patients with diabetes is shifting, and the ADA position statement should reflect this change by backing mandatory referrals for mental health assessment

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and treatment of patients with newly diagnosed diabetes. It is past time that we, the diabetes health care providers, help our patients achieve sound bodies by helping them build the attitudes and behaviors that create them.

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References

1. Powers MA, Bardsley J, Cypress M, et al. Diabetes self-management education and support in type 2 diabetes: a joint position statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Care 2015; 38:1372–1382

2. Holt RI, de Groot M, Lucki I, Hunter CM, Sartorius N, Golden SH. NIDDK international conference report on diabetes and depression: current understanding and future directions. Diabetes Care 2014;37:2067–2077

3. Egede LE, Zheng D, Simpson K. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care 2002;25:464–470

4. Johnson JA, Al Sayah F, Wozniak L, et al. Collaborative care versus screening and follow-up for patients with diabetes and depressive symptoms: results of a primary care-based comparative effectiveness trial. Diabetes Care 2014;37:3220–3226

5. Roszler J, Satin Rapaport W. *Approaches to Behavior: Changing the Dynamic Between Patients and Professionals in Diabetes Education*. American Diabetes Association, Alexandria, VA, 2014