

**A Review of Psychology Provision to  
Adults & Children with Diabetes in Scotland**

**A Report by the Psychology Working Group  
for the Scottish Diabetes Group**

**January 2006**

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## **1.0 EXECUTIVE SUMMARY**

- **The level of psychology provision to people with diabetes is woeful and amounts to about one psychologist for every 11 000 people with diabetes. There is no provision at all to children and adults with diabetes in most health board regions.**
- **Much of the existing provision relies on good will, the personal interests of local psychologists and temporary funding.**
- **There are no signs of significant improvements in the provision of psychology: we found little evidence of plans to develop such services.**
- **There appears to be no psychology provision to primary care patients and staff. Psychology time is used in the most inefficient way, namely delivering psychological therapy to a small number of individuals with mental health problems.**
- **A more systematic approach to psychology provision is required.**
- **Diabetes services should use the breadth of psychologists' knowledge, skills and competencies. Training and supervising colleagues from other professions across primary and secondary care should take precedence over all other roles.**
- **Diabetes services should be mindful that there are a range of potentially employable psychologists in Scotland including clinical, counselling and health psychologists.**
- **Generally, severe and complex mental health cases should be passed to local mental health services.**

## 2.0 BACKGROUND

- In 2004, the Scottish Diabetes Group, acting on behalf of the Scottish Executive, published a discussion document entitled Diabetes in Scotland: Current Challenges and Future Opportunities – Reviewing the Scottish Diabetes Framework. This document indicated current thinking on issues such as the recent progress in the provision of services to people with diabetes; the gaps and problems in the delivery of care, and proposed priorities in service developments. The aim was that following comments the Scottish Diabetes Group would publish an update of the original Scottish Diabetes Framework (Scottish Executive, 2002), which was by then several years old.
- As part of this review process, there were submitted significant comments on the provision of psychology services to adults and children with diabetes, most notably from the Scottish Divisions of Health and Clinical Psychology, which are subsystems of the British Psychological Society. As a result, the Scottish Diabetes Group convened a short-life working group, chaired by Dr Ann Gold, consultant diabetologist. Following discussion within the Scottish Diabetes Group and with the Scottish Divisions of Health and Clinical Psychology, it was agreed that the group would consist of two health psychologists; two clinical psychologists; an adult diabetologist; a paediatric diabetologist, and a general practitioner. The group members were as below.

### ***Membership***

Dr Victoria Alexander	Consultant Paediatrician, Ninewells Hospital & Medical School, Dundee
Dr Colin Cackette	Consultant General Practitioner, South Queensferry Medical Centre, Edinburgh
Dr Ann Gold (Chair)	Consultant Diabetologist, Diabetes Service, Woolmanhill Hospital, Aberdeen.
Dr Helen Griffith	Clinical Psychologist, Psychology Department, St John's Hospital, Livingston.

Dr Andrew Keen (Secretary)	Health Psychologist, Child & Family Mental Health Service, Royal Aberdeen Children's Hospital
Dr Ann Smyth	National Director of Training for Psychology Services, NHS Education for Scotland, Edinburgh.
Dr Vivien Swanson	Senior Lecturer in Health Psychology, Department of Psychology, University of Stirling, Stirling.

The group met on two occasions in September and December 2005 with much of the work being conducted through email discussions. The aims of this group are below.

### ***Aims***

1. Review the extent and nature of psychology provision to people with diabetes in Scotland, which would include identifying examples of good practice.
2. Make recommendations about improving the psychological care of adults and children with diabetes.
3. Suggest a small number of pilot projects which would reflect some of the ways in which the time of chartered psychologists could be effectively used within diabetes services.

## **3.0 INTRODUCTION**

It is not the purpose of this brief report to provide extensive details about psychology, diabetes, and about how they interact. Those interested should refer to the two documents submitted to the Scottish Diabetes Group from the Scottish Divisions of Health & Clinical Psychology. However, we do think that it is worthwhile highlighting a small number of points so that our position is relatively clear.

- The health-related behaviour of people with diabetes as they go about their daily lives is the most important determinant of the outcomes of care (Scottish Diabetes Framework, 2002). This is unsurprising because typically people with diabetes have only about three hours per year contact with health professionals, so must therefore self-care for the remaining 8757 hours (DoH, 2005).

- The majority of people with diabetes do not attain good control of their blood glucose levels. The costs of complications in human terms (blindness, amputations, cardiac disease, renal failure and premature death) and financial terms (in the region of 5% of the NHS budget; the presence of complications increases costs by about five times) are great. Difficulty in obtaining good blood glucose control is frequently due to one or more psychological or social reasons, for example, perceived self-efficacy, mental health (particularly anxiety and depression), knowledge-levels of diabetes, and lifestyle issues.
- The main task of those working in diabetes services, therefore, is to encourage adults and children with diabetes (and their families) to obtain better blood glucose control. Diabetes staff can only achieve this by collaborating with people with diabetes in order to identify and overcome those barriers to improved control.
- Clearly, helping people with diabetes change their health-related behaviour is fundamental to successful delivery of care, regardless of whether the staff are trained in medicine, nursing, podiatry, dietetics or any other health profession.
- There is increasingly robust evidence that psychological interventions are effective. A recent review in the *Lancet* noted improvements in glycated haemoglobin of 1% for relatively intense, short-duration cognitive behavioural therapy based interventions (Ismail *et al*, 2004), which would be sufficient to reduce the risk of the development and progression of serious health complications (DCCT 1993, UKPDS). In addition, although there is a paucity of empirical evidence on longer-term outcomes, self-management training to improve aspects of lifestyle shows promising clinical utility (Norris *et al*, 2001). Primary prevention programmes, for example, reducing the probability of developing type 2 diabetes in high-risk groups using behavioural change programmes, are also effective and economically viable (Tuomilehto *et al.*, 2001).
- In view of these facts, it seems abundantly clear that chartered psychologists, whose primary aim is to understand and change the way people (both the public and colleagues in other health professions) think, feel and behave, have an important role in the delivery of care to those adults and children with diabetes.

## 4.0 METHOD

- The group members designed a relatively brief questionnaire to ascertain the existing nature and extent of psychology provision to children and adults with diabetes in Scotland and to establish the views of diabetes clinic staff and patients about any future provision (Appendix A). This questionnaire was accessible to diabetes clinic staff via an internet link for approximately five weeks. All managed clinical networks (MCNs) were notified by email (Appendix B) about the questionnaire and asked to pass details on to local clinic staff and patient representatives. In addition, all members of the Patients Focus Implementation Group were circulated with details of this internet link. Heads of psychology services in both adult and child services were also asked to complete the questionnaire via an internet link (Appendix C). Contact was again by email. The two internet addresses were dissimilar, which meant that the two sets of data were stored separately.
- Unsurprisingly, respondents within the same Health Board often gave conflicting information. We decided that the responses indicated by most people were in general probably accurate. Of course, that might not always have been the case, but differences were relatively small and the general trends were relatively strong. We also made efforts to clarify information when views within health board regions were especially ambiguous by contacting heads of psychology services or by contacting specific psychologists working in diabetes services.
- It became apparent very early in the review process that there was in fact very little psychology provision to people with diabetes in Scotland. The group therefore decided it would be wise to contact psychologists elsewhere in the UK in order to try to identify good practice, and to obtain advice generally on the merits and demerits of different methods of attempting to influence health care provision to people with diabetes. One group member (AK) conducted telephone calls with three experienced psychologists working in diabetes: Dr Chas Skinner (health psychologist, University of Southampton, Southampton); Dr Yvonne Doherty (clinical psychologist, North Tyneside General Hospital, North Shields), and Dr Kirstine Postner (health & clinical psychologist, Newcastle General Hospital, Newcastle Upon Tyne).

## 5.0 RESULTS

### 5.1 Demographic Information

- A total of 217 people completed the questionnaire via the internet link which was distributed via the MCNs. Although this represents only a minority of health professionals working with people who have diabetes, it is probably a reasonable response rate in view of limited amount of time that the project team had to collect and analyse the data. Table 1 indicates the distribution of responses by health board. Of these respondents, 187 (86%) were health professionals; 23 (11%) were people with diabetes, and we had seven cases of missing data. Overall, there was a reasonable spread of professions (table 2). There were a total of 10 responses from heads of NHS psychology services in Scotland. Of these, 4 were heads of child psychology services (health boards: Dumfries & Galloway; Forth Valley; Highland, & Greater Glasgow) and 6 were heads of adults psychology services (health boards: Argyll & Clyde; Borders; Fife; Forth Valley; Grampian, & Lanarkshire).

**Table 1** Distribution of respondents by health boards.

Health Board	Frequency (percent)
Argyll & Clyde	13 (6)
Ayrshire & Arran	14 (6)
Borders	6 (3)
Dumfries & Galloway	11 (5)
Fife	23 (11)
Forth Valley	3 (1)
Greater Glasgow	29 (13)
Grampian	61 (28)
Highlands	12 (6)
Lanarkshire	1 (1)
Lothian	25 (12)
Orkney	1 (1)
Shetland	1 (1)
Tayside	2 (1)
Western Isles	14 (6)
Missing	1 (1)
Total	217 (100)

**Table 2** Distribution of respondents by profession.

<b>Health Board</b>	<b>Frequency (percent)</b>
Diabetologist	22 (10)
Diabetes Specialist Nurse	32 (15)
Dietician	18 (8)
GP	30 (14)
Health Service Manager	6 (3)
Person with Diabetes	23 (11)
Psychologist	9 (4)
Paediatrician	6 (3)
Practice Nurse	14 (7)
Podiatrist	21 (10)
Other	29 (13)
Missing	7 (3)
Total	217 (100)

- It would appear that the MCNs chose different methods of responding to our request for information. Some, for example, Grampian and Greater Glasgow appear to have solicited widely for views whereas others, for example, Borders and Lanarkshire seem to have nominated one person to respond. This is not especially important regarding details about psychology provision (as long this information is accurate). However, this does mean that respondents' views about the nature of future psychology provision may not fully reflect staff across all Scottish health boards, although the pattern of results is relatively strong.

## **5.2 Current Psychology Provision to Diabetes Services**

### **5.21 Paediatric Services**

#### ***Extent of Provision***

- Of all respondents contacted via MCNs, 35 (16%) worked mainly with children who have diabetes and half of these health professionals provided answers about the provision of psychology to child diabetes services. We also obtained information from four heads of child psychology services, and made contact with two of these to clarify local psychology provision. A summary of this data is provided below.

- At this time, there are about eight and half sessions per week of psychology provision delivered to children with diabetes and their families in Scotland.
- Dumfries & Galloway and Highland have two sessions per week whereas Argyll & Clyde, Fife, Grampian, & Lothian have one, whilst Forth Valley have 0.5 sessions per week. Other health boards report no current input whatsoever.
- This psychology provision is probably located entirely in secondary care.
- In at least three quarters of instances, the psychologist is not a member of the multi-disciplinary team, rather resides in local Child & Adolescent Mental Health Services (CAMHS).
- The nature of funding is somewhat unclear, but from the pattern of responses, we can be only sure that probably Argyll & Clyde, Fife and Forth Valley have permanent NHS funding for a diabetes-specific post. Tayside also has permanent funding for two sessions per week of psychology time, but the associated post is currently vacant. In addition, both Fife and Forth Valley have two sessions of permanent NHS funding but again this is currently not fully provided. This amounts to only seven per week of permanently funded psychology time in the whole of Scotland, of which only two and half is delivered.
- In Lothian, there is no direct funding for psychology provision to the paediatric diabetes service. The member of staff providing this service is funded from general CAMHS monies. The psychology service to diabetes constitutes part of a general provision to the children's hospital, which in turn exists due to historical precedent.
- In Dumfries & Galloway, the two sessions were funded from general CAMHS monies to help fill a previous vacancy (because an applicant had a specific interest in diabetes). This psychologist has now resigned and therefore the service to children with diabetes and their families will discontinue.

- Similarly, in Grampian, it is certainly the case that provision exists only because of the psychologist's personal interest (again funded from general CAMHS monies) and this appears also to be the case in Highland. This means that if these particular psychologists leave their posts, then there is no funding available for future service provision to paediatric diabetes services.

### ***Nature of Provision***

- Respondents in all Health boards with psychology provision indicated that working with individuals and families is a major part of the role.
- Implementing group interventions is typically not a role, with the exception of Dumfries & Galloway wherein this is a minor role.
- Conducting research and audit is a minor role of the psychologist in three of the six Health boards with provision.
- Providing training and supervision is a minor role in all cases.
- Advising about the design of clinical services to children with diabetes is not a role in three of the six health boards with psychology provision. It may be a minor role for the psychologists in Argyll & Clyde, and Fife whereas in Lothian it is definitely is a minor role.

## **5.22 Adult Services**

### ***Extent of Provision***

- Of the 217 respondents, 152 (70%) reported that they worked mostly with adults. Comments on psychology services to adults with diabetes were received by 16 of these respondents. We also obtained data from six heads of NHS adult psychology services. A summary of the data collected is given below.

- There are currently about six sessions of psychology input to adult diabetes services in Scotland. Reportedly, this will increase to ten sessions from February 2006.
- Grampian, Lothian and Forth Valley appear to have two sessions each, and from reports all other Health boards have no input whatsoever. The provision in the Lothian region is to adults with diabetes in West Lothian only. Lanarkshire have recently appointed a chartered psychologist who will be delivering four sessions to diabetes services, from February 2006.
- Again, it is likely that psychology provision exists entirely in secondary care.
- In Grampian and Forth Valley the psychologist is part of the diabetes clinic team and this may also be the case in West Lothian. The situation in Lanarkshire is hard to ascertain because the psychologist is not yet in post.
- West Lothian and Forth Valley have permanent NHS funding whereas Grampian has temporary funding from a pharmaceutical company. The future provision in Lanarkshire exists only because of the personal interest of the post-holder. Thus, there is no specific funding for a psychology service to diabetes in this region.

### ***Nature of Provision***

- In West Lothian and Forth Valley working with individual patients is a major part of the psychologist's role whereas it is a minor role in Grampian. In Lanarkshire, it is intended that delivering individual psychological therapy will be a major part of the role.
- Implementing group interventions is a minor role in Grampian and Forth Valley (as is intended in Lanarkshire) and not a role in West Lothian.
- Conducting research is a minor role in all instances.
- Providing training and supervision is a major role of the psychologist in Grampian; a minor role in Forth Valley and West Lothian (& will be in Lanarkshire).

- Offering advice on the design of clinical services to adults with diabetes is a minor role in West Lothian and Forth Valley; is intended to be a minor role in Lanarkshire, and may be either a minor or major role in Grampian.

### **5.23 Older Adult Service**

- Respondents across all health boards reported no psychology services specifically for older adults with diabetes.

## **5.3 Future Psychology Provision to Diabetes Services**

- We have separated responses from health professionals and responses by service users in this section.

### **5.31 Views of Health Professionals**

- The total number of respondents within this section varied to a small degree from questionnaire item to item (between 175 and 186). A summary of the results are detailed below. The term “respondents” in this section refers to those who completed the questionnaire via the MCNs internet link and therefore does not include the heads of psychology NHS services. However, the views of this group are included below for comparison.
- A vast majority (87%) of respondents believed that working with individual patients should be a major role of psychologists working in diabetes services. About the same proportion of heads of psychology services agreed with this view (8/10; 80%).
- More than half (55%) of those who responded also thought that implementing group interventions should be a major role of psychologists; 38% thought it should be a minor role. A similar proportion of heads of psychology services believed implementing group intervention should be a major role (6/10; 60%).
- 34% of respondents thought that conducting research and audit should be a major role of psychologists working in diabetes care; just over half (54%) thought it should

be a minor role. Half (50%) of the heads of psychology services believed this should be a major role.

- A sizeable majority (69%) believed that training and supervising other clinic staff should be a major role for psychologists working in diabetes services; nearly one in four (24%) thought it should be a minor role. All but one head of psychology services (90%) thought training and supervising other health professionals should be a major role of psychologists attached to diabetes services.
- Nearly half (49%) of respondents thought that advising on service design should be a minor role of psychologists in diabetes services whereas 38% believed it should be a major role. A sizeable majority (8/10; 80%) of the heads of psychology services believed that advising on service design should be a major role.

### **5.32 Views of People with Diabetes**

- As previously indicated, 23 people with diabetes responded to this survey. Between 20 and 23 of these people completed the questionnaire items enquiring about future psychology provision. The views of the service users are detailed below.
- A majority (70%) of service users believed that working with individual patients should be a major role of psychologists working in diabetes services.
- 40% thought that implementing group interventions should be a major role of psychologists; 35% thought it should be a minor role, and 25% didn't know.
- The same percentage of service users believed that conducting research and audit should be a major role as believed it should be a minor role (40% in both cases).
- Nearly two thirds (65%) thought that training and supervising other clinic staff should be a major role for psychologists whereas just over a fifth (22%) thought it should be a minor role.
- 57% who responded thought that advising on service design should be a major role of psychologists; about three in ten (29%) believed it should be a minor role.

#### **5.4 Interviews with Psychologists Working Elsewhere in The UK**

- Interviews with the three experienced psychologists working in diabetes services in English NHS Trusts elicited relatively similar views about psychology provision in diabetes care. These views are below.
- Chartered psychologists working in diabetes services should have a multi-faceted role.
- Their role should include training and supervising other staff; delivering psychological therapy to a small number of people with diabetes; designing, delivering and evaluating group interventions, and conducting research.
- The most effective use of psychology time would be to train and supervise other health professions in the knowledge and skills required to help people with diabetes self-care.
- Funding levels are low, which means that typically psychologists are employed for one-to-two sessions per week.
- The low number of diabetes-specific sessions means that psychologists typically find it difficult to integrate into multi-professional clinic teams. Thus, the process of building-up knowledge about the care of people with diabetes, and about how their colleagues in different professions work, can be frustratingly slow.
- Typically, psychologists with only a few sessions per week in diabetes services spend by the far the majority of their time conducting psychological therapy attempting to treat severe and complex mental health problems. This means few people with diabetes benefit from their presence and this compounds the problems detailed above.
- Where possible, it would be wise for psychologists working in adult diabetes clinics to pass on severe and complex mental health problems to local mental health teams. This would mean that less psychology provision was taken-up delivering long-term psychological therapy to a small number of people with diabetes.

- Diabetes services require greater levels of funding for psychology provision to allow development of a multi-faceted role.
- Efforts to train and supervise colleagues from other professions have resulted in mixed results. The main problem is that clinic staff often lack sufficient time to attend regular training sessions. Planned, graded training from foundation level to higher levels of complexity, slowly increasing psychological knowledge and skills is thus difficult to deliver.
- The time commitment required to develop and consolidate psychological knowledge and skills is commonly underestimated. If this is to be achievable, considerable support from local management is required.
- Staff are invariably keen to receive training and supervision
- Psychologists require diverse knowledge and skills to work effectively in diabetes services. This is because it is most beneficial to people with diabetes role if psychologists adopt multi-faceted roles. Potential employers, therefore, should consider appointing psychologists with somewhat dissimilar core training to ensure coverage of a wide-range of skills and competencies. For example, Gloucester Hospital NHS Foundation Trust currently employ clinical, counselling, and health psychologists to deliver services to medical patients. The pros and cons of this recommendation will need to be considered carefully in those instances wherein there are few funded sessions of psychology time.

## **6.0 DISCUSSION**

- This brief study has obtained a relatively robust picture of the extent and nature of psychology provision in Scotland adopting a triangulated approach, using questionnaire data, information from heads of psychology services and data from personal contacts with psychologists working in this clinical domain. The general trends are very clear, and the data is generally comprehensive. It seems unlikely

that the survey has failed to include any areas of psychology provision for people with diabetes in Scotland.

- The review group had relatively little time to collect and analyse data about psychology provision. Thus, we obtained information using a brief online questionnaire, which we acknowledge is a relatively rough and ready method of data collection. We therefore make no claims about our respondents being representative of all health professionals working with children and adults who have diabetes across primary and secondary care throughout Scotland.
- However, we believe that we have managed to obtain a relatively robust picture of the extent and nature of psychology provision because we have also gathered information from heads of psychology services and through personal contacts with psychologists working in this clinical domain. The general trends are strong and it seems unlikely that there is substantial provision of psychology to people with diabetes of which the above groups are entirely unaware.

## **6.1 Extent of Psychology Provision**

- It is clear that the provision of psychology to children and adult diabetes services is woeful. Currently, the total amount of psychology time delivered to the approximately 200 000 people with diabetes in Scotland is about 18.5 sessions (this figure includes the reported four sessions due to begin in Lanarkshire in February). This amounts to about one psychologist for every 11 000 people with diabetes.
- Psychology provision is inequitable as well as being extremely limited. The extent of psychology services varies across health board, with no provision at all to children with diabetes in most health board regions (9/15; 60%), nor to adults with diabetes in most health board regions (11/15; 73%). Paediatric diabetes services overall are staffed to a somewhat better level than adult diabetes services. However, there is no specific psychology service at all to older adults (those over 65 years) with diabetes despite the fact that they constitute the majority of the diabetes population. This problematic situation is compounded by the fact that there is a marked shortage of psychology provision for older adults in Scotland (NES, 2004).

- Evidently, there is no systematic approach to providing psychology services to the ever-increasing numbers of children and adults with diabetes. Much of the existing provision relies on good will and temporary funding. For example, most (5/8.5; 59%) of the limited number of psychology sessions currently provided to paediatric diabetes services in Scotland exist only because a member of the local CAMHS has a particular interest in the area. Thus, there is no specific funding for these services and they will most probably cease entirely when these particular psychologists leave their current posts (as is happening in Dumfries & Galloway). The situation is similar in adult diabetes services wherein a pharmaceutical company funds temporarily one fifth of the psychology sessions that exist in Scotland. A further two fifths exists only because of a psychologist's personal interest and this service will cease should a future post-holder have other areas of interest.
- The low level of psychology provision to people with diabetes in Scotland does not look likely to improve in the near future. There appears to be very few firm plans to develop psychology provision to diabetes services. In one of only two exceptions that we managed to identify, the Grampian MCN has incorporated a proposal into the local strategic plan to develop a full-time A-grade chartered psychologist post in the adult diabetes service. In addition, there are firm plans in the Borders region to try to obtain funding for psychology input into the paediatric diabetes team.

## **6.2 Nature of Psychology Provision**

- Overall, the nature of psychology provision does not reflect current thinking about the delivery of health care services, for example, as detailed in *The NHS Knowledge & Skills Framework (NHS KSF) and the Development Review Process*. (DoH, 2004); *Self Care – A Real Choice: Self Care – A Practical Option* (DoH, 2005), and *Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland* (Scottish Executive, 2005).
- There appears to be no psychology provision to primary care. This is important because the vast majority of the diabetes population are adults with type 2 diabetes and it is general practitioners and practice nurses who are largely responsible for

their care. Therefore, it is highly unlikely that most people with diabetes, and the primary care staff trying to help patients manage their condition, obtaining access to psychology services. This will be the case even in those instances where there is some funding for psychology input into diabetes care.

- Diabetes services are currently reportedly using the limited amount of available psychology time in a very inefficient way. The primary role of psychologists is delivering individual psychological therapy. One would expect typically that one full-time qualified psychologist take on between 40 and 60 new patients per year (depending on case complexity). This means that even the best staffed diabetes services (two sessions per week) can expect that only up to about 12 new people with diabetes will benefit from the presence of a psychologist every year. It may well be the case that some people with diabetes would benefit from individual input from a psychologist and that this might be one effective way for psychologists to develop knowledge about diabetes. However, it is our view that more people with diabetes would benefit from the presence of psychologists in diabetes services, if a greater proportion of psychology time were spent training and supervising other health professionals.
- A high proportion of diabetes staff indicated that they would welcome training and supervision from qualified psychologists. Clearly, the need for individual and group interventions will always outstrip the supply of psychology time. Therefore, if people with diabetes are to benefit from effective psychological interventions, then we must provide diabetes staff with training in cognitive behavioural techniques; group facilitation; goal-setting and problem solving, because these skills are typically not part of health professionals training (Newman, Steed & Mulligan, 2004).
- The knowledge and skills of psychologists are not currently being utilised to help design and deliver prevention and education programmes. On the contrary, the role is currently focused narrowly on the reactive care of a small number of people with diabetes, managed in secondary care, who have already developed significant mental health problems.

## **7.0 RECOMMENDATIONS**

- This section is in two parts. The first details our general recommendations to the Scottish Diabetes Group whereas the second describes our three proposed pilot projects.

### **7.1 General Recommendations**

1. A more systematic approach to psychology provision in diabetes services is required if people with diabetes, and people at high-risk of developing diabetes, are to benefit from evidence-based psychological interventions. It would be best if these efforts occurred at a national level, however, they should occur at least at the level of MCNs. We recommend therefore that a chartered psychologist be invited to sit on the Scottish Diabetes Group and on every MCN in Scotland. This would potentially provide the opportunity for coordinated plans and development proposals to create psychology posts across Scotland.
2. We recommend that psychologists adopt multi-faceted roles. Diabetes services should be mindful of the potential breadth of the role of chartered psychologists. Psychologists have a range of knowledge and skills that are currently being under-utilised. In particular, their ability to design and deliver behavioural change programmes to people with diabetes as part of preventative care and education programmes; conduct research, and train and supervise other staff are being used only sporadically. We do of course accept that a complex role is difficult in those instances where psychologists have little dedicated time to diabetes.
3. As indicated, we are recommending a multi-faceted role. Hence, those involved with future recruitment of psychologists to diabetes services should bear in mind that there are a range of potentially employable applied psychologists in Scotland including clinical, counselling and health psychologists. Whilst sharing core knowledge, skills and competencies in applied psychology, their somewhat diverse perspectives could add a great deal to diabetes services. However, it is clearly the case that because of their high level of training that chartered psychologists like

other health professionals can develop relatively new knowledge and skills pertinent to specific clinical areas such as diabetes.

4. Diabetes services should use existing, and future, psychology time more efficiently than is currently the case. In particular, services should consider how to use psychology time so that the most people with diabetes can benefit. We recommend that training and supervising other health professionals takes precedent over any other roles, especially in adult diabetes services. Thus, supporting clinic staff in their role of trying to encourage people with diabetes to effectively self-care should be the primary duty. We understand that this might involve management prioritising staff training; however, this is entirely consistent with key recommendations in recent national and UK policy documents (DoH, 2004; DoH, 2005a; DoH, 2005b; Scottish Executive, 2005).
5. We accept that suitably trained health professionals who also have intimate knowledge of diabetes and treatment regimes will at times be most appropriate to treat some relatively straightforward mental health difficulties (mild depression, adjustment disorders, stress, some anxiety disorders, and child behaviour problems). However, we recommend that in general diabetes services (especially adult services) refer those with severe and complex mental health problems to local mental health services. We do accept, however, that on some occasions these mental health problems will be intimately entwined with diabetes and, therefore, that treatment might be best delivered by psychologists working in diabetes services.
6. We recommend that adult diabetes services use the multi-faceted role of qualified psychologists across both primary and secondary care. At this time, the majority of people with diabetes (type 2 adults), and those who manage their care, receive no psychology provision at all.
7. In the first instance, we recommend that on average all health board regions require a minimum of 1.0 f.t.e. chartered psychologists to work in adult services, and a minimum of 0.4 f.t.e. chartered psychologists to work in paediatric diabetes services. This level of provision will need to be adjusted according to the population size of the health board region. This level of funding is required to allow adequate, successful

development of multi-faceted roles and integration into multi-disciplinary teams. We are hopeful also that this level of provision would inhibit the development of some of the other difficulties associated with low levels of psychology provision, highlighted herein.

8. Inherent within our suggestions is the recognition of the scale and complexity of the task of encouraging people with diabetes to self-care. One obvious example is the difficulty that adult diabetes services face when trying to comply with SIGN 55 guidelines on screening all adult with diabetes for clinical depression. Our view is that the wellbeing of adults and children with diabetes is much more complex than merely whether or not they have one particular mental health problem. However, we do acknowledge that there are currently few psychologists in diabetes services and, therefore, that sophisticated attempts to measure quality of life and wellbeing would be impractical. We believe that some form of monitoring of psychological wellbeing is better than no monitoring. Hence, we recommend that diabetes services incorporate the Hospital Anxiety & Depression Scale (Zigmond & Snaith, 1983) into the annual review process and that these results are recorded on the SCI-DC clinical database. This would essentially enable Scotland-wide monitoring of the mental health of adults with diabetes who attend services using this database system. Further investigations are required to establish whether or not this can be incorporated into primary care IT systems.
9. We believe that monitoring of the psychological wellbeing of children is as important as monitoring of adults. However, we acknowledge that there is exists no quick and easy measure similar to the HADS which can be adopted for use throughout childhood. Those working with children and adolescents will need to consider solutions to this problem.

## **7.2 Pilot Projects Recommendations**

- The review group, following extensive discussions, proposes three pilot projects. In view of our findings, it is unsurprisingly that all three concern the training of diabetes clinic staff.

- Of course, these projects can only develop foundation-level knowledge and skills, and there is a fair chance these will attenuate over time. The presence of chartered psychologists in diabetes services would, however, allow staff not only to gain consolidation of basic psychological knowledge and skills, but also promote development of further knowledge and skills through training and on-going supervision. Nonetheless, we think that these three pilot projects would provide some evidence-based training to diabetes staff and provide diabetes services with a flavour of the potential role of chartered psychologists. We would like to emphasise the fact that we do not believe that short-courses of these type can or should replace the need for systematic workforce planning of qualified psychology posts in diabetes services.
  
- In view of the points above, the Scottish Diabetes Group should consider whether or not they wish to add an additional element to the proposed projects, namely the provision of on-going supervision from a chartered psychologist.
  
- At the heart of national clinical guidelines and the expanding empirical literature on the care of people with diabetes, lies a simple truth: changing the way that people behave is difficult. We believe that this is equally true of people with diabetes and of health professionals. We are keen that the pilot projects are conducted in ways that are likely to lead to real changes in the clinical behaviour of staff in diabetes services. Consequently, we would like those making decisions about funding to consider the points below.
  1. All three projects require the development of advanced communication and consultation skills. Broadly speaking, the advanced communication skills that underpin patient-centred interviewing, motivational interviewing, and assessment of relatively straightforward psychological problems are the same.
  
  2. Empirical evidence suggests that about 25 hours of training is required to develop these skills.
  
  3. The only evidence-based training method is the provision of feedback on videotaped performances.

4. In order that the training delivered is educationally meaningful, the amount of teaching time required for our three projects will be more than that required to increase only advanced communication skills. This is because of the time required to attend to the additional components of the three projects (changing health behaviour of individuals; identifying depression, and changing health behaviour of groups of individuals). Of course, we would envisage that the behaviour change skills and the advanced communication skills were developed in parallel throughout the training course, hence, the relatively small increase in training time.
5. Probably the total required amount of training time will be at least 30 hours and we estimate it will take at least another 30 hours to prepare the teaching material.
6. The ratio of trainers to diabetes staff will probably need to be about 1:5.
7. The approximate cost of a senior A-grade chartered psychologist for 60 hours is somewhere in the region of £2000.
8. The Scottish Diabetes Group need to judge whether or not they would allow equipment costs to be added to staff costs. Equipment costs might include items such as a camcorder and television. This would enable those working in services with little technical equipment to consider applying to deliver these proposed projects.
9. The amount of time required to undergo training might be prohibitive for primary and secondary care staff and, therefore, the Scottish Diabetes Group might wish to consider funding backfill, which would of course constitute by far the majority of the costs for any of the proposed projects.
10. We are aware that it may be the case that training staff in services that have currently a psychologist in post might be most effective, because consolidation of knowledge and skills can occur. However, we would be keen that diabetes staff elsewhere in Scotland do have access to these proposed training programmes.

11. We would recommend that decisions about who is to deliver training be made carefully, with reference to knowledge, skills and competencies of potential trainers, and that the delivery of projects is monitored and evaluated. Our group would be happy to be involved in this process.

The three pilot projects are detailed below.

### **1. Training Diabetes Staff in Foundation-Level Behavioural Change Methods**

- Staff in diabetes services routinely meet with people with diabetes to try to help them change aspects of their health-related behaviour. Typical examples include efforts to lower weight; increase exercise levels; lower blood glucose levels, and to follow instructions relating to foot care. The aim of this pilot would be first to provide comprehensive training in advanced communication skills; straightforward psychological assessment skills, and to provide information about the types of difficulties that people with diabetes face when trying to change aspects of their health-related behaviour. This would help staff develop further their ability to identify accurately those factors that are impeding clinically meaningful change. In addition, diabetes staff would also be trained to apply straightforward behavioural therapy techniques in order to overcome these barriers in those situations wherein circumscribed treatments are appropriate. These techniques would include appropriate goal setting and problem solving.

### **2. Training Diabetes Staff in Foundation-Level Skills in Identifying Depression and Anxiety**

- There is extensive evidence that mental health problems are at least twice as common among people with diabetes compared to those without. This is true of adults with types 1 and 2 diabetes, and true of children with diabetes. The primary mental health problems are depression and anxiety, which are notoriously difficult to identify in those with physical health problems. The purpose of this pilot project would be to help diabetes staff develop initially advanced communication skills; straightforward psychological assessment skills, and develop knowledge about the manifestation of clinically significant anxiety among children / adults with diabetes.

We envisage that much of this training would be experiential. Staff would not be trained in the psychological treatments for depression or anxiety. This would help diabetes services meet SIGN 55 requirements regarding screening for depression.

### **3. Training Diabetes Staff in Delivering Group-Level Education and Behavioural Change Programmes Utilising Psychological Principles**

- Routinely staff in diabetes services provide education about many different aspects of diabetes care. This includes both formal educational provision, such as relatively broad information to children and adults with newly diagnosed type 1 and type 2 diabetes, but also more somewhat informal education about issues such as new insulin regimes. Typically, staff have not been trained in how to run groups and often educational groups are not based around valid theoretical models of behavioural change. The aim of this training programme would be to help diabetes staff to develop the required knowledge and skills to be able to facilitate effectively educational and behavioural change groups, and to increase awareness of group-level behavioural change techniques.

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## **9.0 ACKNOWLEDGEMENTS**

The group would like to express particular thanks to Mr John Lemon, Senior Computing Advisor, University of Aberdeen for his help in the design of the questionnaire and collection of online data. We would also like to thank all staff and people with diabetes who took the time to complete our survey.

## **FURTHER INFORMATION**

If you would like further information, then please contact one of those below.

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## **Appendix A**

### **The Questionnaire**

## PSYCHOLOGY & DIABETES IN SCOTLAND

We would be very grateful if you could help us to try to improve the provision of care to people with diabetes in Scotland. We understand that you may well not know the answers to some of these questions but we would appreciate any information that you can provide. Thank you very much for your help and support.

1 Which of these is your health board (please tick):

Argyll and Clyde	<input type="checkbox"/>	Forth valley	<input type="checkbox"/>	Lothian	<input type="checkbox"/>
Ayrshire and Arran	<input type="checkbox"/>	Grampian	<input type="checkbox"/>	Tayside	<input type="checkbox"/>
Borders	<input type="checkbox"/>	Greater Glasgow	<input type="checkbox"/>	Orkney	<input type="checkbox"/>
Dumfries and Galloway	<input type="checkbox"/>	Highlands	<input type="checkbox"/>	Shetland	<input type="checkbox"/>
Fife	<input type="checkbox"/>	Lanarkshire	<input type="checkbox"/>	Western Isles	<input type="checkbox"/>

2 What is your job title (please tick):

Diabetologist	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>	Person with Diabetes	<input type="checkbox"/>
Dietician	<input type="checkbox"/>	Practice Nurse	<input type="checkbox"/>	Clinical Psychologist	<input type="checkbox"/>
Diabetes Specialist Nurse	<input type="checkbox"/>	Health Service Manager	<input type="checkbox"/>	Health Psychologist	<input type="checkbox"/>
Podiatrist	<input type="checkbox"/>	Paediatrician	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

3 Which group of people with diabetes do you mainly work with?

**Children** 
     
 **Adults** 
     
 **Older Adults** 
     
 **NA**

**EXISTING PSYCHOLOGY PROVISION**

4 As far as you know, is there one or more psychologists working specifically with people who have diabetes or with diabetes teams within your health board area?

Yes  No  Don't Know

**If yes, how many?**

**Boxes for 1, 2, 3 and >3 please** \_\_\_\_\_

If yes, continue to question 5, if no go to question 11

5 BEGIN LOOP HERE FOR A) CHILD; B) ADULTS, & C) OLDER ADULTS WITH Q 6-10 ACTIVATED BY A YES TO THE INITIAL QUESTION

With which age group of people with diabetes does the psychologist(s) work (please tick) and what is the approximate amount of time allocated?

a) **Children** Yes/No boxes  Don't Know

If Yes.....BOXES FOR 1, 2, 3.....10 (sessions/week)

b) **Adults** Yes/No boxes  Don't Know

If yes BOXES FOR 1, 2, 3.....10 (sessions/week)

c) **Older Adults**  Don't Know

If yes, BOXES FOR 1, 2, 3.....10 (sessions/week)

6 Where does the psychology service to people with diabetes reside?

**Primary Care**  **Both Primary & Secondary**  e

**Secondary Care**  **Don't Know**

7 How is the diabetes psychology service provided?

- Exists as part of the diabetes team care**
  - Part of Psychology/Mental Health Services**
  - Other (please state below)**
  - Don't Know**
- 

8 What is the funding arrangement for the psychology service to people with diabetes?

- Temporary Funding**  **Combination of Temporary & Permanent**
- Permanent Funding**  **Don't Know**

9 Who funds this/these post(s) funded?

- NHS**  **Pharmaceutical Company**
- Charity**  **Exists only because of a psychologist's personal interest**
- Don't Know**  **Other (Please state below)**

10 To what extent does the psychologist(s) providing a service to people with diabetes do the following? (1 = Not part of the role; 2 = Minor role; 3 = Major role; 0 = Don't Know) BOXES FOR 1, 2 3

- |  |                          |
|--|--------------------------|
| <b>Work with individual patients (and/or families)</b> | <input type="checkbox"/> |
| <b>Implement group interventions</b>                   | <input type="checkbox"/> |
| <b>Conduct research &amp; clinical audit</b>           | <input type="checkbox"/> |
| <b>Provide staff training / supervision / teaching</b> | <input type="checkbox"/> |
| <b>Advise on service design and delivery</b>           | <input type="checkbox"/> |
| <b>Other (please state below)</b>                      | <input type="checkbox"/> |
- 

11 Does a psychologist sit on your local MCN?

- Yes       No       Don't Know

## FUTURE DEVELOPMENTS IN PSYCHOLOGY PROVISION

- 12 Do you know of any firm plans to increase/initiate psychology provision to diabetes services in your health board area?

Yes  No

If not, do you think there is a need for an increase in/some psychology services to diabetes care?

Yes  No

- 13 If there were (further) developments in the provision of psychology to diabetes services, to what extent do you think the role should include the following? (1 = Not part of the role; 2 = Minor role; 3 = Major role; 0 = Don't Know)

<b>Working with individual patients (and/or families)</b>	<input type="checkbox"/>
<b>Implementing group interventions</b>	<input type="checkbox"/>
<b>Conducting research &amp; clinical audit</b>	<input type="checkbox"/>
<b>Providing staff training / supervision / teaching</b>	<input type="checkbox"/>
<b>Advising on service design and delivery</b>	<input type="checkbox"/>
<b>Other (please state below)</b>	<input type="checkbox"/>

---

IF YOU WOULD LIKE TO MAKE ANY OTHER COMMENTS THEN PLEASE USE THE SPACE BELOW

The information that we are collecting using this questionnaire is relatively straightforward. We understand that staff working in diabetes services will have many views about the nature of current and future psychology services to people with diabetes that we have not asked about herein. It is very important to us to try to get a flavour of these opinions so that any recommendations are as representative as possible of those working in this area. We are also eager to hear about any examples of good practice that might already exist in Scotland. Consequently, we are keen to conduct a relatively small number of telephone interviews with health professionals about these topics.

Would you be willing to speak with one of us briefly (for about 10 minutes) on the telephone?

Yes  No

If yes, then could you please provide us with your name, work telephone number and email address.

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Thank you very much for all of your help.

## **Appendix B**

### **Email to Managed Clinical Networks**

Dear Colleague,

You may be aware that as a result of the National Diabetes Framework Review a subgroup of the Scottish Diabetes Group was formed to look at the role and provision of psychology services in diabetes care. As part of the work of this group we wish to ascertain what is actually happening in Scotland in provision of such services, identify any areas of good practice and also establish what health professionals and patients would like to see in the future.

We would be grateful if you could disseminate this questionnaire as widely as possible to health professionals working in diabetes care in your region. The more responses we receive from each area the better. We would also like to hear patients views and would ask you to ensure that your patient representatives see the questionnaire. Some people may receive the website from more than one source - but please just complete the questionnaire once !

The questionnaire will only take 3-4 minutes to complete on-line and can be accessed by clicking on the on the following website :

<http://www.abdn.ac.uk/websurveys/diabpsyc/>

This message has been sent out to all MCNs, the Patient Focus Implementation Group and Heads of Psychology Services.

The results will be made available through the Scottish Diabetes Group.

**I would be grateful if each MCN could confirm receipt of this message.**

Many thanks for you cooperation.

Ann Gold  
On Behalf of the Psychology and Diabetes Subgroup of the Scottish Diabetes Group

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## **Appendix C**

### **Email to Heads of Psychology Services**

Dear Heads of Service,

As you may know, there is currently a Scottish Executive review of the extent and nature of psychology provision to diabetes services in Scotland. As part of this review, all MCNs have been asked to contact diabetes clinic staff to ask them to complete an online questionnaire. This questionnaire is essentially separated into two sections, the first of which asks about current provision and the second of which asks about their opinions on possible future developments. To provide a more comprehensive picture of opinion in Scotland we would be very grateful if you, as heads of psychology services, could also give your views. The questionnaire takes only about 3-4 minutes to complete and is available at the web address below. Please don't pass this email onto psychology colleagues who are working within diabetes services because we already have access to their views through the MCNs. We are specifically interested in your views and hence data collection from yourselves is occurring via a different web address (feeding into a different database) than is the case for those contacted via the MCNs.

Thanks in advance for your time.

[www.abdn.ac.uk/websurveys/psycdiab/](http://www.abdn.ac.uk/websurveys/psycdiab/)

Best wishes

Andy Keen

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