(Music)

>> Joiel: hello, and welcome to public health live, the third Thursday breakfast broadcast.  I’m Joiel ray-Alexander and I’ll be your moderator today.  Before we get started, I’d like to ask that you please fill out your online evaluation.  Continuing education credits are available after you take our short post-test, and your feedback is helpful in planning future programs.  We encourage you to let us know what topics are of interest to you and how we can best serve your needs.  We'll be taking your questions later in the hour.  The toll free number is 800-452-0662, or you may send your written questions by fax any time during the hour.  The fax number is 518-426-0696.  Today's program is "diabetes: what's depression got to do with it?"  Our guest is Dr. Michelle Owens from the CDC, division of diabetes translation.  Dr. Owens, thank you so much for joining us today.

>> Dr. Owens: Thank you so much for having me.

>> Joiel: Dr. Owens, how would you describe diabetes?

>> Dr. Owens: Diabetes is a group of diseases that can be caused by high blood sugar levels, and it also results in a concern regarding insulin production, as well as the way that insulin acts, or it can be some combination of both.

>> Joiel: What is the definition of depression?

>> Dr. Owens: Depression is a mood disorder, and it can really disrupt a person's life.  It can really impact their lives in many different ways.  Currently we know that over 121 million people have depression, and that's worldwide.  We also know that depression can occur for any person, regardless of their age and also for their gender.

>> Joiel: So essentially depression can strike at any point in time in a person's life?

>> Dr. Owens: Yes, it definitely can.

>> Joiel: What are the symptoms of depression?

>> Dr. Owens: To be diagnosed with depression, a person needs to have many symptoms, for at least most days, for two weeks.  That includes loss of self-esteem, sleep problems, thoughts of suicide or homicide, feeling sad quite often, having changes in their mood, changes in their appetite.  They may feel irritable quite often.  They may have changes in their weight gain or weight loss as well.  They may have a hard time concentrating, and they may also feel inappropriate feelings of guilt.

>> Joiel: So if any of these symptoms, either one or more, occur over the duration of two weeks, essentially a person is depressed.

>> Dr. Owens: Yes, they would be diagnosed as being depressed.
>> Joiel: Are there any risk factors that would make a person more susceptible to depression?

>> Dr. Owens: Yes, there are several risk factors that could lead a person to becoming depressed, and that includes being of a certain gender. Being female, we know that women are more likely to be depressed more than men. Also being of a certain age group. For women especially, being in the reproductive age range can lead them to be depressed. There are a lot of hormonal changes that are going on during that range, and also concerns regarding postpartum depression that's very common after delivering a baby. Another concern could be having a limited access to health insurance, as well as limited access to health care. When a person cannot take care of themselves, then that can lead to them not being able to take care of their health, as well they may not be able to take care of their body, their overall well-being, and that can lead to depression. Other concerns include having a lack of access to support. When a person is single, they tend to have less support than a married person. There also might be concern around a history of childhood abuse, as well as having difficulties in one's relationships, and also any recent stressful event could also lead to depression.

>> Joiel: Now you mentioned that women are much more susceptible, and you talked about the impact of hormones and so forth. Are there other reasons why women are more likely to become depressed?

>> Dr. Owens: We know that women play many different roles in their community. They can be the sister. They can be the mother, the wife, the community agent and advocate. Oftentimes women take on a lot more than that they can actually handle in their daily lives, and that can lead to depression because of many stressors that are involved in having so many different roles in their community.

>> Joiel: Is there anyone who is more likely to suffer from depression, Dr. Owens?

>> Dr. Owens: Yes. Actually as I mentioned, women tend to have more depression than men, but we know that men do get depressed, but men may not show that they're depressed. They may tend to mask their symptoms so they may tend to use more alcohol or drugs, and they also tend to have more concern regarding suicide. Men tend to use more lethal methods to harm themselves. So we're really concerned about men and depression and trying to get the men in for screening for depression. We know also that children can become depressed, but they may not seek treatment because we as adults may not see them as depressed. We may see them as being rebellious or shy. Also we know that older adults are also at risk for depression, but they tend not to seek treatment.

>> Joiel: Thank you. We're going to watch a video now of a patient who has both diabetes and depression. Let's take a look.

(Music)

>>Mary: My name is Mary. I’m 64. I live in Albany, and I’ve been here since I was about 3. I came in with my mom, sisters, and I have diabetes. It's very hard for me to realize that I had it
when I was told that, you know, that I had it. I got sick for quite awhile before I realized what the problem was. I was not depressed before became a diabetic. I was happy-go-lucky. I thought I was happy-go-lucky, you know. Nothing held me down. I was going places, doing things. You know, I loved arts and crafts and stuff like that, ceramics. I was doing a lot of that, but lately I haven't had the urge, don't have the feeling, you know? I would cry at the drop of a hat. I would sit in my room, my apartment I should say, and wasn't going nowhere. Didn't clean up, didn't do anything. I don't venture out as much as I used to. I used to love to travel. But now as far as I travel now is to my job and that's about it. When I'm depressed, I don't feel like doing anything. Medicines don't enter my mind. Food don't even enter my mind. I just-- just there, you know, just sitting in the house either watching television or television are watching me. Sometimes I’m not even aware of my surroundings sometimes. I just don't want to be bothered, you know? I could hear the phone ringing. Don't pick it up. I didn't realize that I was depressed. I cried a lot. When people asked me why I'm crying, I couldn't really give them an answer because I really didn't know myself why I was crying. All I know is that I didn't feel good. I felt bad. I was aching. Body just didn't want to seem to function the way I was used to it functioning, you know? It just wasn't functioning right. If I didn't want to see my granddaughter grow up and become a young lady and do her dreams and get married and have kids when it's time, I would have probably gave up five years back. She's very important to me. The worst thing of being a diabetic is the injections, to me. The hardest thing about depression is I’m afraid that I might not never, ever actually get totally get rid of it, you know. It's-- it sneaks up on you when you least expect it, you know? So that's my worst, that I’m never going to see the old Mary, happy-go-lucky, you know, doing things that everybody else did, you know, meeting friends, going to lunch, you know, out to dinner with your beau, boyfriend, things like that. That's no more, you know, so it's pretty-- I guess it's pretty sad.

>> Joiel: that's an extremely heartbreaking story. I hear this patient Mary talk about the impact of depression and diabetes on her life. Is there hope for someone like Mary in terms of treating their diabetes and depression?

>> Dr. Owens: People like Mary need to know that we can definitely treat depression. That's one of the concerns that we just don't know what depression is, first of all. We heard Mary say that she felt like she lost her whole identity. She didn't know who she was any more. People need to know what depression is, how it can change the way they feel about themselves or their mood, but they need to know also that treatment is effective and that it's available.

>> Joiel: and so there is hope.

>> There definitely is hope, yes.

>> Joiel: What is the impact of depression in terms of health care costs for someone who has diabetes?

>> Depression and diabetes is very common, but we also know it's very costly for people who have both diabetes and depression. It costs the health care system about $192 million. We know total health care expenditure is about five times more than for a person than for a person who does not have depression.
>> Joiel: $192 million? Did I hear you correctly?

>> Dr. Owens: Yes, $192 million. And that's per year.

>> Joiel: that's an enormous figure. And I would imagine it's only going to increase.

>> it's only going to increase but we also know that postponing care will make things worse. So when we postpone care, that makes the diabetes complications increase, the risk for complications will increase, and that also will increase health care costs. So we're very concerned about that.

>> Joiel: so what we're talking about-- what happens if someone does not seek treatment for diabetes and depression, when they first notice symptoms, the impact is essentially debilitating.

>> Dr. Owens: It’s very debilitating. The person may not know what's going on in their body. They may not know how to seek help, and when they do eventually seek help, sometimes it can be a little too late to avoid those complications and that's what we're really worried about. How can we get that message out more that you can prevent or at least delay complications?

>> Joiel: what is the effect, Dr. Owens, on health care in terms of diabetes and depression?

>> Dr. Owens: We know that people who have diabetes and depression spend more on their medication. They spend about five times more on their medication than others. They also have more visits to their permanent care provider, and they also visit the ER, the emergency room, more often than those who do not have depression. That's concerning to us as well, because we want to make sure the people who have diabetes and depression, that they seek care on a regular basis and do not use the emergency room, because that will not provide continuity of care. They need to have a regular doctor who sees them during their visit to take care of both their diabetes and their depression.

>> Joiel: why is the frequency of visits to the ER so prevalent?

>> It’s more prevalent because people just are concerned about what's going on in their body. They're concerned about how they're reacting to the depression, and they just don't know who to turn to. So the ER is often one of the places a person might go when they're depressed?

>> Joiel: simply because of convenience?

>> Dr. Owens: Exactly, yes.

>> Joiel: how does depression affect a person with diabetes?

>> Dr. Owens: Well, we do know that there are many changes that occur when a person has both diabetes and depression. Cortisol abnormalities are very common, and that's been associated
with depression. We know that, when that happens, there can be changes in a person's blood sugar level. The same is true when a person gains weight. There can be changes as well in their blood sugar levels, as well as when someone is not being physically active. That can also change their blood sugar levels. The same is true for when a person is not allowing themselves to adhere to a treatment plan. If they do not adhere to a treatment plan, that also can impact their sugar levels, and that also can result in depression.

>> What are some of the reasons a patient would not adhere to a treatment plan?

>> Dr. Owens: One of the reasons might be that they're just so depressed and not able to get out of the bed. They may be sleeping more often. They may be isolating themselves from other people. When that happens, things tend to escalate. The person may not know what to do regarding their depression and they just don't-- they may not eat well. They may not exercise, so those are all concerns.

>> Joiel: today we're talking about depression and diabetes. Is there a link?

>> Dr. Owens: Yes, there definitely is a link between diabetes and depression but it's not clear which one comes first. Perhaps depression may cause diabetes but it's also common that die bow tease itself may result in depression. There's recent research that shows there's a link between depression and increases in blood sugar levels.

>> Joiel: talk to us more about that link and the implication there are.

>> Dr. Owens: Well, we know that when there's improvements in depressive symptoms, that that can increase improvements in the a1-c levels. On the flipside, when we improve glycemic levels that can also improve depressive symptomatology. It's not clear what comes first, depression or diabetes.

>> Joiel: what about depression and its manifestation in adults?

>> Dr. Owens: In terms of depression and manifestation for adults, it's also very common that depression does occur for adults. We also know that for children, they also may develop depression. There's a link between retinopathy and depression as well as how long a child has had depression as well as glycemic control being out of control.

>> Joiel: So when you talk about the children and retinopathy, having your child receive frequent eye appointments could be very important and essential in diagnosing diabetes. Is that correct?

>> Dr. Owens: That is correct, yes. It's very important that we do not ignore children. Sometimes we think that children because they are young that they do not have stress in their lives, but we know that children do have a lot of stress. They also can become depressed. But we may overlook that for something else.
Joiel: are there any psychotropic medications or medications for depression that have an effect on diabetes?

Dr. Owens: We do know that weight gain is a major concern when people are taking different medications. Some medications do cause weight gain, and those include antidepressants as well as antipsychotics and other mood disorder medications. So a person who has weight gain may be more likely to not follow a treatment plan. They may get off of their medication too early and that can result in them being at risk for many other complications. A person who gains weight may be at risk for hypertension, cancer, arthritis, type ii diabetes and also coronary heart disease.

Joiel: why is depression in people with diabetes so serious?

Dr. Owens: Depression and diabetes is very serious because we know the person who's depressed may not have the energy to follow a treatment plan. They may tend to eat more foods that are not healthy for them. They may not want to exercise. It's very difficult for them to get going and to stay going throughout their day. A person who's depressed may also adopt other unhealthy behaviors and become more sedentary. We also know that people who are depressed tend to isolate themselves from other people, and it's really at that time where a person who's depressed needs to spend more time with people to get support.

Joiel: it sounds like a vicious cycle, you know? You have the diabetes or the depression; we're not sure which comes first. You enter into a period of isolation, which is really at the point and juncture that you should be seeking help and getting treatment. How do we address that?

Dr. Owens: It’s really important that we start talking more about diabetes and depression hand in hand. Oftentimes we do not have broadcasts such as this, that look at both diabetes and depression. We know it's very common for people to be depressed. It's very common for people to have diabetes. But we just do not talk a lot about these two together. We need to have more brochures that are available for the patients to learn what diabetes is, to learn what depression is and how they go hand in hand and what we can do to prevent complications from depression.

Joiel: so public health marketing and public awareness campaigns are essential in addressing this area?

Dr. Owens: Yes, they definitely are.

Joiel: what about educating our health professionals and our public health professionals in terms of their schooling and education and better equipping and informing them? Is that occurring currently?

Dr. Owens: That is occurring, but I think it needs to occur more frequently. We need to start very early with medical students when they first start taking classes in their first year, to talk more about chronic illnesses and how depression is so common. Depression not only affects diabetes but also affects cancer, arthritis, Alzheimer’s disease and many other chronic illnesses. The key word there is chronic. Anything that's chronic can lead to depression.
>> Joiel: Is there any particular reason why a person who suffers from depression might be reluctant to seek help?

>> Dr. Owens: There are several different reasons why a person may not seek help when they're depressed. One reason could be cost. A person may be struggling with their budget. They may be concerned about, if I take care of my health, how do I pay for my family's needs on a daily basis? How do I take care of my electric bill that's due tomorrow? So people often postpone care because of realistic needs that they have within their own lives.

>> Joiel: go ahead.

>> Dr. Owens: Another concern would be shame. Many people are ashamed of the diagnosis of depression. They don't want others to know that they're depressed. They may not even want their permanent care provider to know that they're depressed. So they may go without care because they don't want others to know and think about them in a negative way.

>> Joiel: So the mental health aspect of this and addressing the issue of shame and reaching out and seeking help is quite important.

>> Dr. Owens: Yes, it definitely is. It's important for people to realize that it's okay to be depressed, that depression is very common. But again that there is treatment available to deal with depressive symptoms.

>> Joiel: What role do rising costs play in people's health care seeking behavior?

>> Dr. Owens: Cost is very high and people tend to postpone going for care. So we know that for a lot of people it can be a choice between paying for their electric bill or going for their health care. We know that a lot of people may not have insurance, so that's a very big issue for us here in America. We know that many women also tend to delay their care. Again, many women play different roles in their community, so they tend to place their own care last and may take care of their family needs first and those in their community. And when that happens, we know that that can lead to more problems within their own health.

>> Joiel: So it's almost, when we talk about the importance of having a public awareness campaign and the importance of educating the community and the various public about treatment and the various forms of treatment, we also have to talk about prioritizing your health as essential in addressing treatment and getting help.

>> Dr. Owens: Exactly. Women need to know, because they're often the gatekeepers to the family's health as well as the family's meal that they eat every day. Women need to more about how they can take care of their own health because if they're not healthy, then that's going to impact the entire family.

>> Joiel: You mentioned earlier about stigma and you talked about cultural differences. Tell us a little bit more about how cultural differences plays a role in getting help and seeking treatment for those who suffer from diabetes and depression.
Dr. Owens: Well, one of the first things that we need to know is that when a person has a different culture than ourselves, we need to respect that, because a person who may be of a different background may not want to come for mental health care. They may not want to admit that they're depressed. They may not know that they're depressed because they tend to use different words. They may not use the words that we would tend to look for such as sad, feeling blue or feeling helpless. So for example a person who is Latino, they may say that they have bad nerves or they have headaches quite frequently and they may not equate that with being depressed. Someone who's from the Asian background may say that they have feelings of weakness. They feel tired quite often or they have some kind of imbalance in their body. So they also may not say that they're sad but we tend to look for that as primary care providers. Another concern is that, for a person of Middle Eastern background, they may say that they have problems with their heart. Again not using words that we would expect them to. And then someone who's African American may say that they have bad nerves or they feel evil quite often.

Joel: So again, when we talk about educating our medical community and physicians, and you talked about primary care physicians, it's very important that they have not only a respect but a sensitivity to how cultural differences plays a role in various cultural, ethnic and racial groups in their expression of what they may be experiencing.

Dr. Owens: And that needs to be taught early on in the medical school for the students to learn more about cultural differences, how people may approach the health care system, and also how they may present when they are depressed or when they even have diabetes for example.

Joel: Let's talk more about the expression of depression, and tell us more about the diverse expressions of depression and how that plays itself out.

Dr. Owens: Well, we know that people may not express depression in the same way. They may have different ways of showing that they're depressed, as I just talked about a minute ago. But we need to make sure that we as health care providers are aware of that, because we may misdiagnose someone or may even overlook that they are indeed depressed so it's important that we not focus on surveys or questionnaires that are standard for assessing depression. Those are great. We definitely need to use those, but we also need to have other things that accompany those surveys. We need to talk more to our patients. Find out what does it mean when you feel evil or you feel more irritable? What does that mean for their patient? And find out more about how that may be linked to depression.

Joel: when you talk about the area of assessment, what are some of the standard tools that are used in assessing depression?

Dr. Owens: There are several different scales available for the permanent care provider to use. There are fields that are geared towards older adults. There are fields that are geared towards children and very general skills as well for depression.

Joel: are there any studies specific to African Americans and depression?
Dr. Owens: Yes, there are quite a few studies that look at African Americans and depression. Again what they show is that many African Americans do not use the word sad, hopeless or helpless but instead they may say they have changes in their appetite. They may show changes in how they walk. They may walk more slowly. They may talk in a different way. They may talk more slowly. They may also say that they're angry more often than not, that they're irritable and they may be abrupt with a person. They may also overall deny that they have any problems. They may deny that they are indeed depressed.

Joiel: is there support for caretakers and family members in, again, raising their understanding and sensitivity to what their own family members may be experiencing?

Dr. Owens: There are support groups that are available so that it would be important for family members to learn more about what depression is. But also to accompany their family member who they think may be depressed to learn more about how they can help that person deal with their depression.

Joiel: can you describe for us a situation where a woman is dealing with both depression and diabetes?

Dr. Owens: Sure. There's a case of Mrs. Jones. We know that Mrs. Jones is 55 years old, that she has had diabetes for a few years now, but she does not check her sugar levels on a regular basis. She just doesn't feel that she needs to do so. She also has a hard time following her treatment plan that the doctor has prescribed. She doesn't want to exercise because she's concerned about sweating her hair out and we know that that is a real concern for some populations. Mrs. Jones also has—her family regarding her depressive issues. They've also seen that she's been evil quite often, that she also has a bad attitude most days, but she tends to deny it and doesn't want to see a psychiatrist, mainly for fear that they may think that she's crazy, quote-unquote. So she does not admit that she has any depressive symptoms, but people in her family do recognize these symptoms. She responds that she's not crazy and also that she wants to see her doctor. When she does see her doctor, he screens her for depression and it turns out that she does score high on the depressive scale. He then incorporates the depressive medication for a few weeks and then he finds out that she has improved in terms of her depressive symptomatology. This tells us a lot of what we talked about a few minutes ago and that is there's a real stigma regarding depression. People just don't want to talk about it and don't want to deal with it. When it accompanies diabetes, the person may be so depressed that they can't follow a treatment plan. So we see changes in her mood disorder. She's really concerned about how people see her, but she just doesn't have the—to take care of herself. She also finds that when she takes medication she does feel better. So that is the hopeful message is that there are things we can do to help people feel better when they're depressed.

Joiel: I would imagine this case study is not atypical.

Dr. Owens: No, it's not. It's very common.

Joiel: Dr. Owens, can you talk a little bit about the treatment for depression? You know, we're talking about those who suffer from depression and that critical juncture where they really
should be seeking help and getting treatment. They tend to kind of go into kind of a mode of isolation. Treatment is so critical in this area. Please share this with us and talk more about treatment.

>> Dr. Owens: Well, we do know that depression and type II diabetes are potentially preventable as well as controllable. But as you've mentioned, there's concern that people are not seeking treatment. Depression just goes untreated so often. That's concerning for us because we know it can lead to macrovascular complications, which means heart attack and stroke are very common when a person has depression. It can lead to retinopathy. So seeking treatment early on is very important when a person has diabetes and depression. But we know that only 30% of patients receive adequate treatment when they have depression. And of those, only 20% receive more than four visits for psychotherapy. That's also concerning because we know that it takes a few visits for the psychologist, psychiatrist or social worker to make the diagnosis, and then can begin working on a treatment plan. So four visits is really not enough for a patient to make a huge difference in their care.

>> Joiel: what is the ideal number, if not four?

>> Dr. Owens: There's no ideal number, but it's very difficult to make a lot of adjustments or improvements in that short period of time.

>> Joiel: So early diagnosis is absolutely essential in developing a kind of an accurate and timely treatment plan.

>> Dr. Owens: It's definitely important to have early diagnosis because that can lead to-- if you do not have early diagnosis, that can lead to further complications like the ones I just mentioned, heart attack, stroke, and we can prevent many of them.

>> Joiel: and treatment should be inclusive of the multidisciplinary approach or team approach?

>> Dr. Owens: It definitely should include a lot of different practitioners, and that includes psychologists, psychiatrists and social workers. We can make sure we have many people on board to help with the assessment and also to help with the treatment plan itself. So involving people early on is very important in terms of primary care providers.

>> Joiel: What are some of the tools used to screen for depression?

>> Dr. Owens: There are several tools. I just listed three of them for you. One is the geriatric depression scale, and that's geared towards older adults. It's a short form that can be administered very easily. It includes 15 items to look at depression. Another is a patient health questionnaire 9, and that's also self-administered. It looks at nine items for depression. And then finally the depression scale inventory. It's also self-administered and includes 21 items that look at attitudes as well as symptoms of depression.

>> Joiel: What can a family care practitioner do once they've administered the screening and it's determined and diagnosed that the patient indeed is suffering from depression?
Dr. Owens: Administering a survey is just the first step in taking care of a person's needs when they are depressed. It's really important again to involve them as a health provider in that treatment and that can again include a psychiatrist, psychologist or social worker. It's also important to assess the patient for suicidal or homicidal thoughts. We know that oftentimes when a person is depressed they may have some thoughts about just wanting to end it all it's common to have those thoughts but we want to make sure the person is safe. We want to make sure that the care provider assesses for suicide or homicidal thoughts. Sometimes there may not be a chance for them to go on for a visit to a psychologist or psychiatrist or a social worker. So the primary care provider may be the frontline person to ask those questions.

Joiel: Very good. Thank you. Let's take a look now at a video showing the patient that we saw earlier, Mary. We're going to take a look at a video of her doctor, who often sees and screens patients who have both diabetes and depression. Let's take a look. (music)

Dr. Paeglow: My name is Dr. Paeglow and I’m a family physician, and I practice in my own clinic here in west hill, west hill neighborhood in Albany, New York. Depression is an incredible detractor from a person's ability to manage their diabetes on many different levels. You have a situation that's very, very important for a person to self-manage, and they need the tools to be able to do that. However, depression takes those tools away. Depression takes away motivation. They many times don't have the energy to get out of bed. If you don't have the energy to even get out of bed, how can you think up drawing up your insulin, taking your insulin, eating a proper diet, preparing a meal properly at certain times? You have to make an assessment of how sick they are in terms of their depression immediately. I would say that's probably the paramount thing to do. I would say that about 30 to 40% of the patients that I see suffer from depression as well as diabetes, maybe higher. Seemingly there's an aspect of depression, perhaps not full-blown clinical depression, in the majority of these patients. But if you looked at those numbers, I would say they're probably maybe even closer to 50 to 60% with significant depressive symptoms. I think health care professionals are aware of comorbidity-- mental health comorbidity such as depression. I think the problem is they don't have time to deal with it in their, you know, 15-minute office visit. And sometimes you know they may be aware of it. They may think to themselves: I can't open this can of worms right now. It's a little bit safer I think sometimes to deal with things like diabetes, because you can measure how well you're doing much more objectively, I think, than you can with a patient who is depressed. The first thing that I do is I just kind of look at the patient and judge their affect and how they comport themselves in the initial interview, getting a sense of their body language and how-- the rate of their speech and how they're talking, and then I ask them point blank: is your mood down? Do you feel-- have you lost interest in pleasurable activities? What did you used to like to do for fun that you don't do any more? How do you sleep? What's your appetite like? Those kinds of questions I find myself asking a lot in the clinic. Access to mental health services for patients with diabetes, I think in general is abysmal. I think it goes beyond abysmal for those in the Medicaid population and those who are uninsured, which there are a lot of people that are uninsured these days. I think if you are someone who has resources, it's better. But I think that still access is very poor. There are not enough mental health providers. I’m a family doc, and I treat everything from bipolar to depression, anxiety disorders, because people don't have any other choices. So access is very, very limited. And we know in this population in America
Today, diabetes is on the rampage. I mean we're just in the middle of an incredible epidemic. There almost is not a day that goes by that I don't make a diagnosis of diabetes in a patient. It's rare that I don't do that. And we know that depression is the most common chronic disease today on the face of the earth. You put those things together and you see incredible comorbidities. This makes it really difficult because we as a family doc end up dealing with both the depression and the diabetes because of just lack of access to mental health care. The incidence of mental health conditions amongst diabetics is much higher, I believe, because of the change in lifestyle that has to occur to successfully manage the condition. I think any kind of chronic disease, but more so with diabetes because of its prevalence, really mental health plays so much bigger factor than an acute thing which we can say, I'm over that. You know, whether a person has diabetes or a person has asthma or some other kind of chronic condition that—I don't look at depression any different from those. I try and treat my patients who are depressed, who are anxious in the same way I would treat someone who has another kind of chronic and medical condition. We have to look at changing the way we do an office visit. People need to know that you care about them, and it's very hard to do in a ten-minute—I can't do it. I don't do it but I'm an outlier, and I'm very unusual in my approach to things. It has to start with us taking a look at ourselves. This idea has to creep into medical education so that when doctors are in training, right from the very beginning, they don't look at we have the chronic disease people here and we have the mental health people over here. We have people that have problems that need to be cared for, need to be healed. And so we need to break down the stigma that's attached, and we need to get real with ourselves and stop this sense of, oh, you know, that because again someone is depressed or anxious, that they're somehow a lesser individual than someone who has diabetes or asthma or heart failure these are people.

>> Joiel: I tell you, that physician touched on so many excellent points and clearly the patient, Mary that we observed earlier is in excellent hands. How can we get the message out to health care professionals that people with diabetes need to be screened for depression?

>> Dr. Owens: I think the doctor was right on when he said that we need to make sure that we reach out to those physicians during their training, not only just in the medical schools but also when they go for their particular education credits. There needs to be more talked about what is depression and how it coexists with diabetes.

>> Joiel: What are some of the warning signs of depression? We spoke earlier in the program about symptoms. Tell us more about those warnings that we should be observant of?

>> Dr. Owens: It can lead to a lot of different changes in the person's mood. The person may become more depressed, more sad. You may see that in their behavior and whether they talk to you. They may isolate themselves more often, as Mary talked about. May also see just certain stressors in their lives can seem so overwhelming and unbearable that that can lead them to feeling depressed and seek help for it.

>> Joiel: are there certain triggers for depression that are common across the board?
Dr. Owens: stressful events are very common for people so we would want to look at what's happening now, what's changed for that person and also begin to talk about what can we do to make things better for them in terms of alleviating their depression.

Joiel: again when you talk about those things that might change, and we spoke earlier about the importance of continuity of care, that seems to be critical in determining patterns of change.

Dr. Owens: It definitely is very critical in terms of patterns of change. They need to make sure they have continuity of care. Not go to the emergency room for care but seek a psychiatrist, psychologist or social worker along with their care provider because that will help them with making sure there are advancements in their treatment and also able to discuss and deal with their depression.

Joiel: what's the most common form of treatment for depression?

Dr. Owens: The most common form and the most effective form is a combination of psychotherapy and medication. The research has shown that the two together are the most effective. And it's much better than having just psychotherapy alone or medication alone.

Joiel: does depression typically run in families?

Dr. Owens: Depression does run in families. There is a hereditary component of it as well but it also can be a part of a person's environment. Someone who is unemployed may be depressed but it may not run in their family. Someone who's under-employed may also experience depression and that may not run in their family. So it really depends on what's happening in the environment and also with their family history.

Joiel: What resources are available in the community to help people deal with depression?

Dr. Owens: The frontline person would often be the permanent care provider. We know that because of stigma and other issues, a person may not go to a mental provider for services. So it's important that the permanent care provider begins to ask questions about depression to assess for it and then to follow a treatment plan to help alleviate those symptoms. Mental health professionals are definitely a key component for treating depression but we also know people need to know more about their insurance. What kind of insurance do they have is one question they should ask. They should also ask about how many sessions could they receive if they are indeed depressed and they need psychotherapy. They also should find out more about community health centers are in their neighborhoods. We like to consider our community health centers being one-stop shopping. They allow a person to have many different services under one roof. So they can go and see their dentist for their oral health needs. They can go get their eyes examined but they can also see a mental health provider all in the same location. Going to the hospital psychiatry outpatient clinic. That would also be a great resource for someone who is depressed. When someone's depressed they tend to as I mentioned go into emergency rooms. But we don't encourage that, only in times of crisis should a person go to the emergency room. Again there's really a need to make sure they have a doctor who's following their treatment on a regular basis, and that just cannot be provided in the emergency room. Another resource is a
state hospital or outpatient clinics. For someone who's depressed and they have daily stressors they're dealing with, they may want to turn to family agencies or social service agencies. We cannot really deal with the depression unless we deal with their case management issues. So someone is having a hard time dealing with their electric bill for example, it's really important that a case manager help them through those problems first before we can deal with depression, before we can deal with diabetes. Another resource would be private clinics. Also there may be at the work site employee assistance programs. Along with the permanent care provider being on the front line, we often find that the employee assistance programs are also on the front lines. When a person's working, it's often there that we find out that they're depressed. So their supervisor may refer them to an employee assistance program and that person may then refer them to local agencies that can help them in their neighborhoods. Another example for a resource would be the local medical or psychiatric societies. If a person just doesn't know where to turn for help, they can always go to a web site, either go to a library or even at home. Look up these web sites that are medical societies or psychiatric societies and learn more about the American medical association, for example. They can learn more about what doctors are in their neighborhoods. They can learn more about what depression is on the American psychological association's web site. And they can also find out more about psychologists or psychiatrists that are in their neighborhood.

>> Joiel: we spoke about the importance of physicians and health care practitioners, as well as family members, having sensitivity and giving some attention to cultural differences. And we know that in certain cultures, the church plays a key role. Are there resources available at various parishes and churches across the country, educating and raising the awareness of depression and diabetes?

>> Dr. Owens: At lot more churches are involved in looking at diabetes as an issue within the churches. Many churches are leading support groups for diabetes when their church members are dealing with diabetes. There tends to not be a lot of support for depression within faith based organizations but that could be an issue that could be addressed definitely within the church.

>> Joiel: thank you very much, Dr. Owens. We're ready to take your calls now. The toll free number is 800-452-0662 or you may send your written questions by fax to 518-426-0696. Dr. Owens, could you highlight some of the important resources for health care professionals on diabetes and depression?

>> Dr. Owens: Sure. One great example is the American association of diabetes educators. They provide a lot of great resources for diabetes prevention as well as for diabetes control. They also provide information for diabetes support groups that are in local communities across the nation. So this will be a great resource for someone who is dealing with diabetes or just wants to learn more about what diabetes is and how to prevent it or control it.

>> Joiel: are there other resources available to the public?

>> Dr. Owens: Yes. Another great resource is the national diabetes education program. The national diabetes education program, or n.d.e.p. Is co-sponsored by the national institutes of health and also the centres for disease control and prevention. What n.d.e.p. Does is that they try
to reduce the morbidity and mortality associated with diabetes. They produce materials for the public and those include products that are brochures. They provide campaign information regarding awareness for diabetes. They also provide tools that are geared towards different age groups. So a person who may be in their older years can learn about diabetes specifically for their age group. Someone who may be in school and a student can learn more about how to deal with diabetes in the school system.

>> Joiel: is there a support group or resource available for someone who suffers from depression and for example bipolar disorder?

>> Dr. Owens: there are support groups that are available for a person who suffers from depression and/or bipolar disorder, and those could be found also by going to the American psychological association, their web site, to learn more about what groups are out there, what psychologists might be available, even what social workers might have access to these types of groups.

>> Joiel: And what about resources and support systems to begin to address the issue of the stigma of depression?

>> Dr. Owens: There are also resources available regarding stigma. There are some new videotapes that have come out to deal with depression, to talk about what depression is, why it's such a stigma in different communities, but why it's so common but also so treatable. So a person can go to different resources to learn more about depression by using videotapes or audio tapes or even to learn more about self-help books that are out there about depression.

>> Joiel: so there's hope and there's help, and there are just a wealth of resources available.

>> Dr. Owens: Yes, there really are. So people just need to learn more about what it is and how to take care of themselves when they have both diabetes and depression.

>> Joiel: thank you, Dr. Owens. We have a call in from Boston, Massachusetts for dr. Owens. Your question? We're going to take a call from New Jersey on the next line and hopefully Boston will call back. I'm sorry about that, Boston. New Jersey, your question for Dr. Owens?

>> Caller; hi, dr. Owens. First thank you very much for this terrific presentation.

>> Thank you.

>> Caller; I am a nurse. I work for health ways. We provide disease management services and I specifically work with Blue Cross Blue Shield providers who have members in our various programs, one of which is diabetes. And I often come up with the problem with the primary care provider of not getting-- first being uncomfortable treating a diabetic who has depression. Getting them to the right referral if need be to a psychiatrist or a therapist, and then coordinating the care of that diabetic between the psychiatrist or therapist and the primary care physician. Do you have any hints on how best to approach that situation?
It's also a challenge for the care provider to do so much in a short period of time. We know that they spend about 15 to 20 minutes with their patients and they have to cover a lot of different information during that period of time. But it's very important that there is a referral that's made for the psychologist, psychiatrist or social worker to be involved. I found that teaching hospitals do a great job with that and having a multidisciplinary team involved in the care of a patient with both diabetes and depression. I'm not sure what location you are currently in, but if there's a way that you can involve the entire team in the treatment, that's often very helpful to do so.

Joel: thank you for that call coming in from New Jersey. We know that our nurses are quite often on the front line of care and treatment. So we greatly appreciate that call coming in from New Jersey. Do we have Boston back on the line today?

Caller: can you hear me?

Joel: yes! Thanks for calling back.

Caller: I have actually-- it's kind of a personal family-related issue. All of the talk so far has been so relevant. My dad was diagnosed with diabetes a few years ago and became very depressed after a divorce and actually passed away last march, and what I found was that it seemed to affect his personality, and he would not do-- he would not follow his diet. He would not take his medication. He would not surround himself with people. He would not do any of the things that we needed him to do. And it was a very frustrating time for all of us involved, and we also recognized that we couldn't do all of the things for him. What do you do with someone like that and how do you help them?

Dr. Owens: Sometimes it really just takes the family member or the permanent care provider to just be present with them. Sometimes they need to know that they have support, even though they may not show that they want support. They may not know how to take care of themselves but if you can help them prepare healthy meals, perhaps go on walks with them, provide a buddy system for that person. That's often helpful when they have both diabetes and depression. We know that exercise is important when you have diabetes. We know that exercise is important when you have depression, so helping that person in many different ways would be something that I would definitely recommend for you.

Joel: thank you very much for calling in from Boston and sharing that quite personal story with us, and we're sorry to hear of your loss. Here's a fax question that is linked to the earlier question, how important is family support for the person with diabetes and depression?

Dr. Owens: Family support is very, very important. It's important for the person who is depressed and who has diabetes to know that they're not alone. Oftentimes we hear of a person who has diabetes but they feel like they're giving up so much of themselves. They feel like they've lost their culture when they can't even certain foods. A person who's Latino for example may be concerned they can't eat their tamales or tortillas any more. What does that mean for their family? If it's a woman with diabetes or even a man with a loss of their food or their culture, they worry about a stressor on the entire family. So it's really important that people
reach out to help someone who has both diabetes and depression. They do not need to be alone. They may want to feel isolated from others; they may want to lead themselves away from other people, but they really-- it's at a time now that they need support from people.

>> Joiel: Are there support groups for caretakers working with a family member, a loved one who in fact has diabetes and depression? I would imagine they, too, would require some support.

>> Dr. Owens: Usually the support groups are open for anyone to come. So family members are allowed to go to support groups when a person has diabetes or depression. So they definitely should be encouraged to go to show they're supporting that person, but also to learn more about diabetes and depression and how common they are.

>> Joiel: Thank you. We have a call coming in from Atlanta, Georgia, for Dr. Owens. Your question?

>> Caller; yes, ma'am. You mentioned several of the resources that are available, and one of the things that I would ask is how do you evaluate, like, folks or references that you would refer people to?

>> In terms of references, one place to start would be the government agencies that provide a lot of evidence-based science regarding diabetes and depression. I mentioned the national diabetes education program. Anything that the national diabetes education program, anything that they create is based on science. So we know that it's sound and that it's credible. So that would be one great place to start in terms of references. Another great place would be the national institutes of health. Within the national institutes of health, there is the national institute of mental health, and they provide many publications on diabetes alone, but also diabetes and Depression.

>> Joiel: Thank you very much calling in from Atlanta, Georgia with your question for dr. Owens. Here's a question that's come in via fax for you: is depression common in other chronic diseases also?

>> Dr, Owens: Depression is very common in other chronic illnesses. We know that it's very common for people who have cancer, people who have arthritis, and people who have Alzheimer’s disease. But the key word that we're talking about is chronic. So anything that's chronic in a person's life can lead to depression.

>> Joiel: Here's another fax question that's come in: what can someone do if they have a patient who is reluctant to seek help for their depression?

>> Dr. Owens: If a permanent care provider finds that they have a patients who's reluctant to seek treatment, it's really important that they first just acknowledge to the patient that they're concerned. Oftentimes it just takes their acknowledgement that they're concerned for a person to open up and say “yes, I do feel a change in my body and I feel a change in my behavior.” So acknowledging that to a patient is definitely a great first step. We would hope that they would be
more willing to seek treatment for their mental health concerns, but it may take some time to do so.

>> Joiel: Here's a question: can you discuss the link between obesity and diabetes and depression?

>> Dr. Owens: Yes. We know that weight gain is a major concern. When a person gains weight, they tend to not follow through on a treatment plan. They may become more sedentary. They may begin to eat more unhealthy food. And it may become hard for them to follow through on different issues that they're trying to improve. So that can lead to both depression as well as diabetes.

>> Joiel: we mentioned earlier several of the resources and support groups that are available. We talked about the importance of employee assistance programs. Are there resources that employers can tap into to support their employees who may have diabetes and/or depression?

>> Dr. Owens: That's a very good question that you've just asked. And the reason why I'm very excited about that question is that we are actually working at the center for disease control on some work right now on the work site and looking at diabetes and depression. Physicians, nurses, social workers, certified health educators and others can go to the web site for national diabetes education programs to learn more about diabetes at work, how it's impacting the work site. We know that people who have diabetes and depression are able to work in any job. They can function very well in any job. But when they're depressed, that can lead to other concerns in terms of productivity levels. So a person can learn more about diabetes at work by going to our national web site which is called diabetesatwork.org. That's produced by the national diabetes education program.

>> Joiel: Repeat that web site again.

>>Dr. Owens: Sure. Www.diabetesatwork.org.

>> Joiel: Thank you very much. What do you do if a person won't address their depression? You know, you're a family member. Your family member has been diagnosed with depression, or you're a family care practitioner. I'm sure that's got to be very frustrating for both entities. How do you help someone who just simply won't address their depression and, for example, take the medications if in fact it may be antidepressants? How do you address that?

>> Dr. Owens: One thing to do as I mentioned earlier is to just be there with the person. Let them know that you're concerned about them. Let them know that there's been a change that you're worried about. People may not know that untreated depression can lead to complications. So the person who is a caretaker may want to say, you know, I'm concerned about you, but I'm also worried that this is going to lead to other concerns. Can we help you? How can I help you? And begin to take small steps to help that person deal with their depression and their diabetes. So it may mean going for walks with them to help them with their depression, to help them with their diabetes as well. It may mean trying to change the foods the person eats, taking over some of those tasks for that person to help them learn to live a more healthy lifestyle.
>> Joiel: So don't give up, and being somewhat—having some tenacity is important.

>> Dr. Owens: Yes. Don't give up and be proactive for that person.

>> Joiel: Is it important to know whether the diabetes caused the depression or vice versa?

>> Dr. Owens: It’s important to know which one comes first but we just don't know in the science which one comes first. Some of the research says that diabetes can lead to depression, or the flipside, that depression can lead to diabetes. But we do know that treatment is very important. One research study that just came out is called the prospect study. And it looks at older adults who have both diabetes and depression. And what it tells us is that, when a person is receiving treatment for depression, they are less likely to die in a five-year period than those who do not receive treatment for depression. So we know that there's a lot that we can do to prevent complications as well as to prevent mortality.

>> Joiel: In your opinion, Dr. Owens, and your research, do you see this problem improving or getting worse over the course of the next ten years?

>> Dr. Owens: We know that diabetes will be getting worse. We also know that depression probably will also get worse. But because we know that there's so much more that we can do to prevent depression as well as prevent or delay type ii diabetes, we need to make sure we get the word out about these two illnesses. People just don't know that these two coexist. They need to know because we know that, if they don't take care of themselves, take care of their health, then that can lead to future problems down the line.

>> Joiel: Dr. Owens, it's been extremely important having you here today with such relevant and timely information. This has been a comprehensive presentation. We appreciate your joining us today.

>> Dr. Owens: Thank you so much for having me here. I appreciate it.

>> Joiel: And thank you for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs. And continuing education credits are available. This program will be available via web streaming within a week or so. Please see our web site for more details. We hope you will join us next month on March 20th for the start of our maternal child health series. The program will be on public health detailing, using the pharmaceutical sales approach to promote public health, with Kelly Larson, director of the Public health detailing program at the New York City Department of Health and mental hygiene. I’m Joiel Ray-Alexander. See you next time on public health live, the third Thursday breakfast broadcast. Thank you.

>> Thank you so much. Thank you. (Music)