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# Indigenous community care

## Documented depression in patients with diabetes

### Aim

This article reports on documented levels of depression among people with diabetes attending indigenous primary care centres.

### Method

Between 2005 and 2009, clinical audits of diabetes care were conducted in 62 indigenous community health centres from four Australian states and territories.

### Results

The overall prevalence of documented depression among people with diabetes was 8.8%. Fourteen (23%) of the 62 health centres had no record of either diagnosed depression or prescription of selective serotonin reuptake inhibitors among people with diabetes. For the remaining 48 centres, 3.3–36.7% of people with diabetes had documented depression.

### Discussion

The results of this study are inconsistent with the evidence showing high prevalence of mental distress among indigenous people. A more thorough investigation into the capacity, methods and barriers involved in diagnosing and managing depression in indigenous primary care is needed.

**Keywords:** depression; diabetes mellitus; health services, indigenous

Evidence, both internationally<sup>1</sup> and from Australian general practice settings<sup>2</sup> shows that people with diabetes are twice as likely to have depression than people without diabetes. Among those with diabetes, coexisting depression is associated with a 50% increased mortality risk.<sup>3</sup> In Australia, the prevalence of diabetes in Aboriginal and Torres Strait Islander people is at least two times higher than in non-Indigenous Australians, as is the prevalence of reported high or very high levels of psychological distress.<sup>4</sup> However, little is known about the prevalence of depression among Indigenous Australians with diabetes. The aim of this study is to examine documented levels of depression among people with diabetes who attend indigenous primary care centres.

### Method

Between 2005 and 2009, clinical audits of diabetes care were conducted in 62 indigenous community health centres from four Australian states and territories (33 from Northern Territory, five from far west New South Wales, seven from Western Australia and 17 from North Queensland),<sup>5</sup> including centres in urban, regional and remote locations. These centres participated in a national quality improvement project (the ABCD Extension Project).<sup>5</sup> Information on documented comorbidity, delivery of scheduled services, treatments, blood pressure measurements and blood glucose control was collected in each health centre from a random sample of 30 records of clients known to have diabetes. For centres that had 30 or fewer clients with diabetes, all records of patients with diabetes were audited (total records audited n=1592). 'Documented depression' was defined by having a record of a diagnosis of depression in medical summary sheets and/or progress notes or a record

of prescription for a selective serotonin reuptake inhibitor (SSRI) such as citalopram or sertraline.

### Results

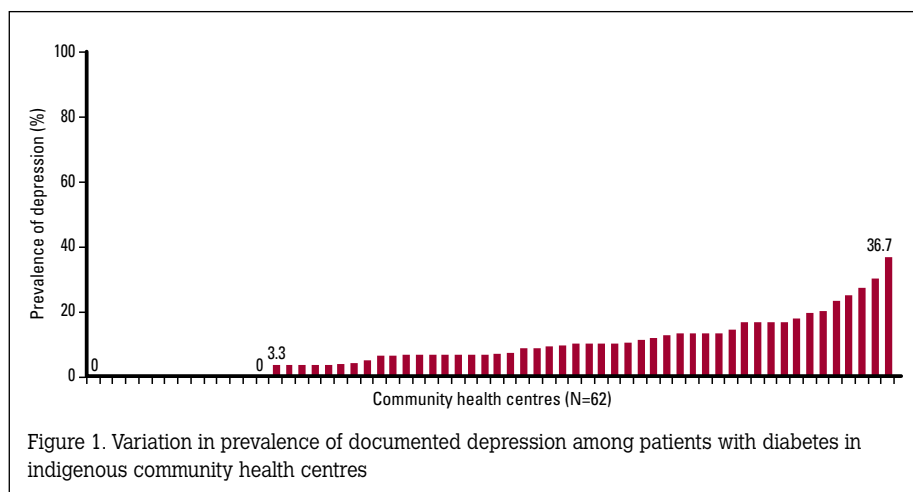
Of the 62 participating indigenous community health centres, 29 (47%) were managed by a regional or local indigenous committee or board, and 33 (53%) were funded and operated by governments. These health centres predominantly served Indigenous Australian clients. Of the 1592 people with diabetes whose clinical records were audited, 1405 (88%) were identified as Aboriginal or Torres Strait Islander.

Of the total 1592 patients, 140 (8.8%) had documented depression; 62 had a record of a diagnosis of depression but did not have a record of prescription of an SSRI; 45 had a record of prescription of an SSRI but without a documented diagnosis of depression; and 33 had a documented diagnosis of depression and prescription of an SSRI. As shown in *Figure 1*, 14 (23%) of the 62 participating health centres had no documented depression among people with diabetes. For the remaining 48 health centres, between 3.3% and 36.7% of clients with diabetes had documented depression. When the calculation was limited to those 48 health centres, the overall prevalence of documented depression among patients with diabetes was 11.2%. Only six out of 62 (10%) health centres showed a prevalence of depression of 20% or more.

### Discussion

In other clinical settings the prevalence of depression among people with diabetes is reported to be about 30%.<sup>1,6</sup> Indigenous people with diabetes in the United States are more likely to report major depression than their non-Indigenous Caucasian counterparts.<sup>7</sup>

The complete absence of documented depression in about one-quarter of participating health centres, and the wide variation in



prevalence of documented depression in others is inconsistent with the evidence showing a disproportionately high prevalence of mental distress among Indigenous Australian people,<sup>4</sup> and with the evidence showing the major contribution that mental health problems are known to make to the burden of disease among Indigenous Australians.<sup>8</sup>

It is also noteworthy that approximately one-third of the patients (45 of 140) who met our definition of documented depression had no recorded diagnosis of depression in their medical records but had a record of prescription of an SSRI medication. This raises some questions: Is there resistance among health professionals working in indigenous healthcare settings to make and/or document a diagnosis of depression? If so, what is the basis of this resistance? Are there other mental disorders (eg. generalised anxiety disorder) that are being treated with SSRIs? Are the SSRIs being used to treat other disorders (as the range of Therapeutic Goods Administration approved indication for some SSRIs covers health issues other than mental health disorders)?

Further research into these issues should help in understanding current practice in relation to comorbid depression and chronic disease, and to enhance efforts to improve quality of care in this area.

While the role of formal screening tools, such as the Patient Health Questionnaire (PHQ-9), in promoting active case findings of depression in primary healthcare is still being debated (for the general population as well as for indigenous patients<sup>9,10</sup>) and their routine use is not universally

recommended, it would nonetheless be expected that clinicians identify and treat depression in patients who have higher than average risk. Further investigation into the screening tools, capacity and barriers involved in diagnosing and managing depression in indigenous primary healthcare settings in Australia is needed.

Local<sup>11</sup> and international experience<sup>12</sup> has demonstrated key strategies for successful integration of mental healthcare into primary care, including adequate training of primary care workers in mental health work (screening, assessment, treatment and referral) and at the same time adequate and effective support and supervision of primary care by specialist mental health professionals. General workforce inadequacy in the face of high burden of disease and service load in indigenous primary healthcare in Australia is a major constraint on the potential for services to provide effective primary mental healthcare. The high burden of mental ill health and the deficiency and inconsistency of data on documented depression in this study of primary care settings may indicate room for improvement in data and service provision.

A significant limitation of this clinical audit is that it would not have captured people who had depression but did not have a diagnosis of depression in their records but were managed with non-SSRI options, which include nonpharmacological therapies and other antidepressants (particularly serotonin noradrenaline reuptake inhibitors, including venlafaxine, which in one study was the second most prescribed antidepressant in Australian general practice<sup>13</sup>).

## Implications for practice

Using information on the documented level of depression among people with diabetes as a starting point, indigenous health centre staff (doctors, nurses, Indigenous Australian health workers and managers) can reflect on their capacity in providing and documenting primary mental health services, and identify areas where there is need for improvement.

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