Evidence, both internationally\(^1\) and from Australian general practice settings\(^2\) 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.\(^3\) 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.\(^4\) 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.

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

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 (e.g., generalised anxiety disorder) that are being treated with SSRIs? Are the SSRIs being used to treat other disorders (as the range of Therapeutic Good 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) 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 and international experience 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).

**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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