Sentara® Health Plans

BEHAVIORAL HEALTH GUIDELINE

SCREENING FOR DEPRESSION IN ADULTS WITH DIABETES

Guideline History

Date Approved	09/24
Date Revised	09/26
Date Reviewed	09/26
Next Review Date	09/28

These Guidelines are promulgated by Sentara Healthcare (SHC) as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The SHC Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment

Depression is twice as common in people with diabetes as in the general population. Major depression is present in at least 15% of patients with diabetes. Depression is associated with poorer glycemic control. (Diabetes Care, 1993, 2001, 2002). From 2011 to 2019 the prevalence of depression in adults with diabetes was about 29%. People with Type 1 diabetes have a higher prevalence of diabetes than people with Type II diabetes. Women with diabetes have a greater prevalence of depression. The prevalence of diabetes in 2021 in the US was 11.6%.

ADDITIONAL STANDARD

As a separate component to the diabetes practice guideline, this guideline specifically focuses on members with diabetes and depression. As a result, a definite timely and necessary intervention, either directly by the clinician or via referral to a specialist will take place.

COMPONENTS OF THE VISIT

Clinical assessment for major depression should be provided for any adult diabetic with poor glucose control or when the patient has symptoms suggesting possible depression such as problems sleeping, changes in appetite, low energy, fatigue, and anhedonia. Ideally screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

While screening instruments (e.g. PHQ-9, PHQ-2, Zung, Beck, CES-D) may be utilized, a positive score on the screen is not sufficient for clinical diagnosis. Diagnosis requires a full history and examination using standard Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5-TR) diagnostic criteria to determine the presence or absence of a specific depressive disorder. FOR THIS TO BE EFFECTIVELY IMPLEMENTED THE ENDOCRINOLOGIST MUST COLLABORATE WITH A QUALIFIED MENTAL HEALTH PROVIDER.

INTERVENTION/FOLLOW-UP/REFERRAL

Intervention, follow-ups, and referrals should happen as needed (may include psychotherapy, nutritionist, pharmacotherapy, and/or other interventions as appropriate). This should occur within 14-30 days after the assessment.

REFERENCES:

1. The Guide to Clinical Preventive Services 2005, Screening for Depression, PP. 98-101.
2. Psychological Aspects of Diabetes, Canadian Diabetes Association, 2003.
3. van der Feltz-Cornelis CM, Muyen J, et al . Effect of interventions for major depressive disorder and significant depressive symptoms in patients with diabetes mellitus: a systematic review and meta-analysis. Gen Hosp Psychiatry. 2010;32:380-95.
4. Holt RI, van der Feltz-Cornelis CM. Key concepts in screening for depression in people J Affect Disord. 2012;142 Suppl:S72-9

1. Integration of Care and Overlap Screening

The American Diabetes Association (ADA) 2026 Standards of Care explicitly shifted toward a **person-centered integrated care approach**. [1]

- **Distinguishing Overlapping Symptoms:** The updated guidelines require at least **annual depression screening** (may use PHQ9 or Beck), which must be conducted alongside screenings for anxiety (may use GAD7) and **diabetes distress** (see link below). Because hyperglycemia and the emotional burden of diabetes mimic or worsen clinical depression, clinicians are instructed to rigorously query the origins of symptoms before prescribing. [1]

- **Collaborative Teams:** Guidelines now strongly recommend that the behavioral health professional managing the depression be formally integrated into, or collaborate directly with, the primary diabetes treatment team. [1]

2. GLP-1 Psychiatric Safety Debate

A major clinical update centered around glucagon-like peptide-1 (GLP-1) receptor agonists (e.g., semaglutide, tirzepatide). [1]

- **Removal of Suicidal Ideation Warnings:** Following early regulatory scrutiny, an extensive FDA review concluded that **GLP-1 medications do not increase the risk of suicidal thoughts or behavior**. By early 2026, the FDA requested that manufacturers remove these warnings from weight-management and diabetes drug labels entirely. [1, 2]

- **The "Double-Benefit" Effect:** Accumulating meta-analyses and data show that GLP-1 RAs are safe for patients with serious mental illness and are actually correlated with **lower overall rates of depression and anxiety diagnoses**, likely due to improved cognitive pathways and metabolic control. [1, 2, 3]

3. Management of Antidepressant-Induced Metabolic Shifts

The ADA continues to push for strict auditing of a patient's existing antidepressant regimen, as certain psychiatric medications directly interfere with glycemic goals: [1, 2]

- **Tricyclic Antidepressants (TCAs):** Older antidepressants (e.g., amitriptyline) are strictly discouraged or discontinued where possible due to their proven link to weight gain and disrupted glucose metabolism.

- **Preferred SSRIs:** If a Selective Serotonin Reuptake Inhibitor (SSRI) is used, **Fluoxetine (Prozac)** or **Citalopram (Celexa)** are highly preferred in diabetic patients because clinical data show they possess mild anti-inflammatory properties and can actively assist in lowering HbA1c and regulating lipid profiles.

- **Agomelatine as an Alternative:** Ongoing clinical research highlights **Agomelatine** (a melatonergic agonist and 5-HT2C antagonist) as an advantageous emerging alternative for diabetes patients because it treats depression without causing weight gain or damaging pancreatic beta-cells. [1, 2]

4. Digital and Lifestyle-Enhanced Psychotherapy

Updated randomized controlled trials featured in the standards of care show that treating depression simultaneously with diabetes yields the highest success rates when combined with lifestyle interventions. Clinicians are increasingly relying on **internet-delivered Cognitive Behavioral Therapy (CBT)** and structured nutrition programs, which have been shown to concurrently lower depressive markers and stabilize blood sugar levels. [1]

1. https://diabetesjournals.org/care/article/49/Supplement_1/S89/163932/5-Facilitating-Positive-Health-Behaviors-and-Well

2. https://www.psychiatrictimes.com/view/the-year-so-far-in-glp-1s-what-psychiatric-clinicians-need-to-know

3. https://www.facebook.com/scienceexplorist/posts/glp-1-drugs-may-do-more-than-help-control-weight-and-diabetes-they-could-also-he/1116363657615327/

Link to Diabetes Distress Tolerance Scale
https://professional.diabetes.org/sites/default/files/media/ada_mental_health_toolkit_questionnaires.pdf

ADA Mental Health Provider Directory Link
https://professional.diabetes.org/ada-mental-health-provider-directory