Insulin, mental health and risks to patient safety – a national examination of the issues

> *"The system is stacked against people with type 1 diabetes and mental illness."*

This statement was heard by the Health Services Safety Investigations Body (HSSIB) during its recent investigation examining patient safety and self-administration of insulin by patients in the community with a mental health problem. It found that people living with diabetes (requiring management with insulin) who experience a mental health problem do not always receive the care they require to ensure their safety and to support their quality of life (HSSIB, 2026a).

This comment piece draws out relevant findings of HSSIB's investigation for readers and their organisations to reflect on in relation to the care they deliver. This comment includes themes around self-harm.

Health Services Safety Investigations Body

HSSIB is an independent arm's-length body of the Department of Health and Social Care. Its role is to investigate patient safety concerns across the NHS and independent healthcare settings in England. Investigations aim to support improvements in patient safety across the healthcare system by making recommendations to national bodies and sharing learning for integrated care boards (ICBs) and other organisations.

HSSIB's work is directed by the *Health and Care Act* (2022), and the *Act* provides powers when undertaking its investigations. HSSIB cannot apportion blame, or civil or criminal liability, or decide whether any action needs to be taken against an individual by a regulatory body. To support this, protections mean specific evidence from its investigations must not be disclosed.

The investigation of focus in this comment was the first in a series examining patient safety associated with the self-administration of insulin (HSSIB, 2026b). It considered adults living in community settings who had experienced harm after not self-administering insulin as prescribed, either by missing doses or by administering too much. The investigation considered adults experiencing a mental health problem, including those with type 1 diabetes and disordered eating (T1DE).

Disengagement and discharge from specialist diabetes services

HSSIB found that, "Patients with a mental health problem and diabetes (requiring management with insulin) in the community are not always under the care of specialist diabetes services when this would be expected (for example, patients with type 1 diabetes)."

Patients described disengaging from specialist diabetes services as a result of feeling "judged" by specialists, who were perceived as taking a "finger-wagging" approach and using negative language about their self-management. Disengagement and/or a patient's mental health problem – such as an anxiety disorder – meant that some did not attend their specialist appointments. Some were then discharged from the specialist diabetes service after missing one or more appointments.

The investigation highlighted the importance of specialist diabetes services recognising the need to take a trauma-informed approach to patient care and to make adjustments to support access based on individual needs. A trauma-informed approach is "grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development" (Office for Health Improvement and Disparities, 2022), and this will influence a person's reaction to situations. Specialists need to explore why a patient may not attend an appointment; one family described non-attendance as a "warning sign" not "disinterest".

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Citation: Woodier N (2026) Insulin, mental health and risks to patient safety – a national examination of the issues. *Journal of Diabetes Nursing* [Early view publication]

“The disconnect between mental and physical healthcare was found to be the result of long-standing beliefs and the historical setup of healthcare models that have not recognised parity between mental and physical healthcare.”

The NHS Standard Contract requires provider organisations to ensure that “…any decisions to discharge patients after non-attendance are made by clinicians in the light of the circumstances of individual Service Users…” (NHS England, 2026). The Equality and Human Rights Commission (EHRC; 2018) states that it is the duty of a public service to anticipate reasonable adjustments for someone experiencing a physical or mental disability and to ensure these are provided on an ongoing basis. This is so that the person has equal access to services and the same level of care as someone without a disability.

Fragmented integration between diabetes and mental health services

HSSIB found that, “There is variable integration of mental health and specialist diabetes services in different parts of the country. This is despite recognition of the disconnect between services and the risks to patient safety and physical health.”

Mental health and diabetes teams involved in the investigation described a lack of collaboration and limited mechanisms for communication and to provide support to each other. As a result, some patients disengaged from specialist diabetes services because their mental health needs had not been adjusted for, and care being “passed back to their GP” and mental health teams with limited specialist knowledge of diabetes.

The disconnect between mental and physical healthcare was found to be the result of long-standing beliefs and the historical setup of healthcare models that have not recognised parity between mental and physical healthcare. Disconnect between the electronic patient record systems of mental health and specialist diabetes services was also found; this has created barriers to information sharing and has contributed to patient safety incidents.

The investigation highlighted the importance of formalising routes for collaboration between different organisations and the role of ICBs in facilitating this. It identified exemplars of successful collaboration, but these were not consistently available across the country. Collaboration includes the development of clear care pathways and routes for seeking advice between mental health and diabetes services, and the integration of digital systems to support data sharing.

Recognition of type 1 diabetes and disordered eating

HSSIB found that, “The combination of type 1 diabetes and disordered eating (T1DE) contributes to significant patient harm.” A person may be described as having T1DE if they have type 1 diabetes and disordered eating behaviours, or an eating disorder, or they restrict the amount of insulin they take – in order to reduce body weight or avoid weight gain (Breakthrough T1D, 2024).

People with T1DE face a three-fold higher mortality rate than people with type 1 diabetes who do not restrict insulin (Goebel-Fabbri et al, 2007). However, the condition is not widely acknowledged in practice or screened for. People with T1DE may present with repeated admissions to hospital in diabetic ketoacidosis. It may not be recognised that a mental health problem and associated self-restriction of insulin is contributing to the recurrence. A lack of recognition means the prevalence of T1DE is unclear; this has affected service planning and the commissioning of specialist care.

The investigation highlighted the importance of recognising the potential for someone to have T1DE and the need for specialist support. The Royal College of Psychiatrists (2022) has published an annexe to its medical emergencies in eating-disorders guidance that focuses on T1DE, with recommendations for assessment and treatment. The findings surrounding T1DE again demonstrate the importance of formalising routes for collaboration between mental health and diabetes specialist services.

Access to diabetes technology

HSSIB found that, “Some patients may be being disadvantaged by not being considered for continuous glucose monitoring or hybrid closed-loop systems due to their mental health problem.”

The investigation met multiple patients with type 1 diabetes who were under the care of mental health services, but only a small number had a continuous glucose monitor (CGM). While some

patients did not want a CGM, others described having never been offered one. None had an insulin pump or hybrid closed-loop system.

The investigation heard about assumptions that, because of a mental health problem, patients may not be able to use diabetes technology safely. By contrast, the investigation also learned about a specialist service that had clear safety criteria for placing a patient with a mental health problem on a hybrid closed-loop system. That service had seen positive outcomes for several patients, including where systems had reduced the burden of injection and decision making.

The investigation highlighted the importance of assessing and supporting patients to access technology safely, where appropriate (Diabetes Technology Network UK and Diabetes Psychology Network, 2023). Some patients may be having technology denied, which could, in certain circumstances, represent discrimination (EHRC, 2020).

Need for national action

As a national body, HSSIB's primary role is to make safety recommendations and observations in support of national action. In this investigation, several national factors were found to be influencing patient safety. These included gaps in regulatory oversight of care pathways, barriers affecting the ability of ICBs to support integration of different services and digital systems, and limitations in the design of diabetes technology to support accessibility and patient safety.

Through this investigation, HSSIB (2026) recommended that NHS England and the Department of Health and Social Care develop a strategic approach to supporting improved collaboration between mental health teams and diabetes specialist services, and to reduce variation across the country. HSSIB also highlighted the need for further research and guidance to support recognition and management of T1DE, greater coverage of diabetes and the risks associated with insulin in undergraduate and pre-registration healthcare programmes, and for manufacturers of insulin pen devices to consider how best to support patient safety through design.

Summary

HSSIB's investigation found that the healthcare system is unable to consistently meet the needs of patients with a mental health problem and diabetes (requiring management with insulin). While national action is required to support improvements in patient safety, the findings of the investigation also highlight considerations for ICBs, and individual organisations and practitioners.

Specifically, HSSIB shared the following local-level learning to be considered by readers:

- How does your organisation ensure patients with a mental health problem are not being discharged from clinics following a "did not attend" without consideration of their circumstances and risks to their safety?
- Do your staff recognise the need to make reasonable adjustments for patients, including for those with a mental health problem, to support access to care?
- Does your organisation have clear routes via which services can seek support from specialists in mental health if a patient is found to be experiencing a crisis?
- How does your organisation identify patients who have had recurrent admissions with diabetic ketoacidosis or hypoglycaemia, and support staff to consider whether these patients require input from mental health services?
- How does your organisation ensure patients with a mental health problem, who meet the criteria for diabetes technology, are receiving support to access it and are not being discriminated against because of their mental health problem?
- How does your organisation ensure information about patients is available to other providers of care when required (for example, to mental health teams about a patient's diabetes care)?
- How does your organisation ensure staff are aware of their responsibilities to report incidents associated with diabetes medication and technology, including to manufacturers and the Medicines and Healthcare products Regulatory Agency?
- Does your organisation have a process for identifying and appropriately supporting patients with type 1 diabetes who also have evidence of disordered eating? ■

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