JBDS-IP Joint British Diabetes Societies for inpatient care

The Management of Diabetes in Adults with Psychiatric Disorders in Inpatient Settings

Prof Hermione Price

Consultant Diabetologist

Hampshire and Isle of Wight Healthcare NHS Foundation Trust

Mustafa Mahdi (Specialist registrar)

Southampton General hospital

On behalf of the Joint British Diabetes Societies for Inpatient Care (JBDS-IP)

Association of British Clinical Diabetologists

DISN UK GROUP

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Declaration for Prof Hermione Price

I have no financial interests or relationships to disclose with regard to the subject matter of this presentation.

JBDS-IP Joint British Diabetes Societies for inpatient care

Contents

- Aimed at non-specialists in acute care and non-specialists in psychiatry.
- How to approach the person with diabetes and a mental disorder when presenting acutely
  - Case vignettes to illustrate applicability and dilemmas
  - Description of how to approach capacity assessments
- Management of complications including weight management and anti-psychotic associated weight gain
- Description of diabetes and psychiatry services

What are you thinking?

- Challenging group of patients perceived as a “problem”
- Often cause upset or disruption in teams and can be frustrating
- Acute colleagues want a solution to prevent further admissions
- Resident doctors feel alone managing patients with potentially life-threatening DKA yet who are refusing treatment
- Patients often unhappy with the care they have received
- Admissions can be extremely frequent and may require ITU care
- “Why can’t they just take their insulin?”

JBDS-IP Joint British Diabetes Societies for inpatient care

Patients requiring acute hospital admission for potentially life-threatening diabetic emergencies

- Acute decompensation of diabetes can result in potentially life-threatening scenarios including diabetic ketoacidosis (DKA) or hyperosmolar hyperglycaemic state (HHS)
- Urgent treatment is indicated and the recommended protocols can be found within other JBDS guidelines
- In general, people presenting with such emergencies are willing to accept hospital admission and the necessary care
- However, circumstances where treatment cannot be delivered as a result of the disordered mental state or pre-existing SMI occur
- Such scenarios are challenging both for healthcare professionals and patients.

JBDS-IP Joint British Diabetes Societies for inpatient care

Capacity

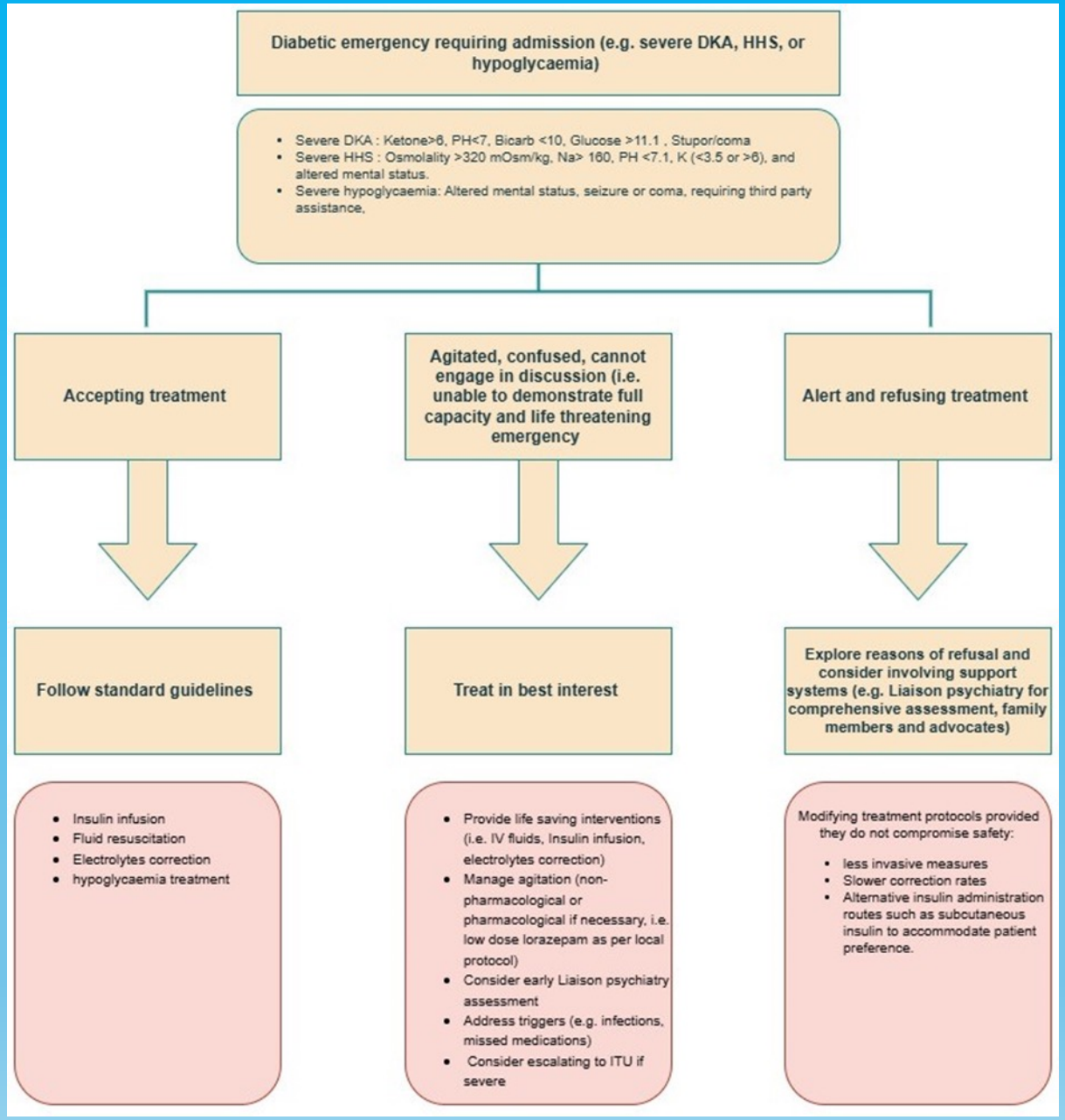
- Acute hospital staff find it difficult to assess mental capacity and to know when to use the Mental Capacity Act
- The assumption must always be that a person has capacity to make a decision until proven otherwise
- The concern lies when a person is felt to have capacity to refuse treatment offered, when a full assessment of their capacity as indicated by the MCA has not been fulfilled.
- This can lead to the withholding of appropriate treatment that would otherwise have been given in their best interest under the MCA
- Treatment against a patient's will is only justified when full capacity is lacking, and the intervention is considered to be in their best interest
- Clinicians should carefully balance patient autonomy with their duty of care, using input from specialists and ethical guidance where necessary
- Establishing trust through clear communication and addressing barriers to care can encourage patients to engage with treatment, reducing adverse outcomes associated with treatment refusal.

JBDS-IP Joint British Diabetes Societies for inpatient care

Considerations

- Talk to the person about their fears and concerns
- Access any mental health records they have that may shed more light on their diagnosis, thoughts and feelings and strategies to manage situations like this
- Can be tricky if records held in another trust or a different electronic patient record
- Liaison psychiatry can facilitate access to records
- Negotiate-can an established protocol be adjusted or adapted safely?
- Recognise when capacity has been regained-even if this means that treatment must stop
- Support staff involved-Balint Groups

JBDS-IP Joint British Diabetes Societies for inpatient care


Diabetic emergency requiring admission (e.g. severe DKA, HHS, or hypoglycaemia)
Severe DKA : Ketone>6, PH<7, Bicarb <10, Glucose >11.1 , Stupor/coma
Severe HHS : Osmolality >320 mOsm/kg, Na> 160, PH <7.1, K (<3.5 or >6), and altered mental status.
Severe hypoglycaemia: Altered mental status, seizure or coma, requiring third party assistance.
Accepting treatment
Agitated, confused, cannot engage in discussion (i.e. unable to demonstrate full capacity and life threatening emergency
Alert and refusing treatment
Follow standard guidelines
Treat in best interest
Explore reasons of refusal and consider involving support systems (e.g. Liaison psychiatry for comprehensive assessment, family members and advocates)
Insulin infusion
Fluid resuscitation
Electrolytes correction
hypoglycaemia treatment
Provide life saving interventions (i.e. IV fluids, Insulin infusion, electrolytes correction)
Manage agitation (non-pharmacological or pharmacological if necessary, i.e. low dose lorazepam as per local protocol)
Consider early Liaison psychiatry assessment
Address triggers (e.g. infections, missed medications)
Consider escalating to ITU if severe
Modifying treatment protocols provided they do not compromise safety:
less invasive measures
Slower correction rates
Alternative insulin administration routes such as subcutaneous insulin to accommodate patient preference.

When capacity is regained after a prolonged period

- A 53 year old gentleman with schizophrenia was detained under section 37/41 of the MHA in a medium security unit
- He has pre-existing type 1 diabetes, having been able to manage it independently and engage with diabetes specialists
- Symptoms from his schizophrenia included beliefs he would be cured of his diabetes from a divine power on the day he is discharged
- The nurses caring for him are now responsible for administering the prescribed doses of insulin at regular times, with no opportunity for the patient to be involved in the adjustment of the dose
- He is struggling with fluctuations in his daily blood glucose levels and cannot access additional doses of insulin for food consumed outside of set mealtimes.
- From the point of view of the mental health team, a discharge plan was proposed with a view to leaving the unit in one year
- This allows time for the man to be supported in regaining his self management skills including carbohydrate counting and insulin dose adjustment

JBDS-IP Joint British Diabetes Societies for inpatient care

When impairment of capacity persists

- Mrs M a 64-year-old woman with diagnosed personality disorder and poorly controlled diabetes was subject to the judicial process in the light of concerns about her welfare in relation to diabetes management
- Mrs M had lived alone since 2014 when her husband died. Concerns arose regarding her health and diabetes management when her condition deteriorated. Mrs M was discovered at home in 2017 in a state of severe self-neglect and was subsequently taken to hospital and then to a nursing home. An independent psychiatrist provided a report in respect of Mrs M's capacity, in which the psychiatrist determined that there would be an "*inevitable variation*" in Mrs M's mental state due to fluctuations in her blood glucose, which stemmed from her poorly controlled diabetes, in the context of diagnosed personality disorder.
- In a previous judgment in the same case, it was concluded that *"Mrs M had fluctuating capacity to decide as to the management of control of her diabetes particularly, as a result of her personality disorder, and that that aggravated her diabetes because it led to poor diabetic control and her making unwise decisions, and therefore her treatment and inability to cooperate with professionals"*.

JBDS-IP Joint British Diabetes Societies for inpatient care

- In the final written judgement by the Court, it was stated that:

a. *on the assessment of capacity to make decisions about diabetes management, in all its health consequences,* ***the matter is a global decision, arising from the inter dependence of diet; testing her blood glucose and ketone levels; administration of insulin; and admission to hospital when necessary, in the light of blood glucose levels****. And;*

b. *that Mrs M lacks the capacity to make those decisions and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change."*

JBDS-IP Joint British Diabetes Societies for inpatient care

Emotionally unstable personality disorder

- People living with an emotionally unstable personality disorder (EUPD) benefit from a structured approach in an acute medical setting
- HCPs may find challenges in balancing their duty to provide care with the expectations of patients in this group.
- Some of the most important principles in engaging with individuals with EUPD include setting boundaries and not over-promising with unrealistic expectations they may have e.g. treatment provided by a single HCP chosen by the patient.
- Whilst compassion towards patients needing care is a widely encouraged virtue in healthcare settings, patients with EUPD may be overly wanting of this compassion and feel personally rejected when the level of attention they seek cannot be met.
- It is to be kind yet firm with boundaries, creating better trust between patients and healthcare providers by being non-judgmental, and allowing patients to talk about their concerns.

JBDS-IP Joint British Diabetes Societies for inpatient care

Interactive cases:

T1DM with Eating Disorder (T1DE) – “Maya”

- Maya, 24, T1DM since 13, BMI 20.5, history of insulin omission.
- Presents with nausea, abdominal pain, ketones 4.8 mmol/L, pH 7.23.
- Refuses insulin: “It makes me gain weight.”

- **Question:** “What is your first action?”
- Start DKA protocol with security present
- Call liaison psychiatry immediately
- Respect autonomy and discharge
- Assess decision-making capacity for refusing treatment

T1DM with Eating Disorder (T1DE) – “Maya”

- Maya, 24, T1DM since 13, BMI 20.5, history of insulin omission.
- Presents with nausea, abdominal pain, ketones 4.8 mmol/L, pH 7.23.
- Refuses insulin: “It makes me gain weight.”

- **Question:** “What is your first action?”
- Start DKA protocol with security present
- Call liaison psychiatry immediately
- Respect autonomy and discharge
- **Assess decision-making capacity for refusing treatment**

Capacity Micro-Checklist

- Understand, Retain, Weigh, Communicate.
- Is refusal proportionate or illness-driven?
- Document and reassess regularly.

“What fears might be driving refusal?”

- **Fear of weight gain** – linked to body image and past comments after diagnosis.
- **Fear of insulin oedema** – swelling after re-insulinisation triggering distress.
- **Fear of loss of control** – anxiety about dependence on staff and treatment.
- **Fear of being judged** – previous negative hospital experiences.
- **Fear of failure or disappointment** – feeling blamed for poor control.
- **Underlying shame and secrecy** – around eating behaviours.

- Recognising these fears is key to empathy and to crafting a treatment plan she can accept

- REMEMBER : Language always matters !

Maya has capacity and continues to refuse IV insulin. What is your best next step?

- Respect autonomy and discharge
- Mental Health Act
- Call family
- Offer alternatives (e.g. SC insulin, slower fluids)

Maya has capacity and continues to refuse IV insulin. What is your best next step?

- Respect autonomy and discharge
- Mental Health Act
- Call family
- **Offer alternatives (e.g. SC insulin, slower fluids)**

Example Compromise Order Set

- SC rapid insulin every 1–2 hours.
- Oral/slow IV fluids.
- Anti-emetic, safety thresholds.

PS: Involve liaison psychiatry, nurse, GP, advocate.

When emotions are high, language matters. A few phrases help:

- ‘I can see this feels overwhelming — can I share why I’m worried?’
- ‘We can try insulin your way — let’s see if this works safely.’
- ‘If your ketones rise, we’ll need to escalate — does that sound okay?’

This preserves dignity and collaboration.

“Alex”: Severe DKA with psychosis

•**Alex**, 36, lives alone, history of **type 1 diabetes** and **schizoaffective disorder**.
•Known to mental health services; normally independent with insulin but recently stopped due to paranoid beliefs that “the insulin is poisoned.”
•Brought in by Ambulance after neighbours noticed confusion and vomiting.
•In ED: **BG 32 mmol/L**, **ketones 6.8 mmol/L**, **pH 6.95**, **K+ 6.0**.
•He’s drowsy but occasionally lucid, pulling out cannulas, saying “You’re trying to kill me.”
•Liaison psychiatry unavailable for 2 hours.

In a patient without capacity refusing treatment, what is your immediate step

- Wait for psychiatry
- Treat in best interests, least-restrictive
- Discharge as per refusal
- Section under MHA immediately for medical treatment

In a patient without capacity refusing treatment, what is your immediate step

- Wait for psychiatry
- **Treat in best interests, least-restrictive**
- Discharge as per refusal
- Section under MHA immediately for medical treatment

- In this case, the Mental Capacity Act applies. Even though his refusal stems from psychosis, the immediate issue is a **life-threatening physical condition** — DKA.
  Under the MCA, we can treat now in his *best interests*, ensuring it's the *least restrictive* way possible.

Six hours later, Alex’s pH has improved, he’s oriented and calm. He recalls earlier events vaguely and apologises. He says he’ll stop insulin again once home because ‘they’ might tamper with it. What is your next step?

- Respect autonomy and discharge
- involve liaison psychiatry for joint plan, and explore safer discharge options
- Compel insulin via MHA
- Keep under observation indefinitely

Six hours later, Alex's pH has improved, he's oriented and calm. He recalls earlier events vaguely and apologises. He says he'll stop insulin again once home because 'they' might tamper with it. What is your next step?

- Respect autonomy and discharge
- **involve liaison psychiatry for joint plan, and explore safer discharge options**
- Compel insulin via MHA
- Keep under observation indefinitely

- He may have regained capacity for simple decisions but not for the *complex* one of managing diabetes safely.

- This is where joint working with psychiatry, early family involvement, and detailed capacity documentation are crucial.

- You can’t discharge blindly — you must ensure a **multi-agency plan** is in place

Wrap up

- Capacity first, every time.
- Least-restrictive doesn’t mean least-effective — it means the minimum that keeps them safe.
- Negotiation beats coercion, and documentation is your safety net

Thank you

Mustafa.mahdi@uhs.nhs.uk