

Article

Barriers and Facilitators to Mental Health Treatment Among Adults with Type 1 Diabetes: Patient Perspectives on Access, Trust, and Care Gaps

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Abstract

Background/Objectives: Adults with type 1 diabetes (T1D) experience disproportionately high rates of depression, anxiety, and psychological distress, yet integration of behavioral health into diabetes care remains limited. The objective of this study was to identify barriers and facilitators to mental health treatment among adults with T1D, using the Behavior Change Wheel as a framework to inform future integrated care strategies. **Methods:** We conducted five online focus groups with 21 adults with T1D. Discussions were guided by a semi-structured guide, with questions on lived experience, accessibility of mental health treatment, and integrated service delivery informed by the COM-B model domains. Transcripts were analyzed using qualitative content analysis, whereby meaning units were open-coded and then deductively categorized into COM-B constructs of capability, opportunity, and motivation. **Results:** Participants described limited psychological capability to address mental health due to the heavy self-management burden of T1D, lack of knowledge about navigating care, and uncertainty about treatment interactions. Physical opportunities were constrained by fragmented systems, high costs, and competing responsibilities. However, co-located services and telehealth were viewed as facilitators. Social opportunity was shaped by stigma, isolation, and feeling burdensome, with peer communities providing critical support. Motivation was undermined by past traumatic encounters with psychiatric care and the burden of educating providers about diabetes, contributing to mistrust and avoidance of treatment. **Conclusions:** Findings highlight how capability, opportunity, and motivation interact to influence engagement with mental health care among adults with T1D. Addressing these barriers through tailored, integrated models of care may strengthen access, trust, and long-term treatment engagement.

Keywords: qualitative; chronic care; implementation processes; depression; behavior change wheel



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1. Introduction

Adults with type 1 diabetes (T1D) account for an increasing proportion of diabetes cases in the United States [1,2], with an estimated 1.7 million people affected [3,4]. This growing population faces a disproportionate burden of mental health challenges. People with T1D experience depression at three times the rate of those without diabetes [5].

Approximately 30% of adults with T1D report depressive symptoms, and 13.6% meet criteria for major depressive disorder [5,6]. Anxiety is also highly prevalent in this population, with about 14% meeting criteria for generalized anxiety disorder and over 40% reporting clinically relevant anxiety symptoms [7,8]. The psychosocial burden of diabetes contributes to diminished self-care behaviors, poorer glycemic control, and elevated risk of complications [9,10], highlighting the need for targeted mental health screening and treatment. Accordingly, the American Diabetes Association recommends routine assessment of diabetes distress, depression, and anxiety using standardized tools at initial visits and periodically throughout treatment of T1D, with more frequent assessments as warranted by changes in clinical status or life circumstances [11,12].

Despite these recommendations, a substantial mental health treatment gap persists among people with T1D [13]. Few cross-sectional and longitudinal studies have examined how often individuals with T1D are screened for mental health concerns or how such screenings influence diagnosis and treatment. Those that do, however, focus on pediatric patient populations across a smaller number of clinical sites, with some studies being conducted exclusively in international settings [14–16]. In addition to overlooking adult mental health care needs, existing research highlights gaps in healthcare systems' ability to provide access to mental health care. Fewer than half of diabetes practices in the U.S. have integrated behavioral health professionals into routine care within their clinical settings [17]. Given that most people with T1D regularly engage with primary care physicians and endocrinologists, these settings represent critical opportunities to implement integrated mental health services [18,19].

Collaborative care has been proposed as one strategy to integrate physical and mental health services for people with diabetes [20–22]. However, most trials have enrolled small samples of adults with T1D or altogether exclude them [23,24], limiting the evidence on the unique mental health needs and barriers to care experienced by people with T1D. Other integrated care models have been developed for youth with T1D [25–27], yet their reach and generalizability remain limited due to small sample sizes and insufficient reporting on racial, ethnic, and socioeconomic diversity [25–27]. To improve the delivery of integrated care for adults with T1D, it is essential to first identify barriers and facilitators to mental health care, with particular attention to the perspectives of those with lived experience [20].

Current implementation approaches in mental health care among people with diabetes are largely technology-driven, including telehealth and smartphone applications that facilitate remote access to services or that provide contextual psychosocial information relevant for self-management [27–30]. While valuable, these models often emphasize short-term, self-directed management rather than sustainable access to clinicians or long-term treatment. Additionally, most strategies are evaluated in a pre–post test design with limited follow-up time for those using randomized control trials. Emerging research highlights the importance of the built environment and telemedicine environments in shaping access to and experiences of mental health care. Studies show that the physical design of clinical spaces can itself act as a therapeutic intervention, influencing patient comfort, trust, and emotional well-being [31]. Similarly, the rapid expansion of telemedicine has underscored how poorly designed virtual environments can create barriers, particularly for groups who may face challenges with privacy, digital literacy, or access to quiet, secure spaces for care [32]. Integrating attention to these environmental factors into diabetes and mental health services could enhance the effectiveness and equity of integrated care models for adults with T1D.

Taken together, these gaps underscore the need for theoretically guided and systematic approaches to understanding how adults with type 1 diabetes access and experience mental health care, yet prior studies have not applied such frameworks to identify barriers and

facilitators to treatment. The COM-B model is one such determinant framework that has been applied to examine targeted healthcare-seeking behavior and chronic disease self-management [33–36]. The COM-B model proposes that the components of capability (i.e., psychological and physical ability), opportunity (i.e., supportive physical and social environments), and motivation (i.e., supportive internal processes) interact to inform behavior [37]. As part of the Behavior Change Wheel framework [37], the COM-B model supports the design of strategies to address identified barriers, making it especially useful in health systems research where gaps between knowledge and practice remain. To date, no studies have applied this model to examine barriers to mental health care, particularly among adults with type 1 diabetes.

The present study addresses this gap by identifying barriers and facilitators to integrating mental health treatment into diabetes care for adults with T1D. Guided by the COM-B model [37], we aim to identify determinants of mental health treatment that can then be used to inform the selection of implementation strategies that advance sustainable integration of physical and mental care for this high-risk population.

2. Materials and Methods

This study employed a qualitative content analysis approach to examine barriers and facilitators to mental health treatment among adults with Type 1 Diabetes [38]. Guided by the COM-B model as a deductive framework [37], participant accounts were categorized into domains and sub-domains of capability (psychological and physical), opportunity (physical and social), and motivation (automatic and reflective) to better understand barriers and facilitators to mental health care in this population. Focus groups were selected as the primary method of data collection because they support sharing and reflection on lived experiences, while also capturing group-level dynamics such as interactions, commonalities, and divergences across participants. This design facilitated the collection of detailed accounts of the psychological, social, and structural complexities of seeking mental health care as an adult with T1D.

2.1. Participants

Data were collected between August 2023 and February 2024. Participants were recruited through informational flyers that invited people with lived experience to contribute to addressing the mental health needs of individuals with type 1 diabetes, with a particular focus on integrating depression and diabetes care. The flyers outlined eligibility criteria, noted that financial compensation would be provided, and included instructions for contacting the study team to be screened for participation. These flyers were distributed in Atlanta diabetes clinics and via ResearchMatch online. Inclusion criteria required participants to be adults aged 18 years or older with a diagnosis of type 1 diabetes who self-reported one or more of the following: having ever sought mental health treatment, having been diagnosed with a mental health condition, or having ever taken or currently taking medication for a mental health condition. While eligible participants were purposively sampled to include variation in the mental health treatment criteria, individuals were not excluded if they had not received a diagnosis or treatment of a mental health condition, as restricting participation to those who successfully accessed care would have systematically biased information on barriers. Individuals who expressed interest were screened by phone, and among those who were screened and found eligible, individuals provided consent before being scheduled for an online focus group discussion.

2.2. Ethical Issues and Consent

The study (#00006177) was considered human subjects research but exempt from further review and approval by Emory University Institutional Review Board (IRB) under 45 CFR 46.104(d)(2)(iii) because the research only involved interactions involving the use of survey and interview procedures. However, researchers adhered to the ethical standards set by the World Medical Association Declaration of Helsinki while performing the research [39]. All participants provided written informed consent prior to data collection activities and confidentiality procedures were implemented during study activities to ensure participants' privacy was protected.

2.3. Data Collection

The first author, a doctoral-level researcher with a decade of experience conducting qualitative research related to chronic disease management and health service delivery, moderated the online focus group discussions. The moderator does not have clinical training and had no prior relationship with study participants. A semi-structured topic guide was used to prompt information on the lived experience of T1D, emphasizing the intersections of T1D and mental health, self-management practices, treatment access, and perspectives on integrated physical and mental health services. The questions on health service integration were informed by the COM-B model, with open-ended probes used to elicit detailed information on the domains of capability (e.g., where to seek treatment and ability to do so when experiencing symptoms of depression and/or T1D), opportunity (e.g., availability of mental health professionals), and motivation (e.g., perceived value of seeking mental health care) to generate feedback for future intervention development. The guide was piloted, though no major revisions were required.

Participants completed an online sociodemographic survey prior to their scheduled focus group discussion. Focus groups were conducted on a rolling basis, with each group convened once 5 to 8 enrolled participants indicated a shared availability, and continued until theoretical saturation was reached [40]. Because coding occurred in parallel with data collection, it was considered complete when no new codes emerged, and it was determined that additional groups would not generate new insights. Sessions lasted 80–100 min, were audio-recorded, transcribed verbatim, and de-identified for analysis. Participants received \$30 compensation for participating.

2.4. Data Analysis

We employed a qualitative content analysis approach [38], whereby transcripts were first de-contextualized into discrete meaning units through an open coding process. Meaning units were then condensed and grouped into preliminary codes. This process was first applied to two transcripts, with the moderator and two master of public health students trained in qualitative methods independently coding, comparing, and establishing an initial codebook. The two students then coded the remaining transcripts, which were iteratively refined through team discussions to ensure consistency and credibility. All study team members identified as female and were in their twenties or thirties.

In the re-contextualization phase, codes were organized deductively according to the domains of the COM-B model (capability, opportunity, and motivation), which served as the guiding framework for categorization. Within each domain, codes were further examined to identify patterns, divergences, and illustrative participant accounts. Throughout the process, we used analytic memos and team debriefing to document decisions and reduce bias. Data management and coding were conducted in MAXQDA version 24.4.1.

3. Results

A total of 21 adults with T1D participated in five focus groups. Table 1 describes the sample characteristics.

Table 1. Sample Characteristics.

Characteristic	N
Age, years, mean (STD)	38.1 (14.5)
Years since diagnosed with T1D, mean (range)	19 (5–50)
Gender	
Female	15
Male	3
Non-binary	3
Race	
White	15
Black/African American	4
Native American/Alaskan native	1
Multi-racial	1
Hispanic/Latino	4
U.S. Region of Residence	
South	15
Northeast	2
Midwest	2
West	2
Education Level	
High school graduate or GED	1
Some college-level technical or vocational degree	4
Bachelor's degree	12
Other advanced degree (master's, doctoral degree)	4
Employment Status	
Working (full-time)	10
Working (part-time)	1
Retired	2
Disabled	4
Staying at home as caregiver	1
Student	3
Marital Status	
Married	5
A member of an unmarried couple	4
Divorced	1
Single	11
Household Composition *	
I live alone	6
Spouse or partner	7
Children	6
Parents	4
Other people not related to me	2
Mental Health Care Experience	
Ever sought mental health treatment	21
Ever diagnosed with a mental health condition	18
Ever or currently taking medication for a mental health condition	15

* Participants could select more than one response option.

The barriers and facilitators of mental health treatment among adults with T1D are presented below according to the corresponding COM-B model domain and sub-domains.

3.1. Capability

3.1.1. Psychological Capability

Participants described how the constant demands of T1D management, including monitoring blood sugar, planning meals, and anticipating diabetes-related emergencies, limit their psychological capacity to also pursue mental health care. As one participant noted:

I think the burden is so great. One of my favorite lines is having type one is like having another full-time job. It's even worse than a full-time job because it's 24/7. And so, there's just so much, I like the word distress because I think there's so much distress involved in it because it's just constant.

Given the amount of self-management behaviors already required for diabetes care, many reported that it was overwhelming to factor in their mental health needs. Individuals repeatedly referenced the mental burden of having T1D, with one individual summing it up as, “[T1D] is something I have to think about every minute of every day.” Eating disorders were also described as particularly common in this population, compounding stress around food and diabetes management and further limiting the capacity to prioritize mental health needs.

While some participants reported currently engaging in therapy or taking medication for mental illness, most noted a lack of knowledge about how to identify and access a mental health professional, even when they wanted to seek care. The majority of individuals were also unsure of what benefits were available through their insurance plan and the best way to use them without incurring out-of-pocket costs. Although all participants recognized the bidirectional impact of T1D and mental health, many expressed uncertainty about how mental health treatments might interact with diabetes care. This lack of knowledge often led them to perceive potential risks as outweighing the benefits, creating hesitation to pursue mental health services. Several participants also highlighted the lack of provider understanding of these intersecting challenges and recommended tailored support from diabetes-specific psychologists. A minority of participants had sought out such services and were more inclined to continue using them because those providers had a baseline knowledge of T1D and knew how to integrate mental health care into their diabetes care.

Participants described coping mechanisms that helped them manage the mental and emotional demands of T1D, thereby increasing their psychological capacity to seek and sustain management of their mental health condition(s). Flexible work arrangements reduced the sense of being overwhelmed, while physical activity and advance planning helped preserve mental bandwidth. Exercise was frequently noted as an effective coping tool:

And for me, especially with my anxiety, exercising really helps me. During the beginning part of the pandemic, I stopped because I was going somewhere to exercise and really noticed a difference in my mood and then found a way how to do it at home so I could get back to it. So, it's been really important, not just for blood sugar and weight loss, but really more for my mental health.

Participant accounts highlighted how supportive social environments designed to enhance knowledge of mental health treatment options, tailored coping strategies, and attention to mental health can strengthen psychological capacity to manage health needs and ease the overall burden of living with T1D.

3.1.2. Physical Capability

Physical limitations linked to depression and burnout were also described. Participants reported difficulty even getting out of bed to manage their diabetes when experiencing symptoms of depression, which in turn worsened both mental and physical health and management practices. This was best summarized by one participant who shared:

And for me, if I get hit with quite a bit of depression, I don't want to get out of the bed. I just want to stay in the bed and try to sleep, because I know when I'm asleep, I wouldn't be thinking about it.

Participants suggested that integrated care delivered via telehealth could help overcome barriers created by symptoms of mood disorders that make it difficult to attend in-person clinic visits.

3.2. Opportunity

3.2.1. Physical Opportunity

Logistical and financial barriers were frequently cited. Short appointment times, fragmented care, and insurance restrictions make it difficult to coordinate diabetes and mental health treatment. Cost was another major barrier. As one participant shared, "I wish I had known it was going to be so [explicative] expensive to be alive." Seeking mental health treatment was viewed as another time and financial costs on top of those already required for diabetes management. For many, the opportunity cost of seeking additional care for their mental health was considered to come at the expense of other work and family responsibilities, which could have negative financial consequences (e.g., asking for too much time off work could result in job loss). Telehealth was viewed as an acceptable way to support access to mental health care, potentially allowing for more flexible scheduling to meet the constraints of competing scheduling demands. However, most expressed a desire to discuss more sensitive mental health concerns with a trained professional, ideally in person, over the use of other mental health support tools (e.g., meditation apps, chatbots).

Participants emphasized that co-located diabetes and mental health services, or the integration of behavioral telehealth, would be key facilitators of integrated care. As one participant explained, "If we can make time for reading my blood and urine numbers, then let's make time for that. And just know that twice a year I'm going to tack on 15 min of appointment or 30." Others agreed that access to a behavioral health professional during routine diabetes visits would reduce the financial and logistical burdens of multiple appointments. Participants perceived that this care model would improve their overall health by overcoming the limitations of working in a siloed medical system, with one sharing:

If this team was like physically in the same area, I can see it maybe being more successful where it's not an additional appointment that takes six weeks to get. It's more like, well, we've had this conversation, let me introduce you and then you're going over to talk to the counselor... physically it'll feel more like a team of we're all working together to feel better and self-manage.

Participants consistently noted that the cost of additional visits, particularly when insurance benefits were exhausted, was a prohibitive factor, underscoring the appeal of co-located or bundled services.

3.2.2. Social Opportunity

Participants described how the natural isolation that accompanies T1D can limit opportunities for social support that encourages and increases access to mental health care, particularly because others often lack an understanding of the disease and its impact on mental health. Others echoed that isolation is pervasive, even when social networks exist, reflecting how difficult it is for those without T1D to fully grasp its toll. One person shared, "So the more so you're feeling depressed and you're feeling lonely, then the isolation it truly does exist. Even with social networking, with all those things... having type one is isolating." Several noted how this disconnect left them feeling like a burden to loved ones when additional needs arose. As one participant explained:

Because if I'm having a lot of mental issues with [T1D], being in a lot of pain, missing out on birthdays, missing out on things that other people, say my family, can do and getting depressed for it. I just have to go to bed because there's not really a solution other than trying to remind myself, did I take my medicine today? Is this because I didn't take my medication? And then feeling like I'm a burden to people.

This lack of shared understanding often reinforced stigma and loneliness. To cope, some participants described seeking support from peers who share the same lived experience. Online and in-person communities were viewed as valuable sources of solidarity and understanding, with one person stating, *"If you don't have physical people around you, I feel like finding a group online or in person at a doctor's office is super helpful."*

Taken together, these accounts highlight how limited awareness of the impact of T1D places the burden on individuals to seek out mental health care and support on their own. Compounded by negative social perceptions of mental illness, many are less vocal about their needs and therefore rely more heavily on peer communities as critical support networks for mental health in the context of T1D. Individuals expressed openness to discussing mental health with a trusted medical provider, including their endocrinologist, if the conversation were initiated in a more conversational manner rather than solely through standardized screening tools.

3.3. Motivation

3.3.1. Automatic Motivation

Past experiences with psychiatric care were often described as traumatizing and diminished participants' willingness to seek future mental health treatment. Medical crises related to T1D, combined with dismissive or uninformed providers, created lasting anxiety and mistrust. Others highlighted how institutionalized psychiatric care reinforced fear and distrust, making them reluctant to disclose symptoms in future encounters:

Especially if you have been institutionalized in psych wards and treatment centers like what I've gone through, then there's a level of trauma there where you don't want people to weaponize your degree of depression. So, there might be incentive to lie about the degree of depression you're actually experiencing.

These accounts underscore how prior negative experiences shape automatic emotional responses, such as fear, avoidance, and mistrust, that reduce motivation to seek mental health care in the future. Nearly all participants expressed that they purposefully provide misleading answers to clinical depression screeners in order to avoid being coerced into a mental health treatment plan that they do not feel is safe or consent to engage in. To overcome these barriers, participants expressed a desire to disclose mental health needs to trusted clinicians. For those who had previously been institutionalized for mental health treatment, they stressed the need for diabetes care providers to take a trauma-informed approach when screening and linking patients to mental health treatment.

3.3.2. Reflective Motivation

Participants emphasized that seeking mental health care was often hindered not by a lack of motivation to care for themselves, but by the exhausting barriers involved in accessing appropriate support. Several described the discouraging process of searching for providers who understood the intersection of T1D and mental health. As one participant explained after recounting the lengthy process of finding a new psychiatrist following several lows that resulted in emergency care and posttraumatic stress disorder symptoms: *"He was blown away that diabetes could cause such a thing. And it was like, have you even thought about what this disease entails? Like how close I've been to dying so many*

times?” The burden of having to educate mental health providers about diabetes was described as unappealing and shaped participants’ willingness to pursue care in the future. This reinforced a sense that mental health treatment might not meet their needs, thereby dampening motivation to engage despite recognizing its potential value.

4. Discussion

Findings from the focus groups highlight the complex and multi-layered barriers and facilitators adults with T1D face to accessing mental health treatment. Participants emphasized how the constant demands of T1D shaped their capability, opportunity, and motivation to pursue mental health services. Psychological capability was constrained by the heavy mental workload of diabetes self-management, limited knowledge of how to access or navigate mental health care, and uncertainty about how treatments might interact with diabetes, though some were successful in accessing care because they identified providers who were educated on treating mental illness in the context of T1D management. Opportunities for accessing mental health care were often curtailed by logistical and financial barriers, including high costs, fragmented systems, and the competing demands of work and family responsibilities. At the same time, participants identified that co-located or telehealth-based services could ease access by reducing travel, cost, and time burdens. Social opportunity was also limited by the isolation of living with a condition few others understood, leading participants to feel stigmatized or burdensome, but some found support through peer communities online. Motivation was shaped by prior negative or traumatic encounters with psychiatric care, which left lingering mistrust and avoidance of future mental health services, while reflective motivation was undermined by the exhausting process of finding providers knowledgeable about the intersection of T1D and mental health. Taken together, these findings illustrate how capability, opportunity, and motivation dynamically interact to influence engagement with mental health care in the context of T1D, underscoring the need for tailored, integrated models of support.

This study contributes an adult-centered and theory-driven perspective that complements the literature dominated by pediatric and adolescent populations. Our findings align with prior work demonstrating that individuals with T1D experience disproportionately high rates of psychological distress, depression, and disordered eating, yet encounter structural barriers in accessing care [41–43]. Consistent with reports in youth populations, participants described limited follow-through after mental health screening, reflecting similar gaps in which only one-quarter to one-half of young people with positive depression screens ultimately engage in therapy [44]. Importantly, participants stressed that routine screening alone is insufficient without warm handoffs, trust-building, and trauma-informed processes to reduce concealment of symptoms, underscoring a refinement to current recommendations that emphasize universal screening as a pathway to care [20].

Novel to this study is the identification of prior negative psychiatric experiences, including coercive treatment or hospitalization, as drivers of avoidance and underreporting. This dimension of automatic motivation is rarely described in existing frameworks, yet it is highly consequential for care engagement. Participants also reported the burden of needing to educate mental health professionals about diabetes-specific issues, a finding that reinforces calls for embedding diabetes-literate mental health specialists into care teams [45]. Together, these results strengthen the rationale for co-located or integrated models, wherein behavioral health support services are delivered alongside diabetes care to reduce logistical and educational burdens for patients.

Our findings are consistent with emerging evidence that technology can bridge gaps in access, particularly through tele-psychology and tele-nursing [46,47]. Participants endorsed telehealth as a valuable tool but also expressed a preference for sustained human connection

over stand-alone digital tools and voiced a need to have clinicians work in communication to meet patient health needs through collaboration across disciplines. This perspective mirrors scoping reviews, which found that while technology-enabled programs effectively support clinical integration (i.e., coordinating person-centered care), they often fail to achieve professional (i.e., interprofessional care models) or organizational integration (i.e., interorganizational relationships to deliver comprehensive services) without parallel system-level reforms [47].

Pharmacological care emerged as another domain of concern. Rising psychotropic prescriptions among youth with T1D [45] and the associated risks of metabolic side effects create tension for adults wary of medication-based approaches. Participants' hesitancy reflects not only concerns about side effects but also distrust in non-specialist prescribers, reinforcing the need for stepped-care pathways where cognitive behavioral therapy and other evidence-based psychotherapies are offered prior to or in conjunction with pharmacotherapy [20,48].

By mapping barriers and facilitators onto the COM-B model, this study provides practical targets for intervention design. Capability deficits (e.g., emotional exhaustion) may be addressed through low-intensity counseling interventions such as problem-solving therapy [48]. Opportunity-related barriers, including cost and scheduling, are mitigated by bundled visits and telehealth integration. Motivational barriers rooted in trauma or stigma necessitate trauma-informed, trust-based engagement strategies. These findings support recent policy recommendations to embed mental health screening, referral pathways, and specialist access within diabetes services [20], while expanding the conversation to include patient-driven solutions such as co-located services and peer support. Findings from this study suggest that co-design methods involving people with lived experience are essential for developing patient engagement strategies that improve mental health care utilization. In addition, participants' perceptions of diabetes care providers point to the need for health system interventions that increase awareness of type 1 diabetes-specific differences in self-management and provide tailored education and training related to mental health treatment.

Strengths and Limitations

In this study, we used online focus group discussions to capture a diverse array of experiences and perspectives on challenges and opportunities to increase access to mental health services for adults with T1D. Strengths of the study include national representation, with participants from all regions of the United States, as well as variation in age, gender identity, and social background, enhancing the breadth of perspectives captured. However, the sample was not sufficiently diverse to support comparisons across participant subgroups. The study was further strengthened by the use of purposive sampling to include individuals with prior experiences seeking or engaging in mental health treatment, ensuring that the sample included those most likely to provide relevant insights into barriers and facilitators of care. Because a minority of individuals were not engaged in treatment, it is possible that findings are biased more towards those who have engaged with care systems. Because we did not collect data on the specific mental health conditions of participants with diagnoses, our ability to compare experiences across conditions was limited. Nevertheless, participants reported unmet treatment needs for conditions beyond depression, which we noted in the results. Conducting discussions virtually also enabled participation from individuals who may not have been able to attend in-person sessions due to geographic, financial, or health-related constraints, thereby increasing accessibility. Although selection bias related to technological literacy may have influenced participation, the study team employed multiple recruitment strategies, both online and in clinical settings, and provided participants with support in advance of sessions to ensure they could access and engage in

discussions. As with any focus group, there is a risk of recall and response bias. We used rapport-building questions to help participants feel comfortable, and this was reflected in their willingness to share sensitive information across all discussions. Finally, the use of the COM-B model to inform both data collection and analysis provided a strong theoretical grounding, enabling the identification of barriers and facilitators in a structured manner that can directly inform the design of future integrated care interventions.

5. Conclusions

This study demonstrates how the COM-B model can illuminate the complex barriers and facilitators shaping mental health care engagement among adults with T1D. Findings show that capability is constrained by the cognitive demands of self-management and limited patient and provider understanding of how mental health treatment impacts T1D management, opportunity is restricted by financial, logistical, and social barriers, and motivation is shaped by both mistrust and prior negative experiences. Participants emphasized that integrated, co-designed models—particularly those embedding mental health specialists within diabetes care and leveraging telehealth—are needed to reduce the treatment gap and support sustainable engagement.

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Data Availability Statement: The datasets presented in this article are not readily available because the data are part of an ongoing study. Requests to access the datasets should be directed to the corresponding author.

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Abbreviations

The following abbreviations are used in this manuscript:

T1D Type 1 Diabetes

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