Implementing a peer-support intervention for people with type 2 diabetes: a qualitative study

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Objective. This qualitative study aimed to explore participants’, peer supporters’ and practice nurses’ experience of the implementation of a peer-support intervention for people with type 2 diabetes.

Methods. The study was conducted in family practice in Ireland. Participants were selected from the patients, peer supporters and practice nurses who participated in a 2-year randomized controlled trial of peer support in type 2 diabetes. The sample consisted of 6 practice nurses, 15 peer supporters and 33 intervention participants. Data were collected using focus groups and semi-structured interviews and transcribed verbatim. Key themes and concepts were identified using framework analysis.

Results. The following themes emerged: who gets invited to be a peer supporter?; training and support for peer supporters; and peer-support meetings and challenges of delivering a peer-support programme. Recruiting peer supporters via the general practices was successful. Although some peer supporters were hesitant to participate initially, they were satisfied in their role and felt well trained and supported. Participants were overwhelmingly positive about the peer-support meetings. They welcomed the fact that the meetings were led by a peer; however, some participants reported that they would have liked occasional input from health professionals. The ‘Frequently Asked Questions’ element of the intervention was very popular with both participants and peer supporters.

Conclusions. This study revealed that it was feasible to implement a peer-support intervention in the general practice setting. Challenges of delivering such an intervention were identified, particularly in relation to meeting attendance, and should be considered in further research in the area.

Keywords. Intervention studies, qualitative research, support groups, type 2 diabetes mellitus.

Introduction

Type 2 diabetes has become a major global public health problem.\textsuperscript{4} In 2005 the prevalence of type 2 diabetes among adults in the Republic of Ireland was estimated at 4.5%.\textsuperscript{2}

Many people with type 2 diabetes have expressed the desire to share personal experiences of their illness.\textsuperscript{3} Dennis et al. define peer support as the provision of support from an individual with experiential knowledge to a person with a similar health-related issue.\textsuperscript{4} The World Health Organization advocates that peer-support programmes may potentially complement the health care provision to people with type 2 diabetes.\textsuperscript{5} It is now emerging as a popular intervention in the management of type 2 diabetes.

The evidence surrounding peer-support programmes for diabetes is growing. A recent systematic review identified 25 studies of peer support in type 2 diabetes that met their inclusion criteria.\textsuperscript{3} Some benefits of peer support were identified; however, the authors conclude that ‘the evidence is too limited and inconsistent to support firm recommendations’ (p. 1361). They also note much heterogeneity in the design of the studies.\textsuperscript{5} There is still limited literature on how best to approach, design and implement such programmes in different contexts.\textsuperscript{6}

This study was part of a research programme designed to develop and evaluate a peer-support programme for people with type 2 diabetes in primary care. It was a qualitative study, nested within a cluster randomized controlled trial (RCT) of peer support in type 2 diabetes that has been described and reported
The intervention consisted of peer-support meetings, which were held in general practice and facilitated by peer supporters. It is outlined further in Box 1. The intervention described was developed using the Medical Research Council Framework for the design and evaluation of complex interventions to improve health outcomes. The selection and training of peer supporters and the timing and content of peer-support meetings were based on pilot and exploratory work including initial qualitative research in order to achieve the best balance between training of peer supporters while maintaining ‘peerness’; feasibility of work for volunteer peer supporters; and timing and content of meetings over a 2-year intervention period.

**Methods**

Participants were selected from the 20 general practices, 395 patients and 29 peer supporters that participated in the main RCT. Six practice nurses, 15 peer supporters and 33 patients from the intervention group participated in this qualitative study. Stratified purposeful sampling was used in order to recruit participants from a wide range of general practices that differed in size (large/small) and location (urban/rural and affluent/deprived areas). Data collection was conducted in the general practices.

Data were collected using focus groups and semi-structured interviews. The focus groups were designed in accordance with the guidelines stipulated by Morgan and Krueger. Prior to the focus groups and semi-structured interviews, participants received a participant information sheet. Five focus groups were conducted with patients. Two focus groups and one semi-structured interview (arranged with an individual who could not attend the focus group) were conducted with peer supporters. Six semi-structured interviews were conducted with practice nurses. Focus groups were conducted by a facilitator/moderator and an observer. The topic guides for the focus groups and interviews with peer supporters, participants and practice nurses are presented in Boxes 2–4. Each focus group and semi-structured interview was audio recorded (with consent) and transcribed verbatim in preparation for data analysis. The semi-structured interviews were conducted by one interviewer.

The transcripts were reviewed and coded by two researchers (KK and MDE). The data were analysed using framework analysis, a matrix-based method of analysing qualitative data. The five key stages of familiarization—identifying a thematic framework; indexing; charting; mapping; and interpretation—were followed. The data were then classified according the emerging key themes and concepts.

Ethical approval for the RCT and the parallel qualitative evaluation was granted by the Irish College of General Practitioners.

**Results**

The following themes related to the design and implementation of the peer-support intervention emerged in the analyses:

(i) Who gets invited to be a peer supporter?
(ii) Training and supporting the peer supporters.
Who gets invited to be a peer supporter?

GPs and practice nurses from the intervention practices selected potential peer supporters from their patient lists. We adopted this approach as they knew their patients well and were therefore in a position to select individuals who met the inclusion criteria for being a peer supporter (Box 1).

Some peer supporters were hesitant to take on the role and needed encouragement from the GPs and practice nurses.

well, I thought I wouldn’t be capable of doing anything like that

(Peer Supporter 5)

I said, ‘well look, I’ve enough problems looking after myself … my opinion was that when I’d go up there that the people that would be there would be expecting me to be medical and that I would have all the answers to their problems

(Peer Supporter 10)

Practice nurses recognized the potential difficulties in identifying appropriate peer supporters and the importance of selection being based on prior knowledge of their patients.

you’d have to have somebody that’ll motivate and, you know, it’s easier said than done to get somebody like that who’s, you know got the condition and has the time. … because often times, if they’re motivated they’re at work or something … (GP’s name) picked the leaders but just from the patients that he knew that he would have thought would have – you know – they would be good at doing these things

(Peer Supporter 13)
I suppose I know the patients … I knew who would be good at it and who wouldn’t be sort of too bossy and who wouldn’t be too pushy and – or too quiet  

(Practice Nurse 4)

Training and supporting the peer supporters

Support from the project team and practice staff. Peer supporters were supported by the project manager and the practice staff. Peer supporters were very positive about the preparation and support for their role they received from the research team and the practice staff.

the organisation was very good, she [project manager] was terrific, anything you wanted she got … she was terrific the way she came back with everything …. I thought the whole thing was very well organised  

(Peer Supporter 1)

If somebody came in with a problem we tried all, not just me … to send that person with the problem away clearly knowing what to do … if they weren’t able to do that at the meeting we would consult [project manager] and the expert group[research team]  

(Peer supporter 2)

It was perfect … it ran fine  

(Practice Nurse 6)

They [peer supporters] had marvellous support from her [project manager]  

(Practice Nurse 4)

The peer supporters valued the perceived ‘back up’ and the sense that the meetings were taking place within a known environment such as their own general practice.

… at least I knew that if anything came up [during the meeting]or anybody took ill, she [practice nurse] was on the premises and that was support for me which I found excellent  

(Peer Supporter 7)

Updates for peer supporters. Peer supporters were invited to two group meetings with other peer supporters during the intervention period. These meetings were informal and led by the research team who provided updates on diabetes management and a guest speaker who was a well-known national figure who herself had diabetes. Several peer supporters would have liked more updates during this time.

the one thing I would have liked from it – the same-developments, what’s taken place since we started? Like, in medicine, new developments, medical science goes very fast and I don’t think we touched that area at all during the two year  

(Peer Supporter 1)

… refresher course, every six months we’ll say – not even, maybe just once in the year, just to top up  

(Peer Supporter 6)

In summary, the peer supporters identified supports needed throughout the process, firstly in preparing for their role, then the support from practice staff if needed during meetings and finally the ongoing support from the research team between meetings.

Peer-support meetings: what helps them work?

Participants’ views. Participants were overwhelmingly positive about their experiences of the meetings there was nothing bad about it  

(Participant 14)

I think it was great now to get altogether and see what they had to say and to meet with other people
... and I felt quite comfortable with that, you know, because if I didn’t go I’d be afraid I’d miss out on something

(Participant 8)

Participants reported positive views about the leaders being their peers

He was just like one of us

(Participant 19)

She’s [peer support leader] a lay person. ... she knows us and we know her, that’s the difference

(Participant 2)

The issue of having health professionals present at the meetings was discussed. This raised some ambivalence. Some felt that the fact that the meetings were not professionally led was attractive.

we all seem to have this thing that we’ve had enough of doctors and nurses, so get over to them that it’s not with doctors and nurses, it’s yourselves and that might bring, it might get people who’d think ‘Oh no, I’m not going to another clinic’, because immediately – well I don’t know about the others but immediately after you’re diagnosed you’re going to so many things and you’ve go to a dietician, you go to a foot person, you go to this person, you go to that person and, you know, and they all chop and change and you’ve nobody else to talk to …

(Participant 1)

However, others didn’t express a preference between professional- or peer-led meetings.

it wouldn’t have bothered us if it was either way. Well I saw it in the same way, it didn’t bother me

(Participant 11)

Some participants suggested it would have been useful to have a health professional present to answer questions.

Someone that knows .... someone to answer questions ... like I mean, I could say to you ‘I have such a thing, can you tell me what to do with it’

(Participant 2)

Somebody high up who could answer a question

(Participant 5)

Participants spoke about the ‘loneliness’ and ‘isolation’ of having diabetes. The support and comfort people received from others at the meetings was apparent.

It was nice meeting people just like myself

(Participant 21)

I was with it for years in myself going alone on the road … and then these meetings came about … and

I thought, a big difference now to find out Jimmy has it, Johnny has it, Mary has it … that was a great boost…

(Participant 15)

When you’re diagnosed you think you’re the only one … and you feel a bit isolated … when I came down here found there were a number of other people in the same boat … that’s why I was coming here … I wasn’t the only one.

(Participant 32)

It’s comforting to have people who have the same complaint … you weren’t on your own with these complaints

(Participant 33)

Time and time again in the focus groups, participants reported that they learnt an incredible amount of new information from participating in the meetings.

…. a learning process … I was learning all the time from it … I did learn a lot from it.

(Participant 4)

I’ve learnt a lot through it …. I found out little bits here and there … It was very helpful

(Participant 2)

One participant spoke about how the information provided in the meetings had challenged some of the misinformation that may circulate about diabetes, for example, on the internet.

… dispelled any of that rubbish that was on the internet about it [diabetes].

(Participant 31)

Participants reported that the intervention was very effective in reducing or lessening any worry or distress participants had related to diabetes and its management.

The less you worry about it the better for yourself … I don’t worry about it as often

(Participant 1)

picked up small things that I would have been anxious about

(Participant 12)

There were mixed responses as to whether or not the intervention had been successful in improving how participants managed their diabetes. Some participants spoke about the lifestyle changes they had made following the peer-support meetings.

Made me try hard to try and keep me sugars down.

(Participant 22)

An awful lot of it was just common sense really, but it might have been things that you still weren’t doing

(Participant 25)
I’m more healthy now than ever I was and I can feel it, even people are saying it. I’ve got me colour back

(Participant 2)

It sharpened up your mind to remind you what to do ...

(Participant 32)

Other participants reported that the intervention did not help them manage their illness any better.

[the meetings] just made you more aware of it … I wouldn’t say it helped

(Participant 19)

It didn’t make much difference except I put on weight

(Participant 29)

It bucked me up in certain areas but one thing it didn't do … I just can’t get to grips with dieting at all

(Participant 31)

Peer supporters’ views. Peer supporters found the suggested meeting structure and the handbook and resources for the meetings very useful.

... it was the same format for each meeting, start off with the questions and answers from the previous meeting and then based on the handbook the issues you wanted to discuss and we used to work our way through that and again, if I thought we weren’t going to achieve the whole agenda I’d sort of truncate the discussion and say ‘Right, move on now’ but by and large I’d have an agenda and let people talk just as we are but keeping an eye on the clock and making sure that we covered the whole agenda and took questions and answers but set a formula, set a format and stick to it and it worked like a treat.

(Peer Supporter 1)

it was really well done and it was done simply and clear ...

(Peer Supporter 2).

It was apparent from the focus groups that the frequently asked questions (FAQs) component of the meetings was highly valued by most peer supporters and participants. Superlatives such as ‘brilliant’, ‘wonderful’ and ‘fantastic’ were used to describe it, and it was said to be

definitely, definitely one of the best things

(Peer Supporter 5)

a massive thing, absolutely a massive thing because it generated discussion

(Peer Supporter 10)

The peer supporters saw themselves as being central to the meetings.

the first thing I would always do at these meetings was to go through the answers to the questions from the previous meeting so there was that continuity

(Peer Supporter 1)

I discussed that at very meeting. I took it out … we discussed that at length and there was a lot of interesting things to come up on that

(Peer Supporter 10)

The FAQs were treated as a resource by some of the participants.

they kept them all, believe it or not, all the questions, the group members particularly wanted them

(Peer Supporter 3)

and they said they used to take them out and read them over

(Peer Supporter 6)

It was suggested that the FAQs be reproduced and distributed to people with diabetes across the country as lasting legacy/resource from the project.

Practice nurses’ views. The cohesiveness of the meetings varied and appeared to be related to the mix of participants allocated to each meeting. One practice nurse noted

if they were lucky enough to have a group that kind of gelled together they were grand … like, if you had a group with somebody, an old moaner or whatever it’s very hard to manage that

(Peer Supporter 10)

Practice nurses felt the participants appreciated the peer element of the intervention.

... obviously there was a completely different kind of atmosphere than there would be if it were a medical lecture or something like that

(Peer Supporter 2).

Challenges of delivering a peer-support intervention: attendance problems and workload issues

The main challenge that emerged in delivering the peer-support intervention was poor attendance of some group members. Establishing peer-support meetings that suited participants in terms of venue, length and frequency was also an issue that was discussed in the focus groups.
Attendance. Several peer supporters expressed disappointment about participants who dropped out of the meetings or failed to attend on a regular basis.

I think the biggest regret that I have is that several people for whatever their reasons, one man was genuinely ill so he couldn’t attend, but there was a core who attended every meeting and then there were the transients, for want of a – who came and went but I think those who didn’t miss and we would have gained a lot more had we a full muster every time, that’s probably expecting a Utopian situation …

(Peer Supporter 2)

Others, however, considered that attendance was good and people did not attend for a reason.

I felt that anyone that didn’t turn up you could think, you know, was it that they didn’t like the meeting but I felt that they were – it was genuine illness that stopped people

(Peer Supporter 3)

One of the meetings was said not to have worked very well due to poor attendance but was still characterized positively.

some parts of the group fell apart, there wasn’t a very good attendance as such but other than that it was quite good ….

(Participant 4)

There was a perception that the non-attenders may have been those who most needed support to improve the management of their diabetes and who despite encouragement would not be interested in attending.

you see, this was the only drawback to the peer support, those that volunteered to come, those that stuck at it, were already those who were looking after their diabetes … and were interested. The ones that you are trying to get and you are chasing down for months and you are trying to get in for bloods are the very ones who wouldn’t dream of even starting to come to peer support and that was the crux – the good ones are always going to work at it.

(Practice Nurse 4)

they just didn’t want to know and that was it. And again, you can’t force them, if they didn’t want to come they didn’t want to come … there were certainly one or two whose wives were really trying to push them to come but they always found an excuse

(Practice Nurse 2)

the one that didn’t really wouldn’t have found anything beneficial any way, you know? … It didn’t matter what you would have done for him, you could have cured his diabetes if possible and he still wouldn’t have been happy

(Practice Nurse 4)

Venue. Distance from the venue, transport and family responsibilities were identified as barriers to attending the meetings.

some of them were maybe six or seven miles, not able to drive … their husband working and that sort of thing …

(Peer Supporter 5)

I missed quite a few because I had to go to work, I missed quite a few ….

(Participant 2)

However, most peer supporters, participants and practice nurses spoke positively about holding the meetings in the general practice as it was a familiar convenient environment and they knew people in their groups.

We’re used to coming here to our doctors.

(Participant 32)

We’re all in the area, you see, not too far away.

(Participant 31)

… definitely, definitely it was a big help … because a lot of them wouldn’t travel any further anyway

(Practice Nurse 4)

It’s near us all

(Participant 17)

It was very good of Dr [GP] to set it up here …. the location was key

(Participant 32)

It was easier talking with people you know than a load of strangers

(Participant 2)

One peer supporter identified that room space as a challenge

I put that on the report I sent in, it was a bit tight but I said also the position is that it would be very difficult because they’re limited up there [in the general practice]

(Peer Supporter 10)

Timing and spacing of meetings. In this study, meetings were held every 3 months over a 2-year period, but participants were asked what they felt in general about timing and spacing of meetings. There was a variety of view points on what time of the day and how often peer-support meetings should take place.
at various times, maybe some meetings during the day for one group but others might like it later in the week or at night time and just allow people choose their groups, you know?

(Participant 19)

Participants supported the idea of running the meetings over a long period of time. Two years, which was the length of the intervention, suited many people as it allowed for a range of issues to emerge and reflected the chronic nature of diabetes.

within that time we'd have maybe thought or something maybe would have happened to you that would have, you know, that wouldn't have happened maybe within 5 or 6 weeks

(Participant 4)

certain things that can develop in any of us over a period of time

(Participant 2)

I think it was good yeah because within that time we'd have maybe thought or something maybe would have happened to you that you would have, you know, that wouldn't happen maybe within five or six weeks.

(Participant 4)

Yeah and certain things that can develop in any of us over a period of time, you will talk with your group and they will encourage you to talk with your doctor which you'll ‘Ah no forget about it, I'm not going near him’, you know, the thing is – I think it made sense over … a prolonged period of time, like.

(Participant 2)

Some participants considered that monthly meetings would be the most beneficial.

well just say you met once a month, at least if something happened to you in that month you come up here and talk about it and query it and, you know, you go into the hospital and you're five minutes with the doctor and out

(Participant 6)

Others disagreed.

I don't think it would be necessary to have it every month

(Participant 29)

Several suggested that once every 3 months would be sufficient.

sort of an update on things, you know, and how you're doing and how everyone else is doing

(Participant 31)

if you are having them once a month you would get fed up, I think, but you are having them once every 3 months roughly, I think that's grand, you actually look forward to them then … it's not the same as too many too often

(Participant 19)

Participants agreed that meetings should be ‘regular’ although there was not consensus on whether that should be monthly, every second month or six or seven times a year. When asked whether they should meet weekly, one participant response was

No, you'd get fed up with it.

(Participant 28)

The length of meetings. Meetings lasted for approximately 1 hour to an hour and a half. This appeared to suit participants.

we could have gone on for twice as long, I had to throw them out once or twice

(Peer Supporter 1)

and the brevity of the meetings, I liked

(Participant 18)

A practice nurse identified that she considered a 1-hour meeting at the intervals that they were held to be optimal.

the hour was enough … anymore and they would have been sitting twiddling their thumbs … an hour was enough to go through what they had to go through, have a bit of a chat about how they were doing … absolutely spot on, you wouldn’t have kept them coming if you'd been oftener and … I suppose if you’d done it any less you wouldn't have got them either because they’d nearly forget about it

(Practice Nurse 4)

Conclusions

The predominantly positive experiences reported in this study suggest the implementation of peer-support meetings for people with type 2 diabetes was acceptable to the participants, peer supporters and practice nurses involved. Peer supporters felt well prepared and supported in their role, and participants were overwhelmingly positive about the meetings though they recognized that non-participants may be more in need of such meetings. These findings should be considered in the light of the results of the randomized trial in which these individuals participated, which did not indicate any significant improvement in diabetes outcomes or measures of psychosocial well-being or support. This may relate to the fact that the intervention was targeted
at all patients with type 2 diabetes rather than just those with poor glycaemic control as other studies have suggested that peer support may be more effective in this higher risk group. \(^6\) Others have suggested that the null findings of the trial may relate to insufficient exposure to peer support and the nature of the peer support provided. \(^1\) However, this qualitative evaluation of our trial does not support this.

There is a further need for studies to examine the effectiveness of peer-support intervention for type 2 diabetes, \(^7\) and this qualitative study raises several important issues, as discussed below, for the increasing numbers of people planning to run and evaluate peer-support interventions for type 2 diabetes.

**Choosing peer supporters**

Recruiting peer supporters via the general practitioners and practice nurses proved successful insofar as all the people selected were deemed suitable for the role by the research team following interview and they all proceeded to complete the training. Joseph et al. argue that if the peer supporters are not known by those that recruit them, there is the danger of them being unsuitable for the role, for example over stepping the boundaries such as giving medical advice. \(^12\)

**Preparing and supporting peer supporters in their role**

While some peer supporters initially felt unsure that they had the capacity to take on the role, they reported that they then felt adequately prepared for and supported in their role. They each received 5 hours of training. The extent of training in previous peer support and education in type 2 diabetes studies ranged from 2 hours to 46 hours. \(^13,14\) At this point in time, there is no evidence available as to what constitutes the ideal model for training. \(^14\) However, the World Health Organization outlines the core competencies for peer supporters as ‘the need to communicate clearly, to be willing to learn, to have confidence, and to be flexible and dependable’ (p. 16). \(^1\) In addition, it is important to retain the ‘peerness’ of the peer supporters and to avoid training them to be para-professionals. \(^15\) The need to maintain this balance will always provide a challenge but must be considered by those planning peer-support interventions.

Our exploratory interviews with voluntary sector leaders when we were designing the intervention indicated that retention of volunteer peer supporters would be very important. \(^16\) We therefore designed the intervention to reflect this, and extensive efforts were made in this study to retain the peer supporters for the duration of the intervention through regular contact with the project manager and regular social occasions. Peer supporters were contacted or met by the research team on a mean number of 25 occasions over the 2 years that they were involved in the study. \(^6\) To date, very little is known about the supervision needed for peer supporters. \(^1\) This qualitative analysis suggests clearly that the support system implemented in the study was adequate and the peer supporters felt well supported in their role. However, it was resource intensive.

**Organization of peer-support meetings**

There was consensus that the general practice setting was an optimal venue for peer-support meetings. This is supported by the view of Boothroyd and Fisher that peer-support programmes have linkages to clinical care. \(^6\) Not only was the general practice setting convenient for the patients it also provided a supportive environment for the peer supporters to facilitate the groups. A practice nurse or GP remained on the premises, while the meetings were held to deal with any problem that arose that was beyond the peer supporter’s role. However, we acknowledge that our participants did not experience other settings and so if a practice was too far from some people’s homes, the use of more local community centres could have been an option.

As type 2 diabetes is a chronic illness, people need ongoing support to manage their illness. Taking this into account the intervention in this study was designed to be delivered over 2 years, notably longer than previous interventions. After the second meeting, the groups in this study met every 3 months. The qualitative analysis suggests that this suited participants. Seevers et al. found that increasing the spacing between meetings to every second month had a positive effect on meeting attendance. \(^17\)

**Anticipating problems**

In our study, attendance varied between meetings and between practices, with low attendance noted in some cases. The problem with attendance was not unique to this study, poor attendance rates have been reported in other recent peer support and peer education studies. \(^18\) Choudhury et al. developed a peer-led education programme for Bangladeshi people with type 2 diabetes. Only 58% of those who registered to attend actually attended. \(^19\)

It is important to consider that the experience of being a peer supporter may not always be positive. Murphy et al. reported that morale of the peer supporters can be affected by issues such as poor uptake of a peer-support programme. \(^20\) In the implementation of a Chronic Disease Self-Management Course, Barlow et al. noted that negative aspects of the peer supporter role identified included isolation in the role, lack of contact with other peer supporters and difficulties adhering to the course protocol. \(^21\) This reinforces the need for a structured support for peer supporters such the system discussed in this article.
Strengths and weaknesses

The study sample represented participants, peer supporters and practice nurses from a range of general practices who had participated in a 2-year peer-support intervention. Individuals from small and large practices, based in urban and rural areas, from both deprived and affluent backgrounds were represented. The involvement of practice nurses, peer supporters and participants ensured that a broad range of ideas and views on peer support in type 2 diabetes were recorded. However, we acknowledge that those who had failed to attend the peer-support meetings did not attend the focus groups either, so the views of these ‘hard to reach’ participants are not captured.

Participants and peer supporters reported the content of the group meetings and issues around group dynamics. A more objective measure of these issues may have been obtained if the groups were observed by an independent observer, possibly with an ethnographic approach. This was considered by the research team at the onset of the study, but it was decided that the presence of an observer or even a video or tape recorder would interfere with the peer group dynamic, but we acknowledge that this means we only have reported accounts of actual group content and dynamics.

Lessons learned and implications for clinical practice

This study contributes to the existing literature on peer support in type 2 diabetes. In the context of the negative results of the main trial, it may be more appropriate to target patients with poor glycaemic control and ensure that the peer-support intervention complements medical management and supports patients to engage more effectively with their health care providers. Our previous experience of specifically targeting patients with poor glycaemic control indicated that this group may be more challenging to reach, but the potential gains in terms of improved long-term outcomes may be higher. In particular, the benefits of integrating a peer-support intervention within the patients’ primary care delivery setting should be noted as this allowed for successful recruitment of peer supporters and also provided venues for the group meetings that were acceptable for both participants and peer supporters. The importance of an ongoing support structure was evident from the data obtained from the peer supporters, and we therefore recommend that future peer-support interventions include an explicit support and retention strategy. The problems of attendance and participation documented in this study reflect previous work in the area of peer support. This highlights one of the most important aspects of engaging and training peer-support workers is that they need to be prepared for disappointments such as failure to engage by participants. Devising an intervention that suits all individuals is difficult, and there is no clear evidence supporting the implementation of one type of peer support over another. Future interventions studies may consider implementing different intervention arms reflecting a variety of patterns of peer support. This article suggests that patients and peer supporters valued this type of intervention, but given the negative results of the main trial, we would suggest that peer support should not be introduced routinely in clinical settings until there is clearer evidence regarding its effectiveness both in terms of improving outcomes for patients and in terms of its effects on peer supporters themselves.

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