Author's response to reviews

Title: Testing a Peer Support Intervention for People with Type 2 Diabetes: a Pilot for a Randomised Controlled Trial

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Author's response to reviews: see over
Dear BioMed Central,

We are pleased to provide a revised manuscript for your consideration. My co-authors and I have given due consideration to the points raised by the two reviewers, who raise some very important points that have helped us to strengthen the article.

We hope the revised paper addresses the issues adequately. Please find our responses to these suggestions below:

**Reviewer 1**

1. The role of peer supporters as understood by the authors is not at all clear. Peer supporters are clearly not expected to provide help and advice on self management (this explains why peer supporters were not given education to equip them with adequate understanding of diabetes and its complications). What role was expected of them? The authors prepared them to facilitate peers to talk to each other, and not to give information. What is the point of facilitating discussion between peers, who may not be well informed? How do peer supporters assist psychological problems without the knowledge of the condition?

**Reply:** This is a very important issue that we have clearly inadequately addressed in the introduction. On page 5 we now do this:

‘A variety of individual and group approaches to providing peer support have been developed (8,16-18) using various methodologies that range from more educational (19) to support (20) and more health services based (21) to community based (22) and we now make this more explicit.’

We also refer to our forthcoming paper (ref 16) that teases out the great range of types of peer support from education to emotional support and guidance and from those embedded in health services to those that are community based. The hypothesis is that this kind of peer support benefits quality of life and mental health issues including diabetes distress and potentially, by doing so, facilitates an increase in self efficacy and an understanding of ways of navigating the health system. One aim is to stimulate peers to seek out additional knowledge and health professional support.
where needed and to increase adherence to health professional advice. Obviously, such an intervention could also improve biomedical outcomes, without detailed knowledge of the condition.

PSF’s are not clinicians and do not need knowledge of the clinical condition of peers (and if they did, would not necessarily be able to use this information to the benefit of the peer). Assistance is through empathy and support and facilitating the seeking of knowledge or health care professional assistance should this be needed.

We have now inserted on page 4:
‘Peer support, involving experience sharing, mentoring and role-modeling, has also been proposed as a way of overcoming some psychosocial barriers through empathy, support and facilitating the seeking of knowledge or health care professional assistance should this be needed’

And on page 6:
‘This research aims to specifically examine a community-based approach to peer support, rather than lay-led diabetes education.’

And on page 10:
‘The training emphasised that the role of the peer supporter was not to replace health care professionals, but to help signpost peers to advice, services or community activities that might help them.’

2. The authors suggest that they will provide peer supporters with a handbook of information to refer to just in case medical information was required. Why not train them properly in the first instance?

Reply: We thank the referee for identifying a more grandiose term than is warranted!. We have changed this paragraph (page 20, para. 2) to:

‘In response to these two issues, the investigators have agreed to distribute a basic diabetes educational booklet during the education session. Participants and peer supporters will be requested to refer to this booklet when they have knowledge-related questions. If information is not within the booklet, then they are advised to ask their practice nurse.’

3. The authors appear to ensure that peer supporters were not directive. In the example of the snooker player, had the peer responded that he did not eat whilst travelling, who would have corrected him?

Reply: This is a difficult point to address. It is a hypothetical situation, but it highlights how psf’s are trained to facilitate not educate. It is not for peers to correct each other, the aim would be to flag this as an issue and something to discuss with a health care practitioner-we have added that the role of signposting is important on page 9, para. 1

4. The absence of a clear description of the functions expected of peer supporters will continue to be a problem in any further studies.

Reply: we hope that our previous amendments address this point and we thank the referee for identifying the need for more clarity. This is a big issue and we have attempted to address it in a full paper (reference 16) It is clearly important that each study reported has to describe the intervention as collated in our paper (16) and in Heisler et al (17).
5. Whist the authors endorsed non directive approach, they felt it acceptable to direct that peers should meet regularly as if it was part of management of diabetes. In reality, peers will seek support as and when they require it.

Reply: When we use the term non-directive, it is to describe the quality of the interaction between the peer and peer supporter. Whilst it is true that naturalistic peer support certainly takes place in an ad hoc and on demand manner, this does not mean that there is chaos. The trial was undertaken within a trial protocol, so that we could provide non directive peer support within a defined framework (that would allow role out should the main trial be successful).

We now clarify this on page 6, para 3 ‘but operating within the trial framework’

6. The aims of the pilot were stated to test the feasibility and acceptability of the individual and group programme planned. The very small numbers of peers involved, and the absence of relevant date before and after the intervention do not provide the answer. The anecdotal style of reporting the results does not help.

Reply: Feasibility was shown by the establishment of the intervention and attendance by peers and acceptability by the re-attendance next time.

The style of investigating is ethnographic. This approach was chosen to explore patient perspectives on the intervention. This enabled us to identify areas that might need to be changed to make the study acceptable to patients and to ensure that the processes involved were efficient. In this setting, with these numbers, it provides more detailed information than a Likkert scale or questionnaire. We have noticed that we did not reference the methodology and now do so (ref 32)

7. Table 2 showed perceptions as a snapshot. What was the benefit of this? No effort was made to measure the effect of intervention on these perceptions.

Reply: Table 2 provides a description of the profile of reported barriers and facilitators to care and allows a comparison of more important differences between those participating and not participating in the pilot. The main trial will be looking at impact on barriers but with adequate power, rather than within a short process pilot.

We now define this in the text on page 7 para. 2

‘This survey allowed a comparison of the clinical and self-reported barriers and facilitators to care among those volunteering to join the study and other survey responders.’

8. There is no data on what were the perceptions of the peer supporters before and after

Reply: As mentioned above, the aim of the pilot was to test process and not to test or measure patient outcomes. The number of participants would not allow valid conclusions to be drawn about the effectiveness of the intervention. Accordingly, this paper cannot report on these.

9. Less than 6% of patients invited consented to participate. The planned RCT will require the involvement of a large number of practices to give it power.

Reply: The main study has a cohort of 1362 and indeed over 70 practices were involved in inviting patients into the study.
10. Participants were randomised into four groups. The authors make no effort to report the results in each of the group. The numbers stated do not match: peer supporters were selected from the total of 61, and yet the groups of peers total 61!

Reply: The CONSORT diagram reports allocation and attendance by arm. The thematic analysis also makes it clear where each ethnographic example is derived from.

We included the peer supporters in the total number, as whilst they have a specialised role in the intervention, they also receive the intervention, as peer support is a relational and reciprocal activity. The Peer supporters are part of the 61 as they are simply peers who have been trained to facilitate

11. In the selection of peer supporters, the level of knowledge of a patient was a requirement. yet, no effort was made to ascertain how this was assessed and neither did the authors. The other requirements were all left to the perceptions of the GP.

Reply: All participants had access to structured type 2 education across the county as now described. As the referee would know, objective assessment of knowledge is difficult and hence we relied on the assessment of the GP as the most objective way that we could within the resources available.

12. It is stated that peer supporters completed a consent and two questionnaires. What were the latter?

Reply: The first questionnaire was the barriers to diabetes care questionnaire, the results of which are displayed in table 2, which were sent with invitations into the study. The second questionnaire contained a variety of diabetes-related measures, and was used to test the questionnaire before the main trial and was only completed among those consenting to enter the trial. We now highlight that this is a second questionnaire on page 7 para 3

13. Education sessions (page 4) was given in one spell of 3.5 hours. Were a group of final year medical students given this training in one spell, few would remember more than seven or eight points. Yet, the authors expected patients, who do not have any medical background, to be adequately informed! The same observation applies to that of peer supporters.

Reply: The education session was provided to address gaps in knowledge. All local patients have access to structured and practice based education. We have addressed this on page 9 para2:

‘As all participants had previously diagnosed Type 2 diabetes, all had access to prior education through a local structured education programme and/or their practice nurse and/or their hospital service.’

Reviewer 2

1. distinguish the terms 'patients' vs 'peers' on page 7. It said recruitment of patients and then switch the term to peers which can be confusing as they are the same people.

Reply: We have changed the terminology to make it more consistent.

2. need to outline strategies you will adopt to improve 'retention' of patients (peers) and peer support facilitators, very challenging
**Reply:** We have made our position more clear on this on page 19. However, specific strategies will be written up in the articles based on the full RCT data.

3. **what incentives were provided for the peer supporters? payment? as it is time consuming**

**Reply:** No incentives were offered. We have made this clearer on P.8.

4. **what about the control group? nothing was mentioned in the pilot study? what did you do with them?**

**Reply:** We have made this clear on p.9

5. **Were there any observable differences in the 1:1 vs group vs combined format? I see 1:1 peer support role having a rather different relationship to a PSF in a group, the dynamics are totally different and finally, what actually happens in a combined intervention, the PSF is available on a 1:1 and then also run a group? not quite clear.**

**Reply:** We’ve drawn together a clearer summary of the differences observed between the 1:1, combined and group settings. See page 18 para 2.

A clearer statement of the combined arm activity has been inserted on p.10

6. **The three intervention arms are complicated and one has to justify why would anyone offer to be a PSF having to deal with one's own DM and to facilitate a group or offer 1:1 support. may be the occupation of the PSF is a confounding factor**

**Reply:** We agree with this comment and have secured additional funding to explore the motivations and experiences of peer supporters involved in the trial. This work is being done in partnership with volunteering specialists and will include an analysis that explores the role of occupation and socio-economic grouping in the decision to volunteer. Over 140 peers volunteered and have been trained in the main trial, so clearly there are individuals willing to take this on—we agree their motivation is of great interest!

7. **will this peer support program be sustainable in the medium and long term? since it has not been sustained in a 2 month period.**

**Reply:** Since the writing of this paper, the pilot cohort has continued to have peer support sessions. This has been running for over 2 years and hence has been found to be sustainable. We have a separate grant to describe this development.