***Table 1: Summary of studies***

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| **Study** | **Aims/design/method** | **Participant characteristics** |
| Rey-Conde et al. (2005)  Australia | Exploring perceptions from PWID and caregivers. Qualitative study using focus groups | *N*= 67:  PWID (*N*= 9);  Family members (*N*= 8);  Paid caregivers (*N*= 31);  Service coordinators (*N* = 12);  Health professionals (*N*= 6);  Sector worker (*N*= 1);  Living status:  Living at home (*N*= 3);  Supported accommodation (*N*= 6);  Further demographics not provided |
| Hale et al. (2011)  NZ | Exploring knowledge and understanding of PWID self-managing T2D. Interviews analyzed using the General Inductive approach | *N*= 14 adults with ID  Age:  Mean: 51 years  Ethnicity:  Maori (*N* = 3);  New Zealand European (*N* = 11)  Gender:  Female 43%  Level of disability:  Mild (*N*= 11);  Moderate (*N*= 3)  Living status:  Residential care (*N*= 11);  Supported independent living (*N*= 2);  Independent living (*N*= 1)  Diabetes type:  Type 1 (*N*= 6);  Type 2 (*N*= 8)  Management approach:  Not specified  Time since diagnosis:  2-5 years (*N*= 3);  6-10 years (*N*= 4);  10+ years (*N*= 7) |
| Dysch et al. (2012)  UK | Exploring experiences and perceptions of people with ID and diabetes. Qualitative study using IPA | N = 4 Adults with ID  Age:  Mean 35 years  Ethnicity:  Not specified  Gender:  Female 75%  Level of disability:  Mild  Living Status:  Residential care (*N*= 2)  With family (*N*= 1)  Independent (*N*= 1)  Diabetes type:  Type 1 (*N*= 2);  Type 2 (*N*= 2)  Management approach:  Not specified  Time since diagnosis:  Mean 17 years |
| Cardol et al. (2012a)  Netherlands | Exploring T2D self-management experiences of PWID.  Qualitative study using Leventhal’s (1997) Illness Perception Framework and Thematic Analysis | N = 17 adults with ID  Age:  mean 52 years  Ethnicity:  Not specified  Gender:  Female 53%  Level of disability:  Mild (*N*= 7);  Moderate (*N*= 7);  Unknown (*N*= 3)  Living status:  Independent living with and without support (numbers not given)  Diabetes type:  Not specified  Management approach:  Diet alone (*N* = 3)  Medication (*N*= 6)  Insulin (*N*= 8)  Time since diagnosis:  Under 5 years (*N*= 5);  5+ years (*N*= 12) |
| Cardol et al. (2012b)  Netherlands | Exploring views of caregivers of PWID who have T2D. | N = 13 caregivers  Age:  Mean 52 years  Ethnicity:  Not specified  Gender: 72% female |
| Trip et al. (2015)  NZ | Exploring the role of key workers in supporting PWID self-managing T2D. Qualitative study using Thomas’ General Inductive Approach | *N*= 17 Support staff  Age:  18-30 (*N*= 3);  41-50 (*N*= 1);  51-60 (*N*= 4);  60+ (*N*= 9)  Ethnicity:  New Zealand European (*N*= 14);  Maori (*N*= 1);  Australian (*N*= 1);  African (*N*= 1)  Gender:  Female 88% |
| Whitehead et al. (2016)  NZ | Exploring the experiences of PWID and their caregivers self-managing T2D with a focus on the practice of autonomy | N = 31    PWID (*N*=14)  Age:  Mean 51 years  Gender:  Female 43%  Ethnicity:  Not specified  Level of disability:  Mild (*N*= 11);  Moderate (*N*= 3)  Living status:  Independent living (*N* = 1)  Supported living (*N* = 2)  Residential care (*N* = 11)  Diabetes type:  Type 1 (*N* = 6)  Type 2 (*N* = 8)  Management approach:  Diet alone (*N* = 1)  Medication (*N* = 8)  Insulin (N = 5)    Time since diagnosis:  Not specified:    Caregivers (*N*= 17)  Age:  18-30 (*N* = 3);  41-50 (*N*= 1);  51-60 (*N* = 4);  60+ (*N* = 9)  Gender:  Female 88%  Ethnicity:  Not specified |
| Rouse and Finlay (2016) | Discourse analysis of the concept of responsibility in people with ID and their caregivers self-managing T2D | N = 14   PWID (*N*=7)  Age:  20-54  Gender:  Female 71%  Ethnicity:  Not specified  Level of disability:  Mild-Moderate (*N*=7)  Living status:  Not specified  Diabetes type:  Type 1 (*N* =2)  Type 2 (*N* = 5)  Management approach:  Not specified  Time since diagnosis:  “At least 6 months prior to interview”  Caregivers (*N*= 7)  Age:  44-51  Gender:  Female 71%  Ethnicity:  Not specified |

*Table 2: Findings and plausibility*

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| **Study** | **Finding Plausibility** | |
| Rey-Conde et al. (2005) | People with ID’s perception of diabetes self-management (DSM) barriers expressed as negative feelings | Unequivocal: Clear transcript excerpt |
| People with ID spoke about practical DSM experiences and abilities | Unsupported: Stated as frequent but number of participants not provided |
| People with ID proud of skills, though these were limited | Equivocal: Transcript excerpt does not illustrate pride or limits |
| Negative responses to question on what is easy about DSM | Unequivocal: Clear transcript excerpt and observations |
| Acknowledgement of dependence on families and support staff | Unequivocal: Clear transcript excerpt and number |
| People with ID made positive comments about exercise | Unequivocal: Clear transcript excerpt |
| Concern and conflict in diet but some positive choices | Equivocal: Transcript excerpt but number of participants not stated |
| Families and support staff felt that cognitive limitations were the biggest barrier but tailored education could help | Equivocal: Frequent observations but no excerpt |
| Staff training was a barrier to DSM | Unequivocal: Clear transcript excerpt and frequencies |
| Staff skills were mainly in observations and taking blood sugar levels | Equivocal: Transcript excerpt only partially illustrates |
| Prompts, diet management and planning works well | Equivocal: Frequency observations |
| Exercise is limited. Walking and bowling are most common | Equivocal: Transcript excerpt does not clearly illustrate |
| Lack of motivation and preferences are seen as barriers for people with ID | Equivocal: Transcript excerpt but number of participants not stated |
| More information on diet is needed | Equivocal: Transcript excerpt limited and number of participants not stated |
| Fear and insecurity in staff over supporting DSM | Equivocal: Transcript excerpt but number of participants not stated |
| Hale et al. (2011) | Three levels of knowledge and understanding of diabetes in people with ID: good, limited and basic | Unequivocal: Clear transcript excerpts and participant numbers |
| Blood Sugar Levels were not fully understood by people with ID but symptoms of blood sugar changes were recognised | Equivocal: Transcript excerpt but number of participants not stated |
| Diet awareness limited to avoiding sugar and difficult to monitor outside of residential care | Unequivocal: Clear transcript excerpts and participant numbers |
| Information provision was limited or not in accessible formats | Unequivocal: Clear transcript excerpts and participant numbers |
| Participants were good at remembering to monitor blood sugar levels but needed support | Equivocal: Transcript excerpt but number of participants not stated |
| Participants were aware that walking was good for DSM and that have a walking “buddy” would help with this | Equivocal: Transcript excerpt but number of participants not stated |
| Most support came from residential carers. Numbers of diabetes care plans were limited and some staff were unaware these existed | Equivocal: Researcher observation of care practice but |
| Frustrations from some participants over lifestyle restrictions | Equivocal: Transcript excerpts but number of participants not stated |
| Dysch et al. (2012) | Participants showed understanding through language related to diabetes | Unequivocal: Transcript excerpts and number clear due to sample size |
| Confusion and over diabetes | Unequivocal: Transcript excerpts and number clear due to sample size |
| Participants described the fluctuating state of having diabetes | Unequivocal: Transcript excerpts and number clear due to sample size |
| Participants described the physical effects of diabetes | Unequivocal: Transcript excerpts and number clear due to sample size |
| Frustration with lifestyle adjustments | Unequivocal: Transcript excerpts and number clear due to sample size |
| Struggling with adherence to DSM | Unequivocal: Transcript excerpts and number clear due to sample size |
| Preparation and planning relating to DSM | Unsupported: Excerpts did not clearly relate to diabetes |
| Diabetes as tolerated | Equivocal: Transcript excerpts but number of participants not stated |
| Diabetes was unwanted | Unsupported: excerpts do not differentiate from “Frustrations” sub-theme |
| Support from others required for DSM | Equivocal: Transcript excerpts do not always describe DSM |
| Participants struggle with the need for support | Equivocal: Transcript excerpts but number of participants not stated |
| Social stigma of diabetes and DSM | Equivocal: Transcript excerpts but number of participants not stated |
| Social comparisons aid understanding of diabetes | Equivocal: Transcript excerpts but number of participants not stated |
| Social interaction impeded by diabetes | Unsupported: excerpt does not clearly relate to DSM |
| Participants reported multiple health difficulties | Unequivocal: Clear transcript excerpts and participant numbers |
| Cardol et al. (2012a) | Feelings with loss regarding food and choice | Equivocal: Transcript excerpts clear but number of participants not stated |
| Feelings of loss of food choice through social comparison | Equivocal: Transcript excerpts but number of participants not stated |
| Medication control: mixed understanding and anxiety | Equivocal: Transcript excerpts but number of participants not stated |
| Not feeling ill: diabetes only perceived as serious when insulin injections are required | Equivocal: Transcript excerpts but number of participants not stated |
| Multiple illnesses make diabetes symptoms hard to understand | Unsupported: No excerpts or frequencies |
| Fear and uncertainty over diabetes consequences | Equivocal: Transcript excerpts but number of participants not stated |
| Check-ups without questions | Unsupported: excerpts do not clearly describe theme |
| Participant’s had practical but limited knowledge of dietary restrictions | Equivocal: Transcript excerpts but number of participants not stated |
| Relationship between understanding of diabetes and DSM | Equivocal: Transcript excerpts but number of participants not stated |
| Lack of tailored resources available | Unsupported: No excerpts, or frequencies |
| Motivation is more important than level of ID | Unsupported: No excerpts or frequencies |
| DSM relaxed during special occasions | Unequivocal: Transcript excerpts clear and all participants included |
| DSM is related to self-confidence | Equivocal: No excerpts but observations which summarize data are clear |
| Opportunities to build self-confidence were limited | Equivocal: No excerpts but observations which summarize data are clear |
| Family members are important for support and feedback | Equivocal: Transcript excerpts but number of participants not stated |
| Participants’ mood can make DSM difficult | Unsupported: No excerpts, observations, or frequencies |
| Financial restrictions can impede DSM | Equivocal: Transcript excerpts but number of participants not stated |
| Communal living arrangements can impede DSM through social comparison | Unsupported: No excerpts, observations, or frequencies |
| Cardol et al. (2012b) | Caregivers did not perceive the seriousness of diabetes | Unequivocal: Clear transcript excerpts and participant numbers |
| Compassion but concern over competence in DSM | Unequivocal: Clear transcript excerpts and participant numbers |
| Lack of motivation for DSM regarded as dispositional in people with ID | Equivocal: Transcript excerpts but number of participants not stated |
| Levels of training were varied: nurses were better qualified and caregivers sought help from doctors | Equivocal: Transcript excerpts and based on observations |
| Diabetes was not a prominent feature in care unless insulin injections required | Equivocal: Transcript excerpts but number of participants not stated |
| Differences between caregivers in level of support for autonomy | Equivocal: Transcript excerpts but number of participants not stated |
| Dilemmas between enabling autonomy and safeguarding health-care using creative solutions | Equivocal: Transcript excerpts but number of participants not stated |
| Trip et al. (2015) | Key-worker knowledge and understanding: diabetes management varied and limited | Unequivocal: Clear transcript excerpts and participant numbers |
| Key-worker knowledge and understanding: Caregivers could recognise that behavioural changes may reflect diabetes symptoms | Unequivocal: Clear transcript excerpts and participant numbers |
| Key-worker knowledge and understanding: knowledge of impact of comorbidities was varied and limited | Unequivocal: Clear transcript excerpts and participant numbers |
| Lifestyle police: caregivers felt personally  responsible for the health status of people with ID  and focussed on controlling dietary intake | Unequivocal: Clear transcript excerpts and participant numbers |
| Frustration over lack of consistency in care | Unequivocal: Clear transcript excerpts and participant numbers |
| Caregivers recognise that training needs are ongoing but are unsure what was required | Unequivocal: Clear transcript excerpts and participant numbers |
| Nurturing self-management skills: creating opportunities to check understanding and providing education on shopping, cooking and menu planning, though this was limited by time | Unequivocal: Clear transcript excerpts and participant numbers |
| Whitehead et al. (2016) | Daily negotiated autonomy in relation to blood glucose: Support needed to record data | Unequivocal: Clear transcript excerpts and participant numbers |
| Daily negotiated autonomy in relation to medication: Participants were almost fully independent with occasional support | Equivocal: Transcript excerpts but number of participants not stated |
| Daily negotiated autonomy in relation to insulin injections: Participants were almost fully independent with occasional support | Equivocal: Transcript excerpts but number of participants not stated |
| Dietary choices described as negotiated, ongoing and supported | Equivocal: Transcript excerpts but number of participants not stated |
| Relationships and trust facilitated diabetes negotiated autonomy | Equivocal: Transcript excerpts but number of participants not stated |
| Caregivers were aware of risks versus autonomy | Equivocal: Transcript excerpts but number of participants not stated |
| People with ID were supported to be autonomous during medication adjustments but control was sometimes increased during these times, then readjusted accordingly | Equivocal: Transcript excerpts but number of participants not stated |
| Renegotiation of autonomy in relation to goals: heathier diet | Equivocal: Transcript excerpts but number of participants not stated |
| Renegotiation of autonomy in relation to goals: living arrangements and diet | Equivocal: Transcript excerpts but number of participants not stated |
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| Rouse and Finlay (2016) | Repertoires of confidence in relation to recognising symptoms | Unequivocal: Clear transcript excerpts and participant numbers |
|  | People with intellectual disabilities as described as themselves competent in relation to DSM | Unequivocal: Clear transcript excerpts and participant numbers |
| People with intellectual disabilities as lacking specific competence in relation to DSM tasks including organising, remembering and meal preparation | Unequivocal: Clear transcript excerpts and participant numbers |
| Caregivers described as intervening to support partial competence | Equivocal: Transcript excerpts but number of participants not stated |
| Repertoires of partial competence were more frequently drawn upon by paid supporters | Equivocal: Transcript excerpts but number of participants not stated |
| Repertoires of incompetence were more frequent in interviews with family supporters | Equivocal: Transcript excerpts but number of participants not stated |
| Lack of competence was often described as due to internal factors by caregivers | Unsupported by transcript excerpt |
| Constructing a positive identity: participants with ID described the needs for support but defended themselves against being seen as incompetent | Equivocal: Transcript excerpts but number of participants not stated |
| Lack of competence was often described as due to external factors by people with ID, such as the attitudes of doctors | Equivocal: Transcript excerpts but number of participants not stated |
| People with ID construct themselves as ‘lazy’ to defend against being seen as disabled | Equivocal: Transcript excerpts but number of participants not stated |
| Health care professionals are positioned as being competent in a broad sense, holding a higher level of diabetes knowledge | Equivocal: Transcript excerpts but number of participants not stated |
| Dilemmatic repertoires were presented regarding people with ID’s independence | Unequivocal: Clear transcript excerpts and participant numbers |
| Repertoires of risk management and control presented dilemmas against independence | Equivocal: Transcript excerpts but number of participants not stated |
| Responsibility and accountability are constructed as shared and problematic | Equivocal: Transcript excerpts but number of participants not stated |

*Table 3: Synthesis of findings*

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| **Finding** | **Category** | **Synthesised finding** |
| People with ID’s perception of diabetes self-management (DSM) expressed as negative feelings (U); (Rey-Conde et al., 2005) | Negative feelings regarding having diabetes | Frustration over lifestyle adjustments |
| Frustrations from some participants over lifestyle restrictions (E); (Hale, 2005) | Frustration over diabetes related lifestyle changes |
| Frustration with lifestyle adjustments (E); (Dysch et al., 2012) |
| Struggling with adherence to DSM (E); (Dysch et al., 2012) |
| Participants struggle with the need for support (E); (Dysch et al., 2012) |
| Feelings with loss regarding food and choice Cardol et al. (E) (2012a) | Feelings of loss following diabetes related lifestyle changes |
| Feelings of loss of food choice through social comparison Cardol et al. (E) (2012a) |
| Social stigma of diabetes and DSM (E); (Dysch et al., 2012) | Impact of social setting |
| Financial restrictions can impede DSM (E); (Cardol et al., 2012a) |
| Social comparisons aid understanding of diabetes (E); (Dysch et al., 2012) |
| **Finding** | **Category** | **Synthesised finding** |
| Acknowledgement of dependence on families and support staff (U); (Rey-Conde et al., 2005) | Limited competencies and dependence on caregivers | Limited understanding and inadequate educational resources |
| People with intellectual disabilities as lacking specific competence in relation to DSM tasks including organising, remembering and meal preparation (U) (Rouse and Finlay, 2016) |
| Diet awareness limited to avoiding sugar and difficult to monitor outside of residential care (U); (Hale et al., 2005) |
| Compassion but concern over competence in DSM (U); (Cardol et al., 2012b) |
| Support from others required for DSM (E); (Dysch et al., 2012) |
| Three levels of knowledge and understanding of diabetes in people with ID: good, limited and basic (U); (Hale et al., 2005) | Understanding is limited leading to limited DSM skills |
| Confusion over diabetes (E); (Dysch et al., 2012) |
| Exercise is limited. Walking and bowling are most common (E); (Rey-Conde et al., 2005) |
| Medication control:  mixed understanding and anxiety (E); (Cardol et al., 2012a) |
| Not feeling ill: diabetes only perceived as serious when insulin injections are required (E); (Cardol et al., 2012a) |
| Fear and uncertainty over diabetes consequences (E); (Cardol et al., 2012a) |
| Participant’s had practical but limited knowledge of dietary restrictions (E); (Cardol et al., 2012a) |
| Relationship between understanding of diabetes and DSM (E); (Cardol et al., 2012a) |
| Opportunities to build self-confidence were limited (E); (Cardol et al., 2012a) | Appropriate resources are required |
| More information on diet is needed (U); (Rey-Conde et al., 2005) |
| Information provision was limited or not in accessible formats (U); (Hale et al., 2005) |
| **Finding** | **Category** | **Synthesised finding** |
| Staff training was a barrier to DSM (U); (Rey-Conde et al., 2005) | Staff training was limited and this was a barrier to DSM | Limited training and knowledge in staff |
| Staff skills were mainly in observations and taking blood sugar levels (E); (Rey-Conde et al., 2005) |
| Caregivers did not perceive the seriousness of diabetes (U); (Cardol et al., 2012b) |
| Diabetes was not a prominent feature in care unless insulin injections required (E); (Cardol et al., 2012b) |
| Levels of training were varied: nurses were better qualified and caregivers sought help from doctors (E); (Cardol et al., 2012b) | Staff training was varied and inconsistent |
| Key-worker knowledge and understanding: diabetes management varied and limited (U); (Trip et al., 2015) |
| Differences between caregivers in level of support for autonomy (E); (Cardol et al., 2012b) |
| Key-worker knowledge and understanding: knowledge of impact of comorbidities was varied and limited (U); (Trip et al., 2015) |
| Frustration over lack of consistency in care (U); (Trip et al., 2015) |
| Lifestyle police: caregivers felt personally responsible for the health status of people with ID and focussed on controlling dietary intake (U); (Trip et al., 2015) | Caregiver attitudes may reflect further training needs |  |
| Fear and insecurity in staff over supporting DSM (E); (Rey-Conde et al., 2005) |
| Lack of motivation for DSM regarded as dispositional in people with ID (E); (Cardol et al., 2012b) |
| Health care professionals are positioned as being competent in a broad sense, holding a higher level of diabetes knowledge (E); (Rouse and Finlay 2016) |
| Lack of motivation and preferences are seen as barriers for people with ID (E); (Rey-Conde et al., 2005) |
| Dilemmas between enabling autonomy and safeguarding health-care (U); (Trip et al., 2015) | Caregiver dilemmas |
| Caregivers were aware of risks versus autonomy (E); (Whitehead et al., 2016) |
| Dilemmatic repertoires were presented regarding people with ID’s independence (U); (Rouse and Finlay 2016) |
| Repertoires of risk management and control presented dilemmas against independence (E); (Rouse and Finlay 2016) |
| Responsibility and accountability are constructed as shared and problematic (E); (Rouse and Finlay 2016) |
| Dilemmas between enabling autonomy and safeguarding health-care (E); (Cardol et al., 2012a) |
| **Finding** | **Category** | **Synthesised finding** |
| People with ID spoke about practical DSM experiences and abilities (E); (Rey-Conde et al., 2005) | Positive perceptions and statements of DSM abilities and awareness from people with ID | Potential for effective DSM with appropriate support |
| People with ID proud of skills, though these were limited (E); (Rey-Conde et al., 2005) |
| People with intellectual disabilities described themselves as competent in relation to DSM (U); (Rouse and Finlay, 2016) |
| Repertoires of confidence in relation to recognising symptoms (U); (Rouse and Finlay, 2016) |
| Constructing a positive identity: participants with ID described the needs for support but defended themselves against being seen as incompetent (E); (Rouse and Finlay, 2016) |
| People with ID construct themselves as ‘lazy’ to defend against being seen as disabled (E); (Rouse and Finlay, 2016) |
| Lack of competence was often described as due to external factors by people with ID, such as the attitudes of doctors (E); (Rouse and Finlay, 2016) |
| Positive comments about exercise from caregivers (U); (Rey-Conde et al., 2005) |
| Blood Sugar Levels were not fully understood by people with ID but symptoms of blood sugar changes were recognised (U); (Hale et al., 2005) |
| Participants were good at remembering to monitor blood sugar levels but needed support (E); (Hale, 2005) |
| DSM is related to self-confidence (E); (Cardol et al., 2012a) |
| Concern and conflict in diet but some positive choices (E); (Rey-Conde et al., 2005) |
| Participants showed understanding through language related to diabetes (E); (Dysch et al., 2012) |
| Participants described the fluctuating state of having diabetes (E); (Dysch et al., 2012) |
| Participants described the physical effects of diabetes (U) (Dysch et al., 2012) |
| Participants were aware that walking was good for DSM and that have a walking “buddy” would help with this (E) (Hale et al., 2011) |
| Participants reported multiple health difficulties (U); (Dysch et al., 2012) |
| Daily negotiated autonomy in relation to medication: Participants were almost fully independent with occasional support (E); (Whitehead et al., 2016) | Examples of effective DSM with flexible and creative support from caregivers |
| Daily negotiated autonomy in relation to insulin injections: Participants were  almost fully independent with occasional support (E); (Whitehead et al., 2016) |
| DSM relaxed during special occasions (E); (Cardol et al., 2012a) |
| Daily negotiated autonomy in relation to insulin injections: Participants were  almost fully independent with occasional support (E); (Whitehead et al., 2016) |
| Renegotiation of autonomy in relation to goals: heathier diet (E); (Whitehead et al. (2016) |
| Renegotiation of autonomy in relation to goals: living arrangements (E); (Whitehead et al. (2016) |
| People with ID were supported to be autonomous during medication adjustments but control was sometimes increased during these times, then readjusted accordingly (E); (Whitehead et al., 2016) |
| Families and support staff felt that cognitive limitations were the biggest barrier but tailored education could help (E); (Rey-Conde et al., 2005) |
| Prompts, diet management and planning works well (E); (Rey-Conde et al., 2005) |
| Nurturing self-management skills: creating opportunities to check understanding and providing education on shopping, cooking and menu planning was limited by time (U); (Whitehead et al., 2016) |
| Dietary choices described as negotiated, ongoing and supported (E); (Whitehead et al., 2016) |