***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:  20-54Gender: Female 71% Ethnicity: Not specified Level of disability:  Mild-Moderate (*N*=7) Living status: Not specifiedDiabetes 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)  |