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Research Paper

Declining structured diabetes education in those with type 2 diabetes: A plethora of individual and organisational reasons

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ABSTRACT

Objective: to identify the expressed reasons adults with type 2 diabetes decline structured diabetes education (SDE).
Methods: cross sectional survey of 335 adults with type 2 diabetes who had declined SDE within the past two years, from across Northern Ireland and England.
Standardised instruments comprising The Diabetes Attitude Scale, Diabetes Empowerment Scale (Short Form), and Diabetes Knowledge Test plus a questionnaire to elicit the reasons for declining SDE were used.
Results: Mean age 57.6 years (±21.1) 50.7% males, predominantly of White ethnicity (85.7%). They were most frequently invited to attend by a diabetes specialist nurse (36%), general practitioner (27%) or practice nurse (19%).
Although a diversity of reasons for declining SDE were cited the most common were; '*The course was too long*' (47.2%), '*I have other health problems*' (41.2%) and they had other priorities (33.4%).
Hierarchical cluster analysis revealed that expressed reasons for declining SDE were highly individualised.
Conclusion: The wide range of reasons that impeded attendance suggests there is no simple solution that will improve attendance rates.
Practice implications: In the same way that medical treatment for diabetes is becoming increasingly individualised, educational provision should be encouraged to move away from a one size fits all model.

1. Introduction

1.1. Structured diabetes education

The importance of people with diabetes self-managing their condition effectively on a daily basis is paramount. NICE Guidelines [1] assert that structured diabetes education (SDE) should be available for all adults with type 2 diabetes near to the time of diagnosis, with ongoing opportunities to reinforce content and review knowledge, understanding and educational needs. It is emphasised that such education is not only an integral part of diabetes management but also a quality indicator for diabetes care.

The purpose of SDE is to provide '. . . people with diabetes, their family and their carers with the knowledge and confidence to self-manage a long-term condition' [2]. High quality programmes should reflect individualised care, be evidence-based, have specified aims and objectives, and follow a written structured curriculum based on theories of learning [1]. The programmes are to be delivered by suitably trained and prepared educators and must be audited to ensure that these and other quality indicators are met. This represents significant progress over the last two decades from the time when education was often provided on an opportunistic basis during routine review appointments.

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1.2. Active self-management

The range of available medical treatments has expanded rapidly over the past ten years in response to increasing knowledge about optimising glycaemic control and reducing or postponing the onset of diabetes related complications. However, at the root of all diabetes care is the need for individuals to understand their role in its management and to have the knowledge, skills and motivation to become active self-managers. Our understanding and appreciation of the impact of psychosocial factors upon diabetes self-management has also evolved. Effective education must include the development of attitudes and beliefs conducive to long-term self-management [3] to support and sustain individuals and their families over time.

1.3. Declining structured diabetes education

Although the effectiveness of structured education has been demonstrated for those with type 2 diabetes [4–7] evidence also suggests that many individuals do not avail themselves of such programmes when referred [8,9]. Whilst lack of service provision and health professional training relating to education, self-management and psychological support may be an issue in some areas [10] there is also a significant number of individuals who, when invited to attend a SDE programme, decline the opportunity to do so. This study was designed to explore in detail the reasons adults with type 2 diabetes choose not to engage with SDE to inform and broaden the reach of SDE from a sound evidence base. The impact of demographic variables, physical wellbeing, depression and anxiety, knowledge, and attitudes towards diabetes upon the decision to decline SDE will also be explored.

2. Methods

The target population were adults, newly diagnosed or having established type 2 diabetes, who had previously declined an invitation to attend an SDE programme in the previous two years, or who had initially accepted but never attended. Diabetes nurse specialists/dietitians in the participating centres who administer SDE programmes were asked to keep records of all potential participants who met the inclusion criteria and inform them by telephone or in person about the study. The study researcher then contacted those interested in participating, provided an information leaflet and ascertained their preferred means of completing the questionnaire. Based on an annual estimated population of 6500 newly diagnosed adults with type 2 diabetes (Leicestershire and Northern Ireland (NI), the target population of those who do not engage in SDE (~40%) was 2600. It was estimated that a sample size of 335 would thus be required based on a 5% margin of error and 95% confidence level.

Participants were recruited between January 2014 and April 2015. Four sites from NI and five (including four Participant Identification Centres) from England participated in the study. All participants who completed a questionnaire received a £15 gift voucher as an acknowledgement of their input and because the cohort were considered to be a difficult to reach group.

2.1. Design

A quantitative survey was conducted using a structured questionnaire. Ethical approval was obtained (ID: 09/NIRO1/31) and completion of the questionnaire indicated informed consent.

Table 1
Demographic characteristics of non-attendees of SDE.

		All (*n* 335)
Age at time of recruitment (y)		57.6 ± 12.1
Years diagnosed (range)		3.3 ± 4.4 (0.1–30)
Gender (%)	Male	170 (50.7)
	Female	165 (49.3)
Marital Status (%)	Single	50 (14.9)
	Married/cohabiting	218 (65.1)
	Widowed	22 (6.6)
	Separated	14 (4.2)
	Divorced	31 (9.3)
Employment (%)	Full time	73 (21.8)
	Part time	33 (9.9)
	Carer/housewife	30 (9.0)
	Unemployed	28 (8.4)
	Education	1 (0.3)
	Retired	112 (33.4)
	Long-term sick	58 (17.3)
Ethnic origin (%)	White British	204 (60.9)
	White Irish	83 (24.8)
	Indian	32 (9.6)
	Caribbean	6 (1.8)
	Other	10 (3.0)
Treatment (%)	Diet and exercise	106 (31.6)
	Diet, exercise and tablets	181 (54.0)
	Non-insulin injections	3 (0.9)
	Insulin injections	13 (3.9)
	A combination of some or all the above	32 (9.6)

Data presented as mean and ±SD. Other Ethnic origin; African, Pakistani, Chinese, other black/white/Asian backgrounds.

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