The Experiences of Peer Leaders in a Driving Cessation Programme

AUTHOR PRE-PRINT VERSION

Accepted for publication in British Journal of Occupational Therapy, April 2014

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Abstract

Introduction: Peer leaders are increasingly involved in health-related programmes due to the perceived benefits that they bring to the group process. This exploratory study examined the experiences of peer leaders in the University of Queensland Driver Retirement Initiative (UQDRIVE), an educational support group for older people undergoing driving cessation.

Method: Semi-structured interviews were conducted with five peer leaders (2 men, 3 women, age range: 67-81 years) regarding their role and involvement as a peer leader in the University of Queensland Driver Retirement Initiative programme as well as their positive and negative experiences.

Results: Inductive thematic analysis revealed three themes: *diversity of peer leaders*, *drawing on personal strengths and experiences*, and *taking the middle ground*.

Conclusion: This study revealed that peer leaders drew from their diverse range of personal resources and experiences to perform the role of peer leader, using varying approaches to perform the role successfully. The provision of broad guidelines in training allowed individual approaches to be developed and this contributed to a positive experience for peer-leaders in UQDRIVE. These findings have implications for the development of future peer-led driving cessation programmes and the selection of their peer leaders.

Keywords: qualitative, driving cessation, lay-led, older people, roles

Accepted for publication April 2014

Note: For the 'Driving and community mobility' special issue in the *British Journal of Occupational Therapy* early 2015.

Introduction

Peer-led programmes have been advocated as a cost-effective way of providing client-centred services to a large population of people (Kennedy et al 2007) and recent decades have witnessed a widespread international use of peer leaders across various health care settings (Foster et al 2007). Peer leaders share a common experience with group members and this places them in a better position than health professionals to empathise with and empower group members to engage in positive behaviour change and manage their health condition (Brown et al 2007, Catalano et al 2009). Peer leaders may also be known as peer or lay advisors, counsellors, educators, or facilitators (Simoni et al 2011). They are typically involved in programmes that aim to provide education and social support to group members with the goal of improving their health behaviours and outcomes (Simoni et al 2011). The perceived benefits of peer leaders involvement has led to the growth in the number of peer-led programmes (Griffiths et al 2007), however studies have indicated that the effectiveness of these programmes varies across different types of health conditions (Chodosh et al 2005) and aspects of health behaviours (Webel et al 2010).

The value of peer leaders in education and support programmes has a long history and is well established with programmes involving older people. The use of peer leaders has a theoretical basis within social learning theory and social identity theory and forms part of the social environment noted within various behaviour change models (Peel and Warburton, 2009). The involvement of peer leaders with older people has noted advantages, including the provision of positive role models, which leads to improved self-efficacy and modelling of desired behaviours, and the perception of the programme being less threatening and more accessible, particularly for difficult to reach groups (Peel and Warburton, 2009)

Literature Review

Experiences of Peer Leaders

Few studies have examined the experiences of peer leaders despite the fact that an understanding of this area could help to identify peer leaders' needs and to guide the development of future programmes (Macdonald et al 2009). Various factors can impact on peer leaders' experiences, including the different types of programmes and their level of collaboration with health professionals (Catalano et al 2009). Studies of peer-led programmes have reported several benefits for the peer leaders including increased confidence (Barlow et al 2005), reduced mental and emotional distress (Hainsworth and Barlow 2001), and a renewed sense of purpose in life from their valued societal role as a leader (Barlow et al 2005).

Studies have also found that peer leaders' experiences can be influenced by their scope of involvement in the programmes with some peer leaders reporting frustration at having to adhere to the course protocol when teaching (Barlow et al 2005). In a study examining the experiences of peer leaders in an asthma self-management education programme, peer leaders reported that the training over a period of six weeks was exhausting (Brown et al 2007). They reported an overall positive peer-leading experience, but there was a dropout rate of 60% which may have been related to the training or other aspects of the programme that the peer leaders found unsustainable. This brings to attention the potential burdens of training and responsibility as part of the peer-leading experience (Hainsworth and Barlow 2001). To understand and address these burdens of peer-leading would require an in-depth investigation of the experiences of peer leaders in individual programmes.

Different peer-led programmes involve varying degrees of collaboration between health professionals and peer leaders. This partnership may allow group members to have access to both professional and experiential knowledge, but may also lead to relationship tensions between the health professionals and peer leaders (Barlow et al 2005, Catalano et al

2009). A qualitative investigation of the experiences of peer leaders in a Chronic Disease Self-Management Programme identified that the health professionals perceived the peer leaders as burdensome and non-essential and the peer leaders reported feeling undervalued (Catalano et al 2009). It was suggested that future peer leaders should be able to negotiate their roles and responsibilities with the health professionals, thereby enhancing satisfaction in their peer-leading role (Catalano et al 2009).

Driving Cessation

The programme of focus in this paper is the University of Queensland Driver Retirement Initiative (UQDRIVE) programme. UQDRIVE is run by health professionals and peer leaders to support older people through their driving cessation journeys. Driving cessation is a life transition occurring when older people stop driving, voluntarily or involuntarily, due to physical, psychological, or financial factors (Liddle et al., 2007). The practical and symbolic significance of driving makes driving cessation difficult (Eisenhandler, 1990), and people retiring from driving can experience negative social and psychological outcomes, including reduced community integration (Mezuk and Rebok, 2008) and an increased risk of depression (Marottoli et al., 1997).

Driving cessation and community mobility interventions

The increasing recognition of the impact of driving cessation and community mobility is leading to the development of supportive interventions (Molnar et al., 2007). These have included support for planning, transition to other transportation, education for family members and drivers, and transportation guides and training for transport use (Molnar et al., 2007). These approaches have often been locally developed, funded through health or seniors' services or interested groups, and run in local areas, including in the United States of America, Canada, and Australia (Eby et al., 2009; Molnar et al., 2007).

UQDRIVE was developed with reference to the expressed needs of older drivers and retired drivers (Liddle et al., 2007), and relevant theoretical literature including a phase-based model of driving cessation (Liddle et al., 2008), related behaviour change models (for example the transtheoretical model of behaviour change), adult learning principles, and occupational therapy models of practice (Kielhofner, 2002; Law et al., 1996). The purpose of UQDRIVE is to help minimise the negative impact of driving cessation and to promote planning, behaviour change, and adjustment to this life transition for people who have stopped driving or plan to stop driving (Liddle et al., 2007). Each group of eight to 15 people attends for 3 to 4 hours per week over a period of 6 weeks. The programme was led by either one or two health professionals together with one or two peer leaders. UQDRIVE is modular and involved written information, workbook exercises, discussions, guest speakers, and practical exercises. Peer leaders attended all sessions and played an important role in facilitating group discussions, activities, and outings. The content delivered included information on the impact of ageing on driving, alternative transport options, and strategies to cope with losses and lifestyle changes (Gustafsson et al., 2011; Liddle et al., 2007).

In research leading to the development of UQDRIVE, older drivers reported that initiating the topic of driving cessation with other people was challenging, and they valued the input and practical coping strategies recommended by peers (Liddle et al., 2007). When asked directly what would assist with adjustment to driving cessation, participants noted that while they recognised the need for input by ‘experts’, they ascribed high value to the involvement of peers, particularly those who had successfully transitioned to retirement from driving. They particularly sought information about transportation options, problem solving, and practical advice from peers. Noting that retiring and retired drivers experienced disempowerment in relation to driving cessation and that they also placed a high value on the

lived experience of retired drivers, these peer leaders were used in conjunction with health professionals in the UQDRIVE programme (Liddle et al., 2007).

UQDRIVE was developed within Australia, with adaptable content to enable locally relevant content and activities to be included in international locations. It received research funding to evaluate its efficacy and enable provision of the intervention as part of a trial, meaning that participants did not pay to attend the programme. Peer leaders received an honorary payment and had their costs for travel to attend the programme covered. UQDRIVE was trialled with 131 participants (67 intervention, 64 waitlist control). Within the trial, the mean age of participants was 78.9 years (SD 7.6), and just over half were retired drivers (51.6%) with the remainder planning to cease driving within 12 months. Just over a quarter (25.6%) of participants were men, more than half (58.3%) lived alone, and just over a fifth (21.4%) described themselves as being in excellent or very good health. Self-reported health conditions included arthritis (60.7%), eye conditions (43.9%), and movement disorders (7%) (Liddle et al., 2013).

Current Study

Previous peer-leading literature provides a picture of its benefits and associated challenges for programmes predominantly focused on chronic disease management. The experience of coping with a chronic disease may be different from that of undergoing driving cessation, which often involves elements of coping with health conditions and adjustment to a life transition (Liddle et al 2007). Therefore, caution needs to be taken when generalising the benefits and challenges faced by peer leaders in chronic disease programmes to their counterparts in a driving cessation programme. UQDRIVE is a relatively new programme and although outcomes for participants have been reported (Gustafsson et al 2011, Gustafsson et al 2012, Liddle et al 2013), the experiences of peer leaders have not been

examined. Therefore, this paper intends to address these gaps by examining the experiences of peer leaders in a driving cessation programme.

Method

Study Design

An exploratory design with semi-structured interviews was used to understand the experiences of peer leaders in UQDRIVE. This qualitative approach is useful when examining experiences in areas where there is little established knowledge and research (Neergaard et al 2009).

Participants

All peer leaders who had been involved in UQDRIVE between 2007 and 2010 were eligible to participate. Older people were qualified to be peer leaders if they were retired drivers who were engaged in the community, using alternative transport, interested in sharing their driving cessation experiences, and possessed good communication skills. No minimum educational qualifications or past occupational role was stipulated. Individuals became peer leaders either by volunteering for the role or through recommendations by staff after attending UQDRIVE as participants.

Peer leaders participated in individual training sessions with a health professional from UQDRIVE. The training sessions outlined an overview of UQDRIVE and explained the peer leader role in broad principles, with a focus on sharing experiences, providing support, and serving as a role model. Peer leaders were not given content to present, nor asked to undertake particular tasks in running the group. They were asked to participate in a natural way within group sessions and share their experiences related to driving cessation with group members. Peer leaders were given clear guidelines regarding their scope of responsibility. They were asked to inform health professionals about any difficult situations that arose as well as any concerns about unlicensed or unsafe driving, or about the physical or emotional

health of group members. Training sessions also involved discussion of the peer leaders' own driving, driving cessation, and current community engagement experiences. Peer leaders were given a copy of the UQDRIVE workbook and asked to read it. At the end of each UQDRIVE session, health professionals debriefed with the peer leaders to discuss any issues and to assist in planning the next session.

Procedure

Following approval from the University of Queensland ethics committee, all peer leaders eligible for this study were contacted by a research team member via telephone and invited to participate in an audiotaped interview. All peer leaders received a participant information sheet and provided written informed consent prior to the interviews. All interviews were conducted at a mutually convenient time and location, generally in the peer leaders' homes.

Individual semi-structured interviews were conducted face-to-face to enable the interviewer to establish and maintain rapport with the peer leaders as well as to observe for non-verbal communication behaviours, which may reveal the intensity of feelings attached to the verbal statements (Hiller and DiLuzio 2004). An interview guide (Table 1) consisting of open-ended questions to provide flexibility for the exploration of individual experiences (Neergaard et al 2009) and prompts and paraphrasing were used. All interviews were conducted by one interviewer to ensure consistency in data collection. The interviewer, TA, had been involved in running the groups and was known to the peer leaders. Interviews lasted between 20 and 45 minutes and ceased when peer leaders indicated that they had nothing more to share about their peer-leading experiences.

Data Analysis

Interviews were audiotaped and transcribed verbatim with all identifying information such as names and locations removed. Inductive thematic analysis began with repeated independent reading of the transcripts by one member of the research team (XL). This incorporated a simultaneous bottom-up and top-down search for meaning by undertaking detailed line-by-line coding as well as coding at the macro level to identify large major units of meaning for each interview transcript (Thomas 2006). Similar or recurring themes, phrases, and features that emerged inductively across cases were identified and discussed with another member of the research team (JL) to help organise and shape the key meaning of the interviews. Five preliminary themes together with 15 subthemes were identified during this initial analysis. Dedoose web-based software (Version 4.3.87) was used to further organise and synthesise the data. JL independently coded two of the transcripts using the working definitions developed for each theme with subsequent discussion and reorganisation of the findings into three major themes. The themes and definitions were checked by a third member of the research team (LG). Final coding using these themes resulted in an inter-coder agreement of 93%, indicating high consistency of coding and reliability of results (Milne and Orberle 2005).

Results

The study sample consisted of 100% of the peer leaders who had been involved in UQDRIVE: two men and three women between 67 and 81 years of age. Three peer leaders lived alone and two lived with their partners. At the time of recruitment, all peer leaders had completely ceased driving for a duration ranging from three months to over twelve years and described accessing the community with the consistent use of alternative transport. Four of the five peer leaders had no experience taking public transport prior to driving cessation. Of the five peer leaders, three had first attended UQDRIVE as participants.

Three core themes emerged following data analysis. They were (a) diversity of peer leaders, (b) drawing on personal strengths and experiences, and (c) taking the middle ground. Pseudonyms are used to protect the peer leaders' anonymity.

Diversity of Peer Leaders

This theme captured the heterogeneity of peer leaders in UQDRIVE indicating there was not a single 'type' of successful peer leader with differences highlighted in their personalities, as well as driving and driving cessation histories. Peer leaders described themselves variously as being reserved, approachable, or talkative. They had different work and life experiences, ranging from health care work to bookkeeping, and were currently engaged in volunteering, community work, and public speaking. No peer leaders had previous involvement in formal peer-leading roles. The diverse backgrounds had an impact on their peer-leading experiences and this is explored further in the second theme.

Peer leaders recounted different driving experiences. Two peer leaders reported a driving history of only using the car occasionally, whereas others drove frequently for work or recreational activities. All peer leaders reported varying paths of adjustment to driving cessation. Jill reported a combination of feelings, identifying that although she suspected that there might be safety concerns with her driving, she still felt shocked when she was told of her need to stop driving immediately. Ruth, who only drove within her local suburb, reported that she did not miss driving the car, while Keith stated that he *"missed the car tremendously."* Nonetheless, all reported coming to terms with the idea of using alternative transport, even though some had initial doubts about its reliability. Stan related his experience, *"I've driven all my life and I thought there was no way in the world I would catch public transport….but when… I had to catch public transport… I love it."*

Drawing on Personal Strengths and Experiences

Peer leaders in UQDRIVE were not given set tasks or allocated content to teach. Instead, they were given broad principles regarding their role as peer leaders. When describing their involvement in the groups, peer leaders reported that they undertook a range of tasks and approaches that they thought would be useful to the group and reflective of their skills and personalities. Keith, who proclaimed himself to be naturally talkative, described how he actively *"directed the [group] to concentrate upon the presenter,"* while having to make a conscious effort to moderate his involvement to avoid his *"natural tendency to takeover and…run the place."* Jill saw herself as "*a quiet person there to give comfort to people that might have needed it"*, and described her perceived need to make an effort *"to be amongst the group"* in order to engage actively with group members.

The peer leaders reported that they opted to share the positive and negative experiences from their own driving cessation journeys with the group members. These included their unexpected discovery of the benefits of taking public transport, such as monetary savings and feeling more relaxed without having to drive through traffic and find parking; through to making errors while familiarising themselves with the use of public transport. Jill shared relevant experiences that exemplified her outlook: *"I forgot to swipe [my electronic ticket] as I got off the bus so I've paid some big bus fares. But that's all part of the learning process."* Jill hoped that by sharing her experiences she would convey the message that mistakes could be part of the process of learning about taking public transport and should not lead them to give up on the option.

Three peer leaders reported that they set personal objectives for their peer-leading role and these revolved around convincing group members about the feasibility of taking public transport and increasing their receptivity towards it. For example, Claire reported, *"I had it in the back of my mind; these people have to know that public transport works."* Peer leaders considered that personal life experiences, such as overcoming adverse events, were helpful

platforms for reaching out to group members. Stan reported, *"I like to think that I was encouraging people…I can get around even though I'm in a wheelchair."* These goals, consciously or unconsciously, shaped the tasks that peer leaders performed in the groups.

Taking the Middle Ground

The peer leaders characterised their role as that of a bridge between the health professionals and group members. Through their role they helped group members to understand and accept information provided by the health professionals, as well as raise group members' concerns to them. Peer leaders described being able to relate to the group members as they were once in their circumstances, adjusting to driving cessation. Ruth elaborated, *"The people… could equate me to somebody in their own age group, and if I can do it they can do it."* The peer leaders possessed experiential knowledge and were able to assist group members with driving cessation by taking on roles of an encourager, role model, or supporter. Peer leaders indicated that they felt distinguished by their experience of having been through driving cessation and using alternative transport. This perception appealed to Claire as she reported, *"I liked the idea that I knew a few answers, but that wasn't because I was a leader and I'd had training. It was because I was the only one there who'd had experience of public transport."* This led peer leaders to clearly differentiate their own role from that of the health professionals.

In their view, health professionals were characterised by their learned health-related knowledge and the peer leaders' experiential knowledge served to complement it. As Jill reasoned, *"There were leaders there to lead it. But you're there for a lay person's support of your experience."* The peer leaders reported feeling comfortable in this position and being able to blend into the group naturally. Keith reported, "*I just felt that my role was to sort of be one of the group… it was all so natural."* A contrasting experience of the middle ground was related by one peer leader who described feeling isolated in belonging neither to the retired

drivers' or the health professionals' group, which seemed to mirror an earlier life experience for her. Claire reported, *"I didn't find myself part of the group…. I was brought up in an 'us and them' situation at home, and I suppose I brought that situation in the… group."*

Recognising their distinct role in the group, peer leaders reported being cautious not to take on the health professionals' responsibilities. Peer leaders indicated that they carefully considered what they contributed to the group and this appeared to enhance their working relationship with the health professionals. Jill reported, *"I never ever tried to take over…. so I kept within my boundary and....we always had a good relationship."* Peer leaders also held the health professionals' expertise in high regard. On reflecting on their experiences, all peer leaders reported enjoying the role and expressed preferences for maintaining the way UQDRIVE programme was operated, where they were granted the flexibility to work within broad guidelines. Claire outlined her reason*, "That depends on your personality… I tend to go for the helping jobs than getting around socialising jobs."* She described feeling more at ease with serving food as a way of approaching group members, instead of directly initiating conversations with them. Peer leaders also reported a desire to continue peer-leading if the opportunity arose in the future.

Discussion

This exploratory study investigated the experiences of peer leaders in a driving cessation education and support programme. The results suggest that the less prescriptive training for the UQDRIVE programme led to the peer leaders developing their roles in different ways, supported by their personal strengths and previous experiences. This is congruent with the individuality that was found in terms of the process, needs and readiness related to driving cessation in developing the UQDRIVE programme (Liddle et al 2007), and has been reported by others (Berg-Weger et al 2013). As well as fitting with driving cessation patterns, allowing peer leaders to perform to their individual capacity may help reduce the

burden associated with having to meet predetermined task requirements or to undergo lengthy training programmes (Barlow et al 2005, Brown et al 2007). Peer leaders in UQDRIVE expressed a preference for this peer-leading approach as it allowed them to perform tasks that they felt comfortable doing. The autonomy for peer leaders to express their individuality may have minimised the loss of ownership previously reported in other programmes where peer leaders reported feeling undervalued (Catalano et al 2009).

Dutcher et al (2011) reported that when peer leaders were not assigned a specific task, they were afforded a flexibility to allow them to vary and widen their scope of work to better suit the needs of the group members. Adult learning principles were an important consideration in the development of the UQDRIVE programme. They recognised that the peer leaders and participants all had life experiences that were likely to be relevant to the group process (Gustafsson et al 2011). Cognisant with adult learning principles, the peer leaders were able to direct their own learning and experiences to contribute to the group (Merriam 2001). The peer leaders in UQDRIVE reported seeking clarification from health professionals as a useful part of their involvement. It was important to allow opportunities for peer leaders to communicate with health professionals during and outside of the groups to provide support (Merrell 2000).

Previous studies have identified relationship tensions between peer leaders and health professionals (Barlow et al 2005, Catalano et al 2009). These issues were purposefully explored in the current study and while peer leaders in UQDRIVE engaged in a range of different tasks, they independently characterised the peer-leading role as one that occupies the middle ground and forms a bridge between the health professionals and group members. This corroborates with findings from a study that examined the relationships between peer leaders and paid workers working in the community wellness woman clinics (Merrell 2000). The peer leaders in the community-based clinics were not given descriptions of the scope of

their role and it was found that they shared a common understanding of the essence of their role as sitting between the participants and the paid workers (Merrell 2000). The training of peer leaders for the UQDRIVE programme included clear identification of boundaries due to the legal and health implications related to driving cessation and this perhaps promoted a clearer understanding of their role. Further reinforcement was derived from the fact that health professionals were primarily responsible for delivering the course content in UQDRIVE while the peer leaders held the essential role of providing experiential knowledge and understanding.

Limitations and Future Directions

There are several limitations to this study. Firstly, due to the small sample size and specific context of the driving cessation programme, generalisation of results needs to occur with caution. Qualitative studies are not designed to involve a sample of participants that represents the entire population but instead, aim to gain an in-depth understanding of the issues facing the people with relevant experiences (Patton 2002). While the study sample involved all the peer leaders in UQDRIVE to date, its small sample size may cause unique experiences of individual participant to take on heightened importance. Secondly, peer leaders knew the interviewer as a health professional from UQDRIVE. This may have influenced what they were willing to say during the interviews (DiCicco-Bloom and Crabtree 2006). Thirdly, all the researchers have a similar professional background in occupational therapy. This may influence the way they viewed the data (Arber 2006). The main researcher analysing the data was not involved in running the UQDRIVE groups and did not know the peer leaders. This may help to facilitate low-inference interpretation as recommended in exploratory studies (Neergaard et al 2009). Participant checking was not undertaken as part of this study due to resource limitations. Lastly, research studies on driving and transport issues must recognise the impact of geographical region and service availability on driving

cessation outcomes. Therefore, readers should note that this study was conducted in South East Queensland in Australia and may be influenced by the licensing requirements for older drivers, climate, availability of alternative transport and cultural value attached to ageing and driving.

Future studies may enhance understanding through increased engagement with peer leaders over time and gaining the health professionals' and group members' perspectives on the use of peer leaders. Researchers may also test the effectiveness of this peer-leading approach by conducting comparative studies of group member outcomes with another where peer leaders are given set tasks. Other methods of peer support delivery such as one-on-one, telephone and Internet services for people undergoing driving cessation could also be explored.

Implications

This study contributes to the emerging body of research on the peer leaders' experiences in peer-led programmes, particularly where they operated within broad guidelines. The findings suggest that guidelines outlining the boundaries of the peer leader role enable peer leaders to apply personal strengths and experiences to make better contributions to the group. These have implications for the development of future peer-led programmes and models that enable peer leaders to apply personal strengths and experiences to make better contributions to the group (Dutcher et al 2011). Characteristics of peer leaders, such as a high level of awareness of their strengths and weaknesses, appeared beneficial to their peer-leading role. This suggests that future training programmes for peer leaders could incorporate activities to increase their awareness of their strengths and weaknesses. This focuses on the development of their existing skills instead of acquiring new knowledge. Peer leaders also appeared to benefit from having opportunities to liaise with health professionals during and after the groups, whether it was by being able to address

concerns or questions as they arose, or feeling comfortable that they could do so if needed. Future peer-led programmes can take these findings into consideration in the development of their programmes.

Conclusion

This study examines the experiences of peer leaders in a driving cessation programme. Peer leaders in UQDRIVE drew on their own strengths and experiences to undertake a range of tasks. They described their peer-leading role as one occupying the middle ground between the health professionals and group members. They also indicated a preference for this peer-leading approach where their role was explained in broad guidelines, but set tasks or content were not allocated. These findings may be applicable to other peer-led programmes adopting similar peer-leading models as well as to other health and life transition programmes.

Acknowledgements

The authors would like to acknowledge and thank the research team and participants for their dedication, time, and support of this project.

Funding

This study was part of a larger study supported by a three-year project grant from the National Health Medical Research Council of Australia.

References

Arber A (2006) Reflexity: a challenge for the researcher as practitioner? *Journal of Research in Nursing*, *11*(2), 147-158.

Barlow JH, Bancroft GV, Turner AP (2005) Volunteer, lay tutors' experiences of the chronic disease self-management course: being valued and adding value. *Health Education Research*, *20*(2), 128-135.

Berg-Weger M, Meuser TM, Stowe J (2013) Addressing individual differences in mobility transition counseling with older adults. *Journal of Gerontological Social Work, 56*(3), 201-218.

Brown C, Hennings J, Caress AL, Patridge MR (2007) Lay educators in asthma self management: reflections on their training and experiences. *Patient Education and Counselling, 68*(2), 131-138.

Catalano T, Kendall E, Vandenberg A, Hunter B (2009) The experiences of leaders of self-management courses in Queensland: exploring health professional and peer leaders' perceptions of working together. *Health and Social Care in the Community, 17*(2), 105-115.

Chodosh J, Morton SC, Mojica W, Maglione M, Suttorp MJ, Hilton L, Rhodes S, Shekelle P (2005) Meta-analysis: chronic disease self-management programs for older adults. *Annals of Internal Medicine, 143*(6), 427-438.

Dedoose (Version 4.3.86) [Web application]. Los Angeles, CA: SocioCultural Research Consultants.

DiCicco-Bloom B, Crabtree BF (2006) The qualitative research interview. *Medical Education, 40*(4), 314–321.

Dutcher MV, Phicil SN, Goldenkranz SB, Rajabiun S, Franks J, Loscher BS, Mabachi NM (2011) “Positive examples”: a bottom-up approach to identifying best practices in HIV care and treatment based on the experiences of peer educators. *AIDS Patient Care and STDs, 25*(7), 403-411.

Eby DW, Molnar LJ and Kartje PS (2009) Maintaining Safe Mobility in an Aging Society. Boca Raton: CRC Press.

Eisenhandler SA (1990) The asphalt identikit: old age and the driver's license. *International Journal of Aging and Human Development, 30*(1), 1-14.

Foster G, Taylor SJC, Eldridge S, Ramsay J, Griffiths CJ (2007) Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane Database of Systematic Reviews, 4* (CD005108).

Griffiths C, Foster G, Ramsay J, Eldridge S, Taylor S (2007) How effective are expert patient (lay led) education programmes for chronic disease? *British Medical Journal, 334*(7606), 1254-1256.

Gustafsson LA, Liddle JM, Lua S, Hoyle MF, Pachana NA, Mitchell GK, McKenna KT (2011) Participant feedback and satisfaction with the UQDRIVE groups for driving cessation. *Canadian Journal of Occupational Therapy, 78*(2), 110-117.

Gustafsson L, Liddle J, Liang P, Pachana N, Mitchell G, McKenna K (2012) Use of a driving cessation program to identify and improve transport and lifestyle issues of older retired and retiring drivers. *International Journal of Psychogeriatrics. 24(5),* 794-802.

Hainsworth J, Barlow JH (2001) Volunteers' experiences of becoming an arthritis self-management lay-leader: 'It's almost as if I've stopped ageing and started to get younger!' *Arthritis Care and Research, 45*(4), 378-383.

Hiller HH, DiLuzio L (2004) The participants and the research interview: analysing a neglected dimension in research. *Canadian Review of Sociology, 41*(1), 1-26.

Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Richardson G, Gardner C, Gately C, Rogers A (2007) The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial. *Journal of Epidemiology and Community Health, 61*(3), 254-261.

Kielhofner G (2012) *Model of human occupation.* 4th ed. Philadelphia: Lippincott Williams & Wilkins.

Law M, Cooper B, Strong S, Stewart D, Rigby P, Letts L (1996). The person-environment-occupation model: a transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*(1), 9-23.

Liddle J, McKenna K, Barlett H (2007) Improving outcomes for older retired drivers: the UQDRIVE program. *Australian Occupational Therapy Journal, 54*(4), 303-306.

Liddle J, Turpin M, Carlson G, McKenna K (2008). The needs and experiences related to driving cessation for older people. *British Journal of Occupational Therapy, 71*(9), 379-388.

Liddle J, Haynes M, Pachana NA, Mitchell G, McKenna K, Gustafsson L (2013) Effect of a group intervention to promote older adults' adjustment to driving cessation on community mobility: a randomized controlled trial. *The Gerontologist.* doi: 10.1093/geront/gnt019.

Macdonald W, Kontopantelis E, Bower P, Kennedy A, Rogers A, Reeves D (2009) What makes a successful volunteer expert patients programme tutor? Factors predicting satisfaction, productivity and intention to continue tutoring of a new public health workforce in the United Kingdom. *Patient Education and Counselling, 75*(1), 128-134.

Marottoli RA, Mendes de Leon CF, Glass TA, Williams CS, Cooney LM, Berkman LF, Tinetti ME (1997) Driving cessation and increased depressive symptoms: prospective evidence from the New Haven EPESE. *Journal of the American Geriatrics Society, 45*(2), 202-206.

Merrell J (2000). Ambiguity: exploring the complexity of roles and boundaries when working with volunteers in well woman clinics. *Social Science & Medicine, 51*(1), 93-102.

Merriam SB (2001) Andragogy and self-directed learning: pillars of adult learning theory. *New Directions for Adult and Continuing Education, 89*, 3-14.

Mezuk B, Rebok GW (2008) Social integration and social support among older adults following driving cessation. *The Journals of Gerontology, 63*(5), 298-303.

Milne J, Orberle K (2005) Enhancing rigor in qualitative description: a case study. *Journal of Wound, Ostomy and Continence Nursing, 32*(6), 413-420.

Molnar LJ, Eby DW, St Louis RM, et al. (2007) Promising Approaches for Promoting Lifelong Community Mobility. Ann Arbor, MI: Transport Research Institute, University of Michigan.

Neergaard MA, Olesen F, Andersen RS, Sondergaard J (2009) Qualitative description- the poor cousin of health research? *BMC Medical Research Methodology*, *9*(52).

Patton MQ (2002) *Qualitative research and evaluation methods*. 3rd ed. Thousand Oaks: Sage Publications.

Peel NM and Warburton J (2009) Using senior volunteers as peer educators: what is the evidence of effectiveness in falls prevention? Australasian Journal on Ageing 28(1): 7–11.

Simoni JM, Franks JC, Lehavot K, Yard SS (2011). Peer interventions to promote health: conceptual considerations. *American Journal of Orthopsychiatry, 81*(3), 351-359.

Thomas DR (2006) A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

Webel AR, Okonsky J, Trompeta J, Holzemer WL (2010). A systematic review of the effectiveness of peer-based interventions on health-behaviors in adults. *American Journal of Public Health, 100*(2), 247-253.

Table 1

Semi-structured Interview Guide

Could you describe your past driving history?
Could you describe your driving cessation journey?
What were your experiences with taking public transport prior to driving cessation?
How are your current community engagement experiences?
How would you describe your role as a peer leader in UQDRIVE?
What were your most enjoyable aspects of being peer leader?
What were your least enjoyable aspects of being a peer leader?
What were some challenges with being a peer leader in UQDRIVE?
How was your experience working with the health professionals in UQDRIVE?
Is there anything that would have made you more prepared to be a peer leader?
What are your views of having peer leaders in a group like UQDRIVE?
Do you have anything else to add about your experience as a peer leader?

Note. UQDRIVE=University of Queensland Driver Retirement Initiative

Box details:
Key findings

- A range of people were able to be effective peer leaders in a driving cessation programme.
- Peer leaders organised their involvement based on personal resources and experiences.

What the study has added

Retired drivers take on differing peer leader roles within a driving cessation programme.

Despite differences, peer leaders felt effective and valued, taking the “middle ground” between health professionals and group members.