Promoting Active Ageing in Older People with Mental Disorders in Thai Primary Care Units: The Development and Psychometric Testing of an Assessment Tool, A Mixed Methods Study

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STATEMENT OF ORIGINALITY

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. This thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

Signed…….

(Kedsaraporn Kenbubpha)

Date……22nd June 2018…….

DEDICATION

I dedicate this thesis and degree to my beloved parents;

Thana Kenbubpha and Jirawan Kenbubpha (ธนา เคนบุปผา และ จิราวัณย์ เคนบุปผา). In particular, I dedicate this thesis to my father who passed away during the second year of my PhD journey. He urged me to continue my studies even after he was admitted to hospital in Thailand. He said; “you are my only daughter who can reach my dream for being Dr in our family. Please, return to Australia for study and do not give up my beloved daughter.”

Finally, I reach your dream, Dad.

My parent’s unconditional love and endless loving-kindness gave me strength and encouragement to complete the PhD journey.

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Submitted Articles

Kenbubpha K, Higgins I, Wilson A, Chan W-CS. Testing psychometric properties of a new instrument from a cross-sectional study "Promoting Active Ageing in Older People with Mental Disorders Scale" Submitted to Patient Education and Counselling 4th January 2018.

Kenbubpha K, Higgins I, Wilson A, Chan W-CS. "How primary care providers promote active ageing in community-dwelling older people with mental disorders: a qualitative study" Submitted to Asian Journal of Psychiatry on 4th January 2018.

Kenbubpha K, Higgins I, Wilson A, Chan W-CS. Development and pilot testing of a new instrument "Promoting Active Ageing in Older People with Mental Disorders Scale" Submitted to Journal of Mental Health on 16th April 2018.

Conference Presentation

Kenbubpha K, Higgins I, Chan W-CS, Wilson A. Promoting Active Ageing in Older People with Mental Disorders: Development and Testing of a Tool. Poster presentation at the 21st International Association of Gerontology and Geriatrics, World Congress in San Francisco, California, the United States of America during 23rd -27th July 2017.

Kenbubpha K, Higgins I, Chan W-CS, Wilson A. Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD). Oral presentation on the 2017 Research Week program, School of Nursing and Midwifery, the University of Newcastle during 3rd –5th July 2017.

Kenbubpha K, Higgins I, Chan W-CS, Wilson A. Promoting active ageing in older people with mental disorders in communities: Development and testing of a survey instrument. Oral presentation at 15th National Conference of Emerging Researchers in Ageing, The Australian National University, Canberra during 31st October–1st November 2016.

Kenbubpha K, Higgins I, Chan W-CS, Wilson A. Promoting active ageing in older people with mental disorders in Thai primary care units: The findings of focus groups with healthcare workers. Poster presentation at 15th National Conference of Emerging Researchers in Ageing, The Australian National University, Canberra during 31st October–1st November 2016.

Kenbubpha K, Higgins I, Chan W-CS, Wilson A. Promoting active ageing amongst older people with mental disorders in primary care: an integrative review of the literature. Oral presentation on the 10th International Association of Gerontology and Geriatric, Asia/Oceania Regional Congress, Chiang Mai, Thailand during 19th –22nd October 2015.

ABSTRACT

Aims: were to develop and test a new survey instrument designed to measure the promotion of active ageing in older people with mental disorders living in the community of Thailand and identify factors that influence the promotion of active ageing in this group.

Design: Mixed methods research with exploratory sequential design divided into two phases; a qualitative exploration of the topic followed by a quantitative approach.

Methods: Instrument development consisted of two focus group interviews, item generation, content validity testing, face validity, and a pilot study. A cross-sectional study was then conducted. Psychometric properties were tested using content validity index, Cronbach's alpha, Spearman's coefficient of correlation, and exploratory factor analysis.

Results: The Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD) contains 104 items categorised into three sections based on findings from focus groups, literature review, and the concept of active ageing. Section I examines general information and familiarity of active ageing and related concepts. Section II measures the promotion of active ageing in older people with mental disorders. Section III identifies factors that influence the promotion of active ageing. Each item of section II and III is rated on a five-point Likert scale. Content validity index of section II and III were 0.82 and 0.84 respectively. Face validity was suitable for respondents. Internal reliability from the pilot study of section II and III were 0.975 and 0.964 respectively. Scores of section II and III correlated significantly with the total score: 0.970 ($P<0.01$) and 0.988 ($P<0.01$) that supported good external reliability. Construct validity of sections II and III indicated five factors each. Cronbach's Alpha from a large sample of sections

II and III were 0.974 and 0.966 that indicated good internal consistency. All items had corrected item-total correlation coefficient greater than 0.30.

Conclusion: The PAA-MD has high levels reliability and validity.

STRUCTURE OF THESIS

Chapter One, the introduction and background to the study addresses the problem of promoting active ageing in older people with mental disorders in primary care units in Thailand. The aims, objectives, and research questions for the study are outlined along with a detailed analysis of the background literature which focuses on issues relating to the ageing population, health system, health workforce, and mental disorders in older people living in the community around the world. Chapter Two presents an integrative review of the relevant and recent literature relating to active ageing, and related concepts, in older people with mental disorders living in the community. Chapter Three provides a detailed discussion of the mixed methods methodology and design employed in this PhD research. The discussion is also provided on the methodological challenges relating to the execution of this PhD research. Details regarding the research design, plan, methods used, the ethical considerations and the researcher's background in the study are described in Chapter Four.

In Chapter Five I report the findings of the qualitative phase (phase one) from the Focus Group interviews following with discussions, strengths and limitations. Chapter Six presents the findings of quantitative phase (phase two-step one), the development and pilot testing of a new survey instrument along with discussions, strengths and limitations. Chapter Seven shows the findings of the quantitative phase (phase two-step two), testing of the psychometric properties of the new survey instrument from a cross-sectional study along with discussions, strengths and limitations. Chapter Eight presents an overview and summary of the research, discussion of the overall research, its strengths and limitations, implications for practice, health policy, and education, recommendations for future research, and the conclusion of this PhD research.

ABBREVIATIONS

Department of Mental Health, Thailand: DMH

Focus groups: FGs

Joanna Briggs Institute: JBI

Ministry of Public Health, Thailand: MoPH

Primary health care: PHC

Promoting Active Ageing in Older People with Mental Disorders Scale: PAA-MD

Standard deviation: SD

The content validity index for individual items: I-CVI

The content validity index for the overall survey: S-CVI

The United Kingdom: the UK

The United State of America: the USA

The World Health Organization: WHO

World Federation for Mental Health: WFMH

DEFINITION OF TERMS

In this PhD research, **active ageing** is defined by the World Health Organization as; *"…the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age"* (World Health Organization (WHO), 2002, p. 12). A detailed description of this concept is described in the background to study.

The American Psychiatric Association defines a **mental disorder** as; "*a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities."* (American Psychiatric Association, 2013b, p. 20).

The World Health Organization defined **primary health care (PHC)** as "*essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*" (Alma-Ata, 1978, p. 4).

Primary care providers are defined as; interdisciplinary healthcare workers, who include; general medical doctors, assistant dentists, assistant pharmacists, registered nurses, assistant nurses, health officers, and primary care workers who work in primary care units or Health Promoting Hospitals in Thailand and are employed under the Ministry of Public Health, the Royal Thai Government. The details of their education and roles are discussed in the background to study.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 STATEMENT OF PROBLEM AND SIGNIFICANCE OF RESEARCH

The world's population is ageing rapidly. According to the United Nations, an ageing society is defined as when the proportion of a country's people aged 60 years and over is more than 10%, or aged 65 years and above is more than 7% (United Nations, Department of Economic and Social Affairs, & Population Division, 2013). This trend is apparent in nearly all countries of the world, and the number of older people is increasing faster than another age group (United Nations, Department of Economic and Social Affairs, & Population Division, 2015). Over the next 50 years, the number of people over the age of 60 will increase from 600 million to 2 billion (World Health Organization (WHO), 2013). The speed of population ageing in many developing countries is substantially faster than in developed countries (United Nations et al., 2015). In light of this, developing countries need to adjust rapidly to the changing demographics and with lower levels of national income compared to developed countries (United Nations et al., 2015).

In most westernised countries people over 60 and 65 are generally considered to remain healthy as they age (Rau, Soroko, Jasilionis, & Vaupel, 2008), although ageing is associated with increased chronic disease, multiple co-morbidities, disability, frailty, and death (Christensen, Doblhammer, Rau, & Vaupel, 2009; Nobili, Garattini, & Mannucci, 2011). Many older people also have mental illness as well as physical illness and disease (Age Concern and the Mental Health Foundation, 2006; Collingwood, 2015). Older people with multiple medical conditions are also known to often suffer from mental health problems, such as depression and anxiety (Jones, Amtmann, & Gell, 2016) and frequently attend outpatient clinics in primary care settings (Fortin et al., 2004).

It is widely known that primary care centres can positively influence the health of older people living in communities worldwide (WHO, 2015b). In developing countries, they are the front line of health services in caring for older persons with the majority of older people living in the community (WHO, 2004). However, most primary care units are busy places where doctors, nurses, and other healthcare providers lack time and resources to address all the needs of people in their care, especially psychosocial needs (WHO, 2004; World Health Organization & Wonca Working Party on Mental Health, 2008). Many primary care providers also lack the skill needed to care and support older people living in communities particularly those with mental illnesses (Petersen, Ssebunnya, Bhana, & Baillie, 2011). For example, they lack understanding and skills for; detecting psychological problems, managing depression and anxiety, intervening in crises, enhancing medication compliance (Haddad et al., 2005) and using validated instruments to assess mental health problems (Grundberg, Hansson, Hillerås, & Religa, 2016). More importantly, they do not use evidence-based guidelines care in their primary care settings (Grundberg et al., 2016). Primary care staff note that older patients rarely complain about their psychological concerns or difficulties; they do not talk about non-medical problems, in particular, depression symptoms (Murray et al., 2006). Notably, older people perceive depression as a normal part of the ageing process and as a sign of weakness (Murray et al., 2006). As a result, older people with mental illness presenting to primary care settings are often not detected, diagnosed, and they are, therefore, left untreated (Grundberg et al., 2016; Muir-Cochrane, O'Kane, Barkway, Oster, & Fuller, 2014; Richardson, He, Podgorski, Tu, & Conwell, 2010; Runciman, Watson, McIntosh, & Tolson, 2006; WHO, 2013).

In 2002, the World Health Organization (WHO) launched a policy framework to promote active ageing for older people (WHO, 2002). Many countries have since implemented

active ageing policies, including Australia, New Zealand, the United Kingdom (UK), Canada, Sweden, the United States of America (USA), Taiwan and Thailand (Hutchison, Morrison, & Mikhailovich, 2006; Jitapunkul & Wivatvanit, 2008; Lin, Chen, & Cheng, 2013). Active ageing, discussed in more detail later, focuses on engaging older people to improve their health, ensure their security, and maximise their social participation for optimising the quality of life in older people (WHO, 2002). Good physical and mental health will increase as a result. The notion of active ageing has become an important area for older people living in the community because of the policy move toward encouraging older people to remain living in their home as they age (Provencher, Keating, Warburton, & Roos, 2014). Indeed, older people would prefer to live independently in their own homes in the community (Gilleard, Hyde, & Higgs, 2007; Lehning, Scharlach, & Wolf, 2012).

Whilst some research on the concept of active ageing has been conducted, these studies focus on healthy older adults and do not include older people with mental health issues (Lin et al., 2013; Mendoza-Ruvalcaba & Arias-Merino, 2015; Thanakwang, Isaramalai, & Hattakit, 2014; Thanakwang, Isaramalai, & Hatthakit, 2014). The promotion of active ageing in older people with mental disorders, a marginalised population, remain under-researched. In addition, there is no validated instrument that measures the promotion of active ageing of older people with mental illnesses or the factors that influence the promotion of active ageing in this group. A standard instrument that measures active ageing is essential to be able to assess and monitor the levels and range of activities associated with active ageing and to examine factors that influence the promotion of active ageing in this group. The outcomes from such a standard instrument testing process would be able to indicate the level of promoting active ageing in this group and would be useful to identify strategies for developing successful programs.

1.2 AIMS AND OBJECTIVES OF THE STUDY

1.2.1 Aims

The aims of the study were to develop and test a new survey instrument designed to: a) measure the promotion of active ageing in older people with mental disorders living in the community of Thailand, and b) identify factors that influence the promotion of active ageing in this group.

1.2.2 The objectives were:

1. To explore how primary care providers understand the concept of active ageing.

2. To explore how primary care providers use/apply the concept of active ageing.

3. To examine the perspectives of primary care providers regarding the promotion of active ageing.

4. To identify the perspectives of primary care providers regarding factors that influence the promotion of active ageing.

5. To develop an instrument for measuring the promotion of active ageing and identifying factors that influence the promotion of active ageing.

6. To psychometrically test an instrument for measuring the promotion of active ageing and identifying factors that influence promotion active ageing in this group.

1.3 RESEARCH QUESTIONS

The research questions were:

1. What are the perspectives of primary care providers about promoting active ageing in older people with mental disorders living in a Thai community?

1.1 What do they understand the concept ‘active ageing’?

1.2 How do they use/apply the concept of active ageing?

1.3 What is the promotion of active ageing in this group?

1.4 What are the factors that influence the promotion of active ageing in this group?

2. What are the main components of an instrument designed to measure the promotion of active ageing in older people with mental disorders living in a Thai community and that identifies factors that influence the promotion of active ageing in this group?

3. What are the psychometric properties of the new survey instrument?

3.1 What is the content validity?

3.2 What is the face validity?

3.3 What are the internal and external reliability?

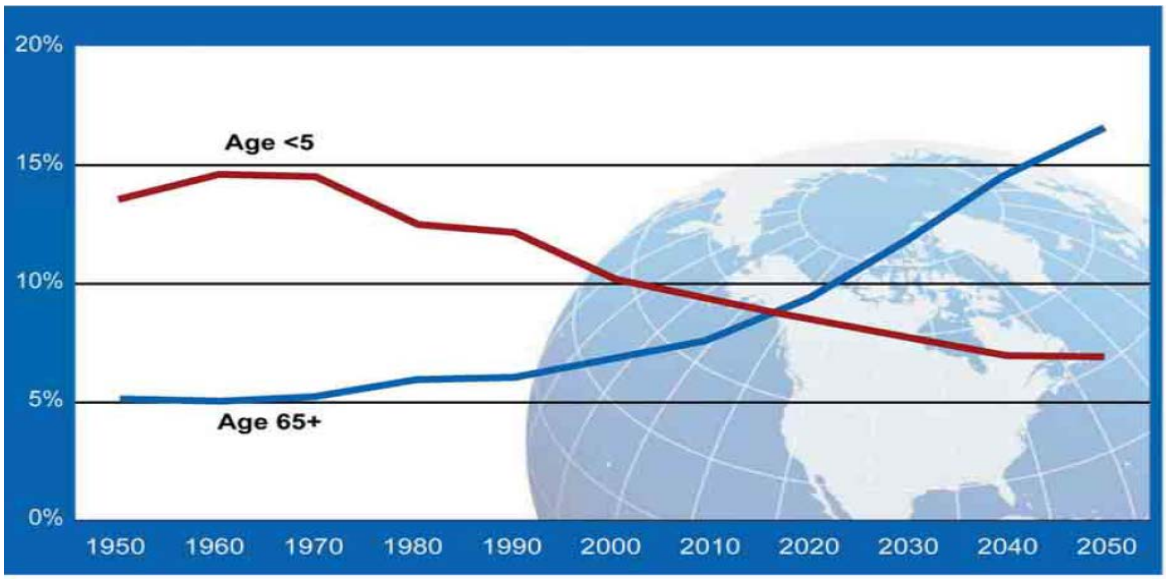
3.4 What is the construct validity?

1.4 BACKGROUND TO STUDY

1.4.1 POPULATION AGEING

As noted in the introduction to this thesis, the world is reaching a new demographic milestone about the number of people aged 65 or older. It was predicted that by the year 2015, they would outnumber children under five years of age (WHO, 2011) as seen in (Figure 1-1).

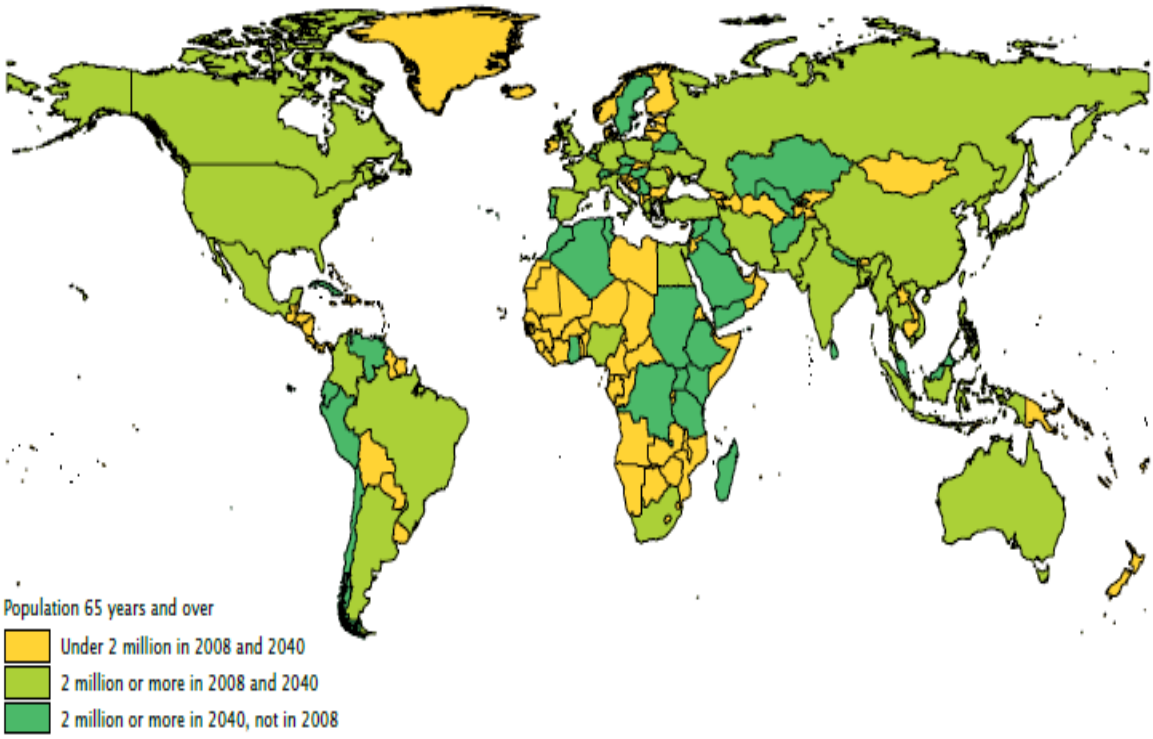
Figure 1-1: Young children and older people as a percentage of global population: 1950-2050



(Source: World Health Organization (2011, p. 7). *Global health and aging*.)

An international population report commissioned by the USA Department of Health and Human Services and Department of Commerce shows that by the year 2040, 72 countries are projected to have 20 million people aged 65 and older (Kinsell & He, 2009) (Figure 1-2).

Figure 1-2: Population aged 65 and over by size threshold (2 million): 2008 and 2040



(Source: Kinsell and He (2009, p. 9). *An aging world: 2008*.)

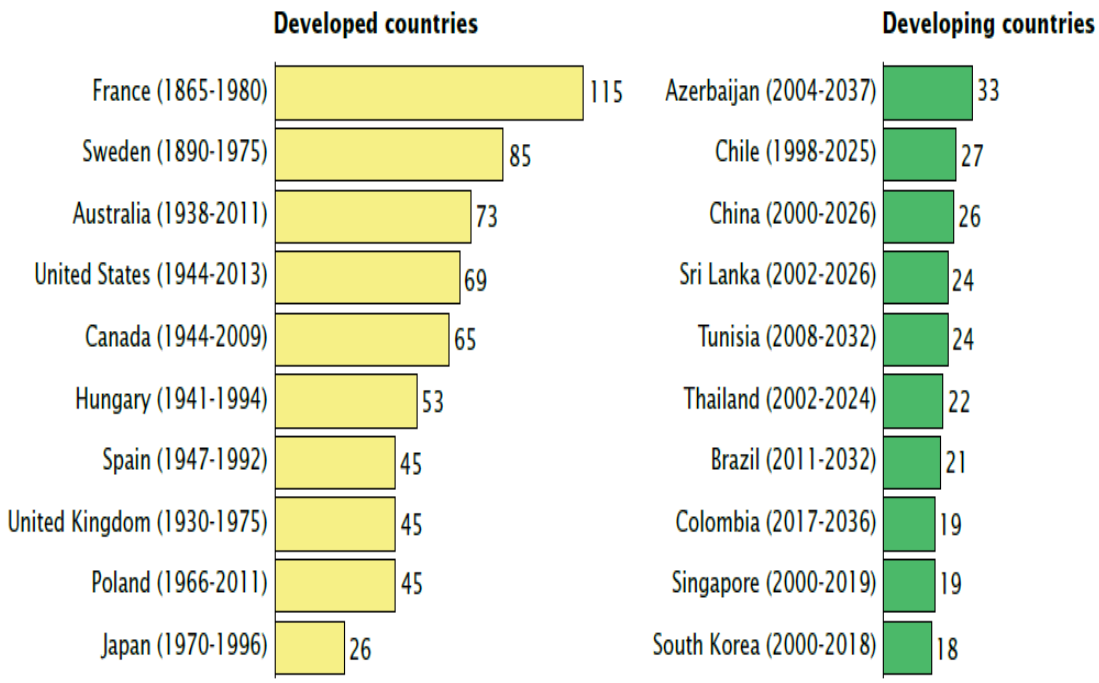
Changes in demographics and family trends have affected the lives of older people with fewer older people living with families to support them (WHO, 2011). Today, people have fewer children with many older people single and/or living alone (WHO, 2011). In light of this, professional health carers and communities need information about promoting health with programmes designed to enhance the well-being of older people.

The changing age structure is different between developed and emerging nations, as shown in Figure 1-3. The majority of developed countries take time about decades to adjust to the changing age structure in their nations (WHO, 2011). For instance, in France, it took over a century for the age group of 65 years and over to increase from 7% to 14%. France has had time to develop appropriate infrastructure, health services, and social welfare. Conversely, many developing countries are experiencing a rapid growth in both

the number and percentage of older people (WHO, 2011). Thailand, for example, has experienced a similar increase in their aged population to France but only 22 years. Thailand has created a challenge for the country as it prepares for an ever-increasing ageing society.

In many less developed countries, the tsunami of ageing will challenge national policy and infrastructures, particularly health service systems. This is because as the ageing population rapidly increases, economic growth has slowed (WHO, 2011). In other words, developing nations are more likely to grow old before they grow rich.

Figure 1-3: Time expected for the percentage of population aged 65 and over to increase from 7 to 14 percent among developed and developing countries



(Source: Kinsell and He (2009, p. 14). *An aging world: 2008.*)

1.4.2 ISSUES RELATING TO POPULATION AGEING

Ageing impacts health care, social costs and infrastructure, and increases illnesses, disability, and dependency (WHO, 2004). Older people are commonly experiencing poverty, inadequate income, security and safety issues, and have limited access to health services and social care (WHO, 2017a). As stated previously, the ageing process is associated with an increased risk of developing chronic diseases and disability. To prepare for population ageing, health systems need to address the consequence of these demographic trends, and this is particularly so for developing nations (WHO, 2004).

1.4.2.1 Health service systems

A world report on ageing and health (WHO, 2017a), shows older people experience barriers in accessing adequate health care and may have been poorly treated. Lack of quality healthcare systems is a crucial barrier for older people and includes inadequate support equipment and health care providers' skills. The details of the findings from WHO world health survey are summarized in Table 1-1.

Table 1-1: Reasons were given by adults aged 60 years or older for not accessing healthcare services, by countries' income category

Reason for not accessing health-care services	Country income category (% of respondents)			
	High-income	**Upper-middle income**	**Lower-middle-income**	**Low-income**
Could not afford the visit	15.7	30.9	60.9	60.2
No transport	12.1	19.3	20.7	29.1
Could not afford transport	8.7	12.9	28.1	33.0
Health-care providers's equipment inadequate	11.2	10.5	14.1	16.7
Health-care providers's skills inadequate	19.0	8.3	7.8	13.1
Previously treated badly	23.8	8.7	7.9	8.3
Did not know where to go	12.2	9.7	9.8	7.8
Was not sick enough	21.5	31.8	27.3	25.8
Tried but was denied health	20.0	16.2	8.3	8.5
Other	43.8	22.5	23.5	13.9

(Source: World Health Organization (2017a, p. 91). *World report on ageing and health*.)

Health care workers today are primarily trained to examine and treat symptoms and conditions as they arise rather than engage with preventive, holistic care. Current training courses were developed in the 20th century when acute infectious diseases were the most prevalent health problems in the world (WHO, 2017a). However, more recently, the WHO (WHO, 2017a) suggests that holistic approaches may be more appropriate and effective for older people to prevent disease, and control and manage their chronic conditions.

1.4.2.2 Mental health and older people

Hundreds of millions of people are affecting from mental disorders causing suffering, disability and economic burden (World Health Organization & World Organization of Family Doctors, 2008). The WHO reported those living with a mental illness constituted approximately 31% of the total population (11% major depressive disorder[1], 3.7% alcohol use disorder[2], 2.7% schizophrenia[3], and 2.4% bipolar disorder[4]). It is predicted that unipolar depressive disorder will be the leading cause of the total mental disorders burden globally by 2030 (Mathers & Loncar, 2006; WHO, 2008a).

Mental and general health is affected by many factors including, poverty, social isolation, loss of independence, and loneliness (World Federation for Mental Health, 2013). Older people are more likely to get at high risk of experiencing many of these factors, as well as physical conditions that influence emotional well-being, thus resulting in poorer mental health than the general population (World Federation for Mental Health, 2013).

Mental disorders in older people living in the community are common, ranging from 8.54% to 33% of a 12-month prevalence (Gum, King-Kallimanis, & Kohn, 2009; Olafsdottir, Marcusson, & Skoog, 2001; Ritchie et al., 2004). Internationally, nearly 20% of older people visiting primary care facilities were found to have experienced a mental disorder in the previous 12 months (Baladón et al., 2015).

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[1] Major depressive disorder is a serious mental illness characterized by depressed mood or a loss of interest or pleasure in daily activities for more than two weeks (American Psychiatric Association, 2013a).

[2] Alcohol use disorder is excessive alcohol use causes symptoms affecting the body, thoughts, and behavior (American Psychiatric Association, 2013a).

[3] Schizophrenia is a serious mental illness characterized by incoherent or illogical thoughts, bizarre behavior and speech, and delusions or hallucinations, such as hearing voices (American Psychiatric Association, 2013a).

[4] Bipolar disorder is a serious mental illness in which common emotions become intensely and often unpredictably magnified, including manic episodes — abnormally elevated or irritable moods — and possibly depression (American Psychiatric Association, 2013a).

However, the outcomes for older people with mental disorders can be improved through the promotion of active and healthy ageing (World Federation for Mental Health, 2013). The World Federation for Mental Health (2013) suggested strategies for improving mental health in older populations as follows:

1. Social support and family interactions are vital protective factors.
2. Participation should engage in meaningful activities, strong personal relationships, and good physical health.
3. The promotion of mental health is critically important in addressing maltreatment of older people in health services and social services.
4. Primary health care in the community and social service sectors should be sensitised and supported by specialists to deal with ageism in older people.
5. Promoting healthy lifestyles among the general population should be started from an earlier age, which can result in better mental health among older people. For example, increasing physical and mental activity, avoiding smoking, preventing harmful use of alcohol, and providing early identification and treatment of non-communicable disease.
6. The implementation of mental health promotion strategies should be facilitated by cooperation amongst civil society, non-government and non-profit organisations, including public-private partnerships.

To summarise, promotion of active ageing can improve mental health for older people. They should be started to promote active ageing from an earlier age by enhancing a healthy lifestyle, increasing social support and family interaction, encouraging participation in the community activities. The primary health care services and social sectors in the community should cooperate to provide the promotion of active ageing in this group.

1.4.2.3 The burden of mental health care in primary care

In all countries around the world, mental health services have been integrated into primary care to help more people receive mental health care from health care professionals (World Health Organization & World Organization of Family Doctors, 2008). Assessing and supporting people with clinical manifestations and comorbidities associated with mental disorders are significant concerns for the health provision of care in primary health care (Roca et al., 2009). Unexplained physical symptoms, such as a headache and back pain, are correlated to common mental disorders (Aiarzaguena, Grandes, Salazar, Gaminde, & Sánchez, 2008). Mental health disorders interact with other physical illnesses and injuries (Prince et al., 2007) and are related to poorer quality of life and disability than chronic diseases (Grandes, Montoya, Arietaleanizbeaskoa, Arce, & Sanchez, 2011). This means that the care of people with mental illness is very challenging for primary care providers (Grandes et al., 2011). All Primary care providers prioritise care regarding chronic physical diseases such as cardiovascular disease, diabetes mellitus, and hypertension focusing on those that cause early mortality. Promotion of mental health and management of mental disorders in primary health care are not a high priority (World Health Organization & World Organization of Family Doctors, 2008). Primary healthcare staff find it difficult to distinguish between physical and mental illnesses with the diagnosis of mental disorders difficult for them to assess in the absence of training, assessment guidelines, and tools (World Federation for Mental Health, 2013). To compound matters, older adults are also often unwilling to seek help for mental health issues (World Federation for Mental Health, 2013).

1.4.3 WHO HEALTH POLICIES FOR AGEING POPULATIONS

The World Health Organization has developed policies frameworks to promote active ageing (WHO, 2002), global age-friendly cities (WHO, 2007), and age-friendly primary health care (WHO, 2004) as a means of addressing population ageing concerns.

1.4.3.1 Active Ageing

In 2002, the Active Ageing Framework was launched globally by the World Health Organization to provide guidelines to engage older people to improve their health, ensure their security, and maximise their social participation (WHO, 2002) with the aim of optimising the quality of life in older people. By focusing on active ageing, it is expected older people will achieve healthy, productive, safe and fulfilling lifestyles. Similar concepts include terms such as healthy ageing, productive ageing, ageing well, optimal ageing, positive ageing and successful ageing which are often used interchangeably with active ageing (Hutchison et al., 2006).

The concept of active ageing is widespread and is used to drive ageing policy in national and international levels (Walker, 2006). Active ageing is related to the concept of successful ageing which originated in the USA in the 1960s (Hutchison et al., 2006) where it was argued that the key indicators of successful ageing were the maintenance of activity patterns in old age and values similar to those in middle age (Walker, 2006). Successful ageing referred to the idea of middle-aged populations maintaining typical activity pattern values as they moved into older age. It targeted at healthy populations of people and did not include those experiencing morbidity, disability, obesity, drug and substance use, and those who could not work (Hutchison et al., 2006; Walker, 2006). This concept focused only on older people who had succeeded in their lives, especially those who were successful in their work. In 1980, the concept of ‘successful ageing’ was

reconceptualised and termed ‘productive ageing’ to focus on the process of human development over the lifespan rather than merely focusing on older people (Walker, 2006).

Healthy ageing is defined as *“a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions”* (Health Canada, 2002, p. 1). This definition is a comprehensive view of physical and mental health, social and spiritual well-being during life. However, the concept of ‘healthy ageing’ focuses at the individual level regarding health.

In the late 1990s, a new concept termed ‘active ageing’ emerged under the influence of WHO. This concept is now widely used and focuses not only on individual personal health, but also includes family, community, social, and national levels in term of groups of people (Hutchison et al., 2006). Active ageing is broader than the previous concepts; ‘successful’ ageing, ‘productive’ ageing, and ‘healthy’ ageing which focused on productivity, working longer, and health (Walker, 2006). Active ageing is a combination of all the previously stated precursor concepts and includes aspects of quality of life, a mental and physical health and well-being focus, independence, and also promotes the idea that people should remain productive as they age (WHO, 2002).

The core concept of ‘active’ involves individuals continuing to perform, and participate in social, economic, cultural, spiritual and civic affairs, above and beyond simply being physically active or participating in the labour force (WHO, 2002). It allows older persons to realize their potential for physical, social, and mental well-being for health and activity throughout life as participants in society, and includes having security, with adequate

protection and care (Chong, Ng, Woo, & Kwan, 2006; Stenner, McFarquhar, & Bowling, 2011; WHO, 2002).

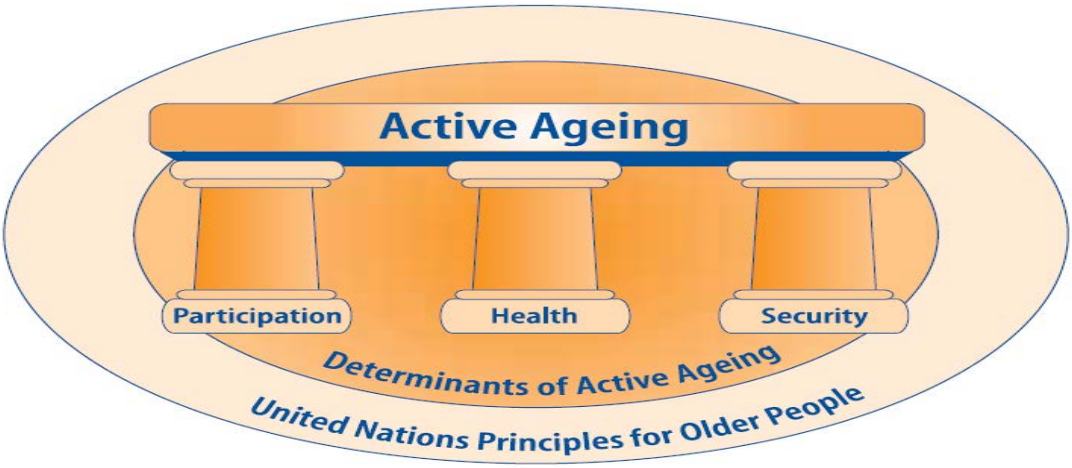
The WHO developed the following three basic pillars of a policy framework for active ageing (see Figure 1-4) (WHO, 2002):

1. Health: "*health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO,1946, p. 100)."* It involves keeping levels of risk factors for functional decline and chronic diseases low, and protective factors high. It means older people remain healthy and able to manage their own lives as they age. They should have access to appropriate health and social services and maintain their rights as they age.

2. Participation: Older people should be supported so they can participate in family, community, and society regarding their socioeconomic stability, culturally and spiritually according to their needs, preferences, and capacities under their fundamental human rights.

3. Security: This means ensuring older people are afforded protection, dignity, and care if they are no longer able to support and protect themselves as they age.

Figure 1-4: The three basic pillars of a policy framework for active ageing



(Source: World Health Organization (2002, p. 45). *Active ageing: A policy framework*)

Active ageing depends on many determinants that surround individuals, family, and nations and includes six determinants that underpin the pillars. The determinants are embedded in a cultural and gender context, referred to as cross-cutting dominants as they overlap. These are shown in Figure 1-5 and described below (WHO, 2002).

Cross-cutting determinants (WHO, 2002):

Culture and gender are major factors which affect the process of development and enhance the quality of life. Culture, which surrounds, and is embedded, in all individuals and populations, shapes the way in which we age because it influences all of the other determinates of active ageing. Cultural values and traditions determine how societal views have impacted on older people and the ageing process. Cultural factors also influence health-seeking behaviour. Gender is a perspective that should be considered regarding various policy options and how they affect human well-being.

Determinants that impact ageing and enhance the quality of life (WHO, 2002):

1. Determinates related to health and social services systems

Health and social service systems should be integrated, coordinated and cost-effective about health promotion and disease prevention, curative services, mental health services and long-term care, including coverage and access to health services. Service providers should treat people of all ages with dignity and respect. Service providers should also provide caring without age discrimination (WHO, 2002).

2. Behavioural determinants

It is important to adopt healthy lifestyles and actively participate in one’s care in all stages of life. People should be encouraged inappropriate physical activity, healthy eating, maintaining oral health, avoid smoking, low alcohol use, appropriate medications use,

and adherence to healthy lifestyles to prevent disease and functional decline, extend longevity and enhance the quality of life (WHO, 2002).

3. Determinants related to personal factors

Biology and genetics strongly influence the ageing process. Genes may be involved in the disease causation. Psychological factors including intelligence and cognitive capacities, such as the ability to solve problems and adapt to change and loss, are also strong predictors of active ageing and longevity. Even though normal ageing, such as cognitive capacities declining due to age-related changes, these losses can be compensated by gains in wisdom (WHO, 2002).

4. Determinants related to the physical environment

The physical environment is an important factor which can make the difference between independence and dependence for older people. Older people living in an unsecured environment and suffering multiple physical barriers are less likely to leave their home. Consequently, they may succumb to isolation, depression, reduced fitness and increased morbidity. Security, accommodation, clean water, clean air, and food are important physical environmental factors that impact upon how people age (WHO, 2002).

5. Determinants related to the social environment

Social support, protection from violence and abuse, education and literacy are key factors that enhance health, participation, and security as people age. Older people who experience loneliness, social isolation, illiteracy or have low levels of education, are abused or exposed to conflict situations, are more likely to experience disability and early death (WHO, 2002).

6. Economic determinants

Three aspects of the economic environment, namely income, work, and social protection effect active ageing. Older people who have no assets, little or no saving money, no

pensions or social security, are more likely to lack of access to nutritional foods, adequate housing, and healthcare. Therefore, they tend to be low on the active ageing level. Older people can also work in formal or informal work, unpaid activities in their home or involuntary occupations to maintain active in old age. Each country of the world should provide a system to support those older people who require help as they age (WHO, 2002).

Figure 1-5: The determinants of active ageing

(Source: World Health Organization (2002, p. 19). *Active ageing: A policy framework*)

In Thailand, researchers use a modified definition of active ageing to enable their research (Saengprachaksakula, 2014). For example, active ageing was defined by Chansarn (2012, p. 2) "*as the circumstance that elderly people have good physical and mental health, have work, family and community participants, and have income and living securities*". Briefly, researchers focus on physical health, independence, volunteering, participation in social activities, and living safely and these are similar to the concept of active ageing from the WHO model (WHO, 2002).

Principles of active ageing

Walker (2006), recommended seven principles of active ageing which should be implemented in practice to support a population to remain active. These are based on a partnership between the citizen and society and are as follows:

1. Activities of active ageing should comprise of meaningful pursuits that contribute to the well-being of the individual, their family, local community, and society rather than focus on paid employment or production.

2. Active ageing should mainly emphasise a preventative concept which involves preventing ill-health, disability, dependency, and loss of skills. The concept of active ageing covers all age groups in the process of optimising ageing actively over the whole of a life course.

3. It must encompass all older people, including those who are vulnerable, frail, dependent or have mental illnesses. The process optimises both physical and mental health (WHO, 2002).

4. Active ageing is for all people, and it is not only for older people. All humans are stakeholders in this concept because all people would like to live a long and healthy life.

5. The concept of active ageing should represent both rights and obligations of all older people. The policymakers should develop active ageing strategies based on the right balance between rights and obligations.

6. Active ageing should be participative and empower for all people. It should involve a combination of top-down policy action to enable and motivate action.

7. Activities of active ageing should include differences between national and cultural contexts.

Promoting active ageing

With regards to European Commission (2011), promoting active ageing has been summarised as:

1. Activities in society

1.1 Senior volunteering can be a key aspect of active ageing in the community. The activities of senior volunteering are considered to be a way of offering new learning opportunities for older people.

1.2 Older people should have access to political and civic processes as these are an essential aspect of active ageing in society. These processes can ensure older people participate in the broader society and enhance active ageing in this group.

1.3 A key facilitator, regarding participation in the society, is participating in social networks. The local and regional organisations can help older people network to participate in their preferred activities. The activities should encourage learning and engage with their friends, family, and neighbours.

1.4 Informal carers should support older people who have an ill, frail or disabled family member, friend, or partner. The local and regional organisations should provide training, respite care, support equipment and services to support them during the illness burden.

2. Activities for healthy ageing and independent living

2.1 The local and regional organisations can create a venue for the exchange of best practice to enhance independence in older people in the community. They can also conduct high-level research for translating current practice into ‘best practice’ that matches their contexts and needs.

2.2 The local and regional organisations should support independent living for all older people. Home-based ICT solutions may be a way to provide independent living in this group.

2.3 The local and regional organisations should promote quality health and long-term care for all older people. The approaches should involve practices that match their needs in cost-effective ways.

2.4 The local and regional organisations should improve the accessibility of transport and physical infrastructure for older people. The physical environment and transport services should ensure that older people can move around freely and safely to increase their independence and to support their active participation in the community.

Assessment of active ageing

Older people or their significant other, should be assessed by interview to prepare them for enhancing active ageing and to measure their level of active ageing. Currently, there is no gold standard tool to measure this. However, the methods and instruments for assessment active ageing can be found in different studies. For example, Bowling (2008) used a tool which is a self-rating scale of active ageing in his study. The tool consists of two questions:

1) What in your opinion, are the things associated with active ageing?

2) Thinking of all the things you have listed as associated with active ageing, would you say you are ageing so far: ‘Very actively, Fairly actively, Neither actively nor inactively, Fairly inactively, Very inactively’.

In Thailand, a recent study developed and tested the active ageing scale for Thai adults (AAS-Thai) (Thanakwang, Isaramalai, & Hatthakit, 2014). The 36-item scale consist of seven factors of active ageing: 1) being self-reliant, 2) being actively engaged with

society, 3) developing spiritual wisdom, 4) building up financial security, 5) maintaining a healthy lifestyle, 6) engaging in active learning, and 7) strengthening family ties to ensure care in later life. This measurement demonstrated acceptable overall validity and reliability for use as a screening tool to assess active ageing levels among older Thai adults in both community and clinical practice settings.

The main purpose of these instruments is to assess levels of active ageing in older people. The results are used to promote active ageing in older people themselves rather than a tool to evaluate levels of promotion of active ageing in organisations, particularly government institutions. There is an urgent need to develop a tool to measure the promotion of active ageing in the community or primary health care centres.

1.4.3.2 Ageing and community

The community plays a crucial role among diverse groups of older people around the world. There are three conceptualisations of the community as mentioned by Provencher et al. (2014, p. 4): *"as a physical bounded place, as a set of shared interests and as a sense of belonging"*. These can explain as follow:

1. A physical bounded place or ageing in place

The community is related to the importance of place, for older people (Provencher et al., 2014). The vital elements of 'place' includes familiarity with the area, connection to the environment, knowing and being known by people in the community (Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009). Good 'places' can improve the well-being of older people.

2. A set of shared interest

The community means a set of shared interest and is not just bounded by physical settings (Provencher et al., 2014). The community of interest is crucial and significant for older

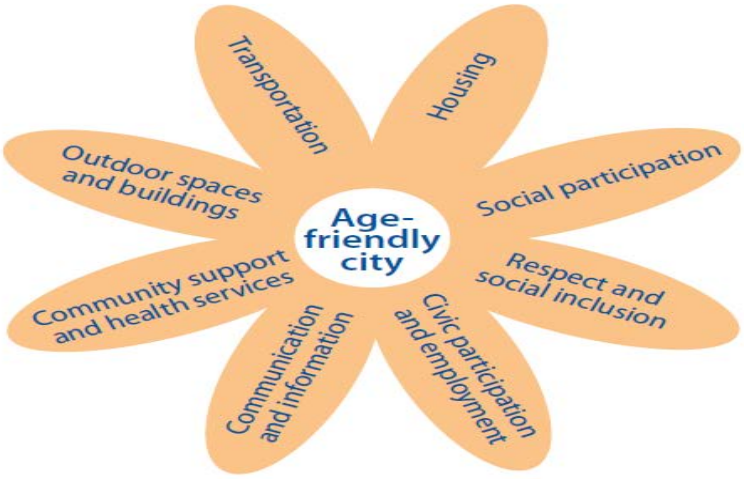
people to make friendships and maintain enthusiasm, and increase their power (Means & Evans, 2012).

3. A sense of belonging

There is diversity in the sense of belonging to each will base this on their perception (Provencher et al., 2014). It means the satisfaction of individual needs (Li, Hodgetts, & Sonn, 2014). The sense of community in older people are usually active participation, history of residence, and assistance to a neighbour (Li et al., 2014).

The WHO has developed a global age-friendly cities project that guides cities and communities in making their communities more age-friendly for all older people (WHO, 2007). The notion of an age-friendly city builds on WHO's model of active ageing (WHO, 2007; WHO, 2002). The notion of global age-friendly cities cover the features of the city about structure, environment, services, and policies, which relate to the determinants of active ageing. The age-friendly cities consist of eight domains; namely, outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, and communication including community support and health services (see Figure 1-6).

Figure 1-6: Age-friendly city topic areas



(Source: World Health Organization (2007, p. 9). Global age-friendly cities: A guide)

Active ageing is a lifelong process, but an age-friendly community is not just a friendly city for older people. Recommendations from WHO to the age-friendly city, service providers, public officials, and leaders of the community should (WHO, 2017b, p. 1) include:

- *"recognise the great diversity among older persons,*
- *promote their inclusion and contribution in all areas of community life,*
- *respect their decision and lifestyle choices, and*
- *anticipate and respond flexibly to ageing-related needs and preferences."*

The concept of an age-friendly city, policies, services, and infrastructure, is related to the physical and social environment which are built to support and engage older people to be as active as they can (WHO, 2017b).

According to WHO, the concept of active ageing can integrate with the project of the age-friendly community as follow (WHO, 2017b):

1. Participation

Older people can access public and private transportation including accessible and useful transport information. They are engaged in opportunities for civic, cultural, education and voluntary activities. People in the community should be positive role models for older people (WHO, 2017b).

2. Health

The community should provide place and programmes for older people about active leisure and socialisation. The activities and programmes in the community should help promote health, social and spiritual well-being of older people. Older people in the

community should be able to access appropriate health services, including social support when needed. The environment should have good air and water quality (WHO, 2017b).

3. Security and independence

Older people should have access to appropriate and affordable housing with the appropriate home-safety design. The environment in the community should include hazard-free streets and buildings, safe roadways and road signals for drivers. The community should provide services to assist with household chores and home maintenance. It should also provide appropriate and accessible employment opportunities including flexible work practices. Emergency plans and disaster recovery should prepare suitably for older people (WHO, 2017b).

The principles of primary health care

Primary health care (PHC) is a philosophy based on practical, scientifically sound and socially acceptable methods and technology and is vital for effective health care (Talbot & Verrinder, 2009, 2014). PHC can enable societies to take action on the prerequisites for health and address the social determinants of health that are risk factors for illnesses (Talbot & Verrinder, 2014).

The Declaration of Alma-Ata provided the principles for primary health care regarding achieving a level of health for permitting people in the world to lead a socially and economically productive life (Talbot & Verrinder, 2014). In 2003, a set of principles of primary health care based on the Declaration of Alma-Ata (WHO, 1978) were concluded (Bengoa, Adams, & Kawar, 2003) as follows:

1. It should be the reflection of the economic conditions, sociocultural, political characteristics of the country and their community, which based on the relevant findings of social, public health research and experience.

2. It should address the main health problems in the community, which include health promotion, prevention, curative and rehabilitative services respectively.

3. It should involve health sector and all stakeholder sectors at both national and community levels, particularly agriculture, animal husbandry, food industry, education, housing, public works, and communication, and ensure a coordinated approach between all sectors.

4. It should promote maximum community and individual independence and community participation in the planning, organisation, operation, and control of primary health care for either local and national resources, or other available resources including education.

5. It should be sustained by integrated referral systems, a comprehensive health care for all, and provide a priority for those most in need.

6. It should rely on both local and medical referrals and cover all suitably trained health care professionals working as a health team to provide care for the people in the community.

The 1978 Declaration of Alma-Ata also proposed a set of core activities that should at least be provided at national or local level (Bengoa et al., 2003, p. 6). These are:

> "*1. Education concerning prevailing health problems and the methods of preventing and controlling them,*
>
> *2. Promotion of food supply and proper nutrition,*
>
> *3. An adequate supply of safe water and basic sanitation,*
>
> *4. Maternal and child health care, including family planning,*
>
> *5. Immunization against major infectious diseases,*
>
> *6. Prevention and control of locally endemic disease,*
>
> *7. Appropriate treatment of common diseases and injuries,*

8. Provision of essential drugs."

The philosophy of primary health care represents the principles described above and enables health staff to deal with the causes of illnesses (Talbot & Verrinder, 2009). It highlights working with people to enable them to make decisions about their needs and how best to address them. These principles reflect the philosophy of primary health care, which emphasises participation in decision-making, the promotion of health activities, and the provision of services that are affordable and sustainable (Talbot & Verrinder, 2014).

The term 'primary health care' is often used interchangeably with 'primary care'. Also, primary care is often viewed as being synonymous with primary health care (Talbot & Verrinder, 2009). The Alma Alta Declaration defined primary care as "the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constituting the first element of a continuing health care process" (WHO,1978, p. 16). However, primary care is not necessarily the same as primary health care, unless it is underpinned by the philosophy and meets all of the criteria set out in the section above (Talbot & Verrinder, 2009).

The principles of primary care health care need to be applied throughout the health system and in every interaction between health workers and community members to be effective. Most preventive health care and screening for early disease detection take place in primary care settings at the community level (WHO, 2004). The majority of older people worldwide live in developing countries in their homes within communities (WHO, 2015a). Importantly, primary care centres have recognised the critical role of health and

well-being of older people (WHO, 2004). To meet these needs health policymakers and leaders need to ensure the provision of training and education for the care of older people.

Roles and responsibilities of primary care providers

Primary care providers are a critical role in promoting better health outcomes for people living in the community. There are four crucial roles and responsibilities of PHC providers for caring for patients who access primary care (Family Health Teams, 2005):

1. Assessment

Assessment and screening by a nurse is the first step for a patient in primary care before they are treated and managed and the assessment includes the patient's physical and/or mental health and screening for diseases. Nurses assess holistically and provide services to patients at all developmental stages as well as to families and communities (Family Health Teams, 2005).

2. Treatment and management

Primary care professionals including medical doctors and nurses, treat a patient for a specific illness to ensure the patient is in the best health possible and provide any necessary patient follow-ups. Nurses initiate and manage the care of patients with diseases or disorders based on best practice evidence consistently incorporating the perspective of patients (Family Health Teams, 2005).

3. Education and advocacy

Nurses determine the need for implementing nursing care about health promotion, primary and secondary prevention strategies for individuals, families, and communities, for specific ages and cultural groups. They provide health education for both individuals and groups as necessary. Nurses may also identify community needs and resources for developing culturally sensitive community programmes (Family Health Teams, 2005).

4. Referrals and collaboration

Primary care teams, including medical doctors, nurses, and allied health workers assist clients in discharge planning, rehabilitation services, and outpatients follow-up including home care services. They coordinate referrals to other healthcare professionals, and agencies, including specialists, rehabilitation services, home care, palliative care, and diagnostic services to refer clients to the required health services (Family Health Teams, 2005).

Nurses usually work in collaboration with other healthcare providers, and they also adopt an intersectional approach working with other organisations in the community, namely, local and central government, non-government organisations, education, employment, transport and recreation (Community Health Nurses of Canada, 2011). Moreover, they advocate and engage in public health policy, even during the political action, to develop and facilitate healthy living for people living in the community (Community Health Nurses of Canada, 2011).

However, primary care providers including nurses, physicians, and allied health workers, often lack time and resources to care and manage their patients, in particular, health promotion (WHO, 2004). Older people commonly present with multiple issues and sometimes confusing descriptions (Nobili et al., 2011). Medical symptoms often manifest differently in older people and are harder to diagnose (Nobili et al., 2011). They need primary care workers to pay attention to the cause of symptoms which may be warning signals of impending problems (WHO, 2004). However, some practitioners dismiss symptoms by simply attributing them to old age. They often do not prioritise their older patients, and this is even more noticeable with older people who are experiencing mental health problems as described in previous section (World Health Organization & World Organization of Family Doctors, 2008).

Primary Health Care and Health Promotion

The principles of primary health care are critical and based on health promotion and illness prevention (Talbot & Verrinder, 2009). The global concept of health promotion is an extension of the philosophy of primary health care and health for all launched by the WHO in the late 1970s (Talbot & Verrinder, 2014).

According to WHO (WHO 2005, p. 1), health promotion has been defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health". Health promotion practice incorporates disease prevention but extends beyond it to address broader social, environmental and cultural issues impacting on health (Talbot & Verrinder, 2009). Health promotion should result in a state of physical, mental and social well-being for individuals or groups of people (Talbot & Verrinder, 2009; WHO, 1986). They should be able to recognise and to realise aspirations, to satisfy needs, and to adapt or cope with changing the environment (WHO, 1986). Therefore, health promotion is not only the responsibility of health services, but individuals should aspire beyond healthy lifestyles to total well-being. Interestingly, some topics of health promotion are quite similar to the concept of active ageing which is to enhance well-being for people of all ages.

Key requirements for health promotion practice which draws on philosophical guidelines of the primary health care are as follows (Talbot & Verrinder, 2014, p. 18):

"1. It is done with and by the people, not for them: it encourages participation in decision making at all levels.

2. It usually involves a range of different approaches that include structural and policy changes for people in the context of their everyday lives, not just a focus on individual behaviour change approaches.

3. It is directed at improving people's control over the determinants of their health."

Health promotion activities should be complementary but they can be organised from a variety of different views depending on the evidence and the key priorities identified.

1.4.3.3 Towards Age-friendly Primary Health Care

Internationally, primary health care centres have a critical role in providing and supporting older people living in the community (WHO, 2004). In 2004, WHO developed a project framework on Age-friendly Primary Health Care as a part of the active ageing framework (WHO, 2004). This project aimed to sensitise and educate primary care providers about the specific needs of their older clients. The principle of this framework was to increase provider awareness and empower older people using primary health care centres. The three main areas were (WHO, 2004, p. ill):

"1. improving the attitudes, education, and training of healthcare providers so that they can assess and treat conditions that afflict older persons and empower them to remain healthy,

2. adapting primary healthcare management systems to the needs of older persons,

3. making physical access easier for older persons who may have mobility, vision or hearing impairments."

As the world's population ages, primary health care systems become outdated and do not match the needs of increasing numbers of older people (WHO, 2004). This WHO policy can raise awareness for all governments to prepare primary health care to better manage the ageing society (WHO, 2004).

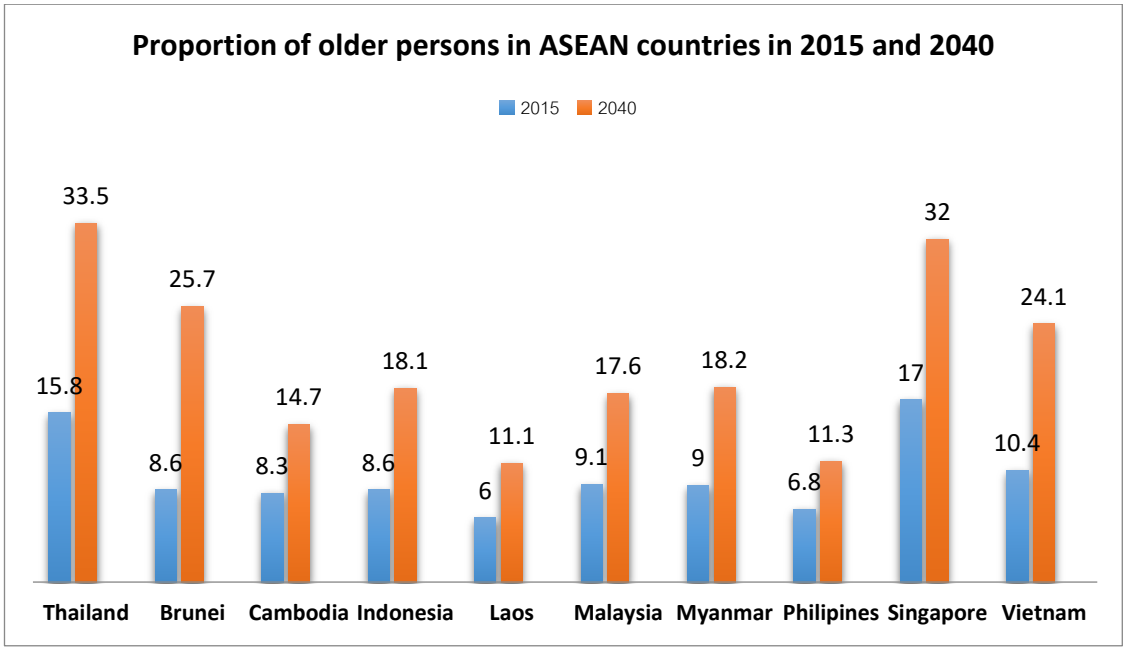
Although the age-friendly principles in primary care settings or health services have been implemented in several countries, health care systems still need to improve special health care programmes for older people, training programmes that focus on geriatrics and gerontology, and communication among healthcare staff and senior patients including systems of priority for older people (Ahmadi, Seyedin, & Fadaye-Vatan, 2015; Woo, Mak, & Yeung, 2013).

1.4.4 THE AGEING POPULATION IN THAILAND

Thailand is one of many countries whose ageing society is growing exponentially (TGRI, 2013). It is a lower middle-income country with an estimated total population of 65.9 million (National Statistical Office, 2017). Thai older people are defined as anyone who is 60 years of age or older (TGRI, 2013). At this age, a person is entitled to receive government benefits such as government retirement and other allowances for older persons including free access to public health services (TGRI, 2013).

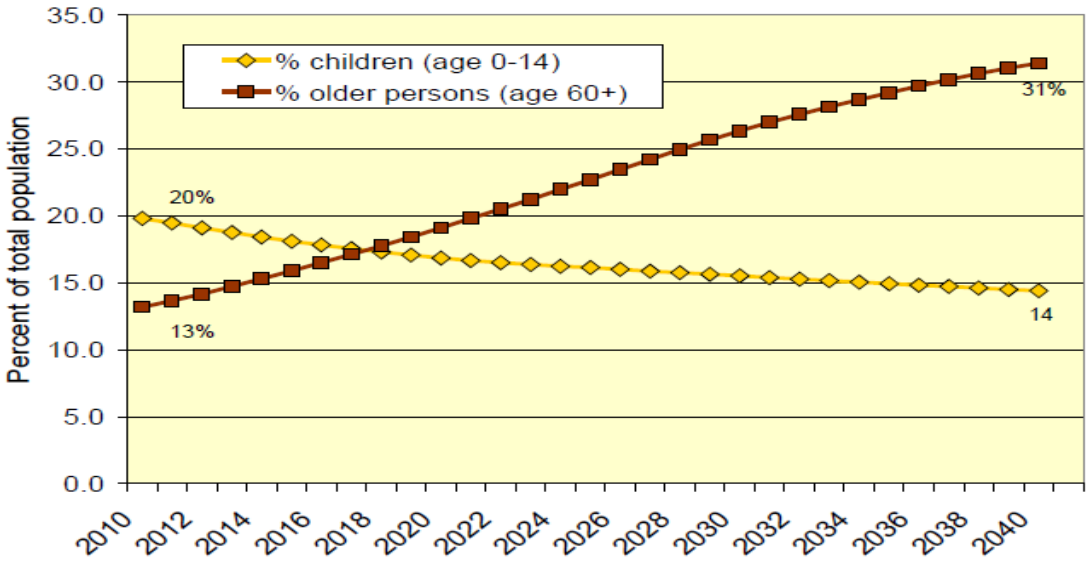
Thailand has faced rapid population growth during the past 40 years (TGRI, 2013). Among the Association of Southeast Asian Nations (ASEAN) member countries, the proportion of older persons in Thailand is ranked second after Singapore in 2015 and by 2040 is predicted to be the first, as shown in Figure 1-7 (TGRI, 2013). The demographic shift from younger to older population means that older people will outnumber children under age 15 in 2018 for the first time in Thai history, as indicated in Figure 1-8 (Knodel, Prachuabmoh, & Chayovan, 2013). The percentage of older people in the total population was 15.8% in 2015, making Thailand an ageing society with the proportion increasing faster than others countries in Southeast Asia (United Nations, 2013; United Nations Population Fund, 2006). This proportion of older people is expected to increase to 33.5% by 2040 (United Nations, 2013).

Figure 1-7: Proportions of older persons in the ASEAN countries in 2015 and 2040



(Source: As cited in Foundation of Thai Gerontology Research and Development Institute (TGRI) (2013, p. 37). *Population Division of Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2012 Revision*)

Figure 1-8: Percentage of Thai total population under age 15 years and 60 or older, 2010-2040



(Source: Knodel et al. (2013, p. 10). *The changing well-being of Thai elderly: An update from the 2011 survey of older persons in Thailand*.)

The proportion of older people in Thailand is highest in the North and Northeast regions which, in 2015 accounted for 16.0% and 14.7% respectively, as presented in Table 1-2 (Institute for Population and Social Research, 2006). Approximately 74.3% of older people live in rural areas of Thailand (Institute for Population and Social Research, 2006) and the expectation is that the middle and oldest old will increase during 2010-2040 as reported in Table 1-3.

Table 1-2: Proportion of older people in each region of Thailand

Region	Percentage of older people in total population		
	2005	**2015**	**2025**
THAILAND	10.3	14.0	19.9
Bangkok Metropolitan	8.6	11.9	18.6
Central (excluding Bangkok)	10.8	13.1	17.9
North	12.1	16.0	23.9
Northeast	9.6	14.7	21.4
South	10.4	13.2	17.8

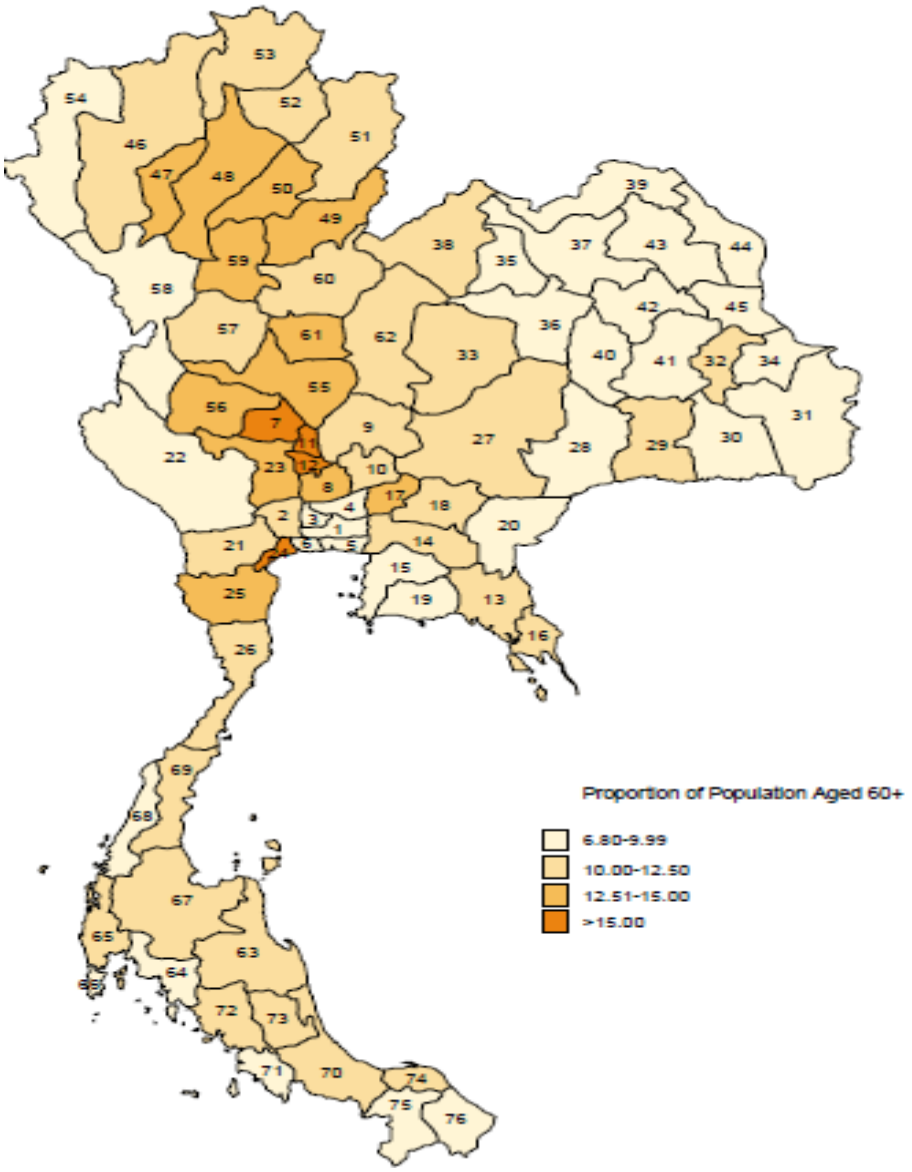
(Source: Institute for Population and Social Research (2006, p. 5). *Population projections for Thailand, 2005-2025*)

Table 1-3: Projected groups of older Thai people during 2010 - 2040

Proportion of age group/years	2010	2020	2030	2040
Young old (60-69 years old)	55.1	57.5	52.7	43.7
Middle old (70-79 years old)	32.2	29.1	33.6	37.2
Oldest old (80 and over years old)	12.7	13.4	13.7	19.1
Total	**100.0**	**100.0**	**100.0**	**100.0**

(Source: Sripana (2014, p. 2). *Social welfare for the elderly in Thailand*)

Figure 1-9: Proportion of population aged 60 and older in each province of Thailand



(Source: United Nations Population Fund (2006, p. 7). *Population ageing in Thailand: Prognosis and policy response*.)

As indicated in Figure 1-9, Ubonratchathani (No.31) and Yasothon (No.32) provinces, located in the northeast of Thailand (the geographical settings of the Phase 1 and Phase 2 Step one, and the Phase 2 Step two of this PhD research), comprise 14.84% and 17.00%, respectively, of the total older people from the total population in the provinces (National Statistical Office, 2014).

1.4.4.1 Characteristics of older persons in Thailand

According to the National Survey of Older Persons from Thailand in 2011 (Knodel et al., 2013), women constitute 56% of older people aged 60 years or older. Examining the marital status, one found that the number of women widowed is the same as those married and living with a spouse, whereas the majority of men are married. The percentage of older people who have never been married is increasing, and women comprise a large number of this group. The 2011 survey also shows that almost 90% of people aged 60 and older only have a basic primary school education, especially those living in rural areas. Approximately 38% of older people undertake daily paid work, which was men accounting for 50% (Knodel et al., 2013). Other key sources of income included government pensions or old age allowances, intergenerational exchanges or other family support (Knodel et al., 2013).

Traditionally in Thailand, older people have been supported by adult children living together in the same house or village (TGRI, 2013). However, there has also been increasing migration of adult children from rural areas to urban areas for employment (Knodel et al., 2013). As a result, there is a steady increase of older people living alone (n=9% of older people) or living with a spouse only (n=17% of older people) (TGRI, 2013). This change in demographic characteristics and cultural expectations for care and support of older people is affecting the well-being of older persons (Knodel et al., 2013). Older people can no longer rely on their adult children to support them and their age-related needs. This means the health status of older Thai persons will increasingly be a concern for individuals, local and national governments (Knodel et al., 2013). A major concern for older people in these situations is the need to maintain good health (Knodel et al., 2013).

1.4.4.2 Government policies related to older people

The Royal Thai Government established a national policy relating to older people in 1982 (TGRI, 2013). Currently, the Government's policies and programs are in line with the Second National Plan for Older Person (2002-2021) which was developed based on empirical data from demographic data, identified issues, and various challenges of the country (TGRI, 2013). The national ageing policy, which was revised in 2009, aims to achieve five main objectives (TGRI, 2013, p. 42). These are:

1. *"to improve the quality of life of older people by promoting value, dignity, self-reliance, and life security;*
2. *to increase recognition of older people as a valuable group;*
3. *to help people realise the significance of ageing preparedness and readiness to promote quality ageing;*
4. *to encourage people, family, community, local administration, and public and private entities to participate in activities concerning older people;*
5. *to establish a framework and guidelines for collaboration among all entities for integral and comprehensive implementation concerning older people."*

Although the Second National Plan for Older Persons (as cited in TGRI, 2013) in Thailand is being successfully implemented and there has been an improvement at various levels in creating an ageing-friendly society, health care systems still need to improve the quality of the way we care for older people. Healthcare professionals are an essential part of the systems, and the Government now needs to focus on how to enhance their practice to enable them to provide appropriate care for older people, and of particular concern to this research, how they provide appropriate care to older people with mental health disorders.

1.4.5 ISSUES OF AGEING IN THAILAND

Thailand has recently reached a new demographic turning point regarding its ageing society because the number of older adults has significantly increased (TGRI, 2013; United Nations, 2013). Furthermore, care and support of older persons have steadily moved away from the traditional family support, to more and more older people living independently in their homes (TGRI, 2013). As a consequence, the country has a short period to prepare and develop appropriate programmes and resources for older people (Kespichayawattana & Jitapunkul, 2008).

Several barriers and obstacles are preventing optimal social welfare for older Thai people (Jitramontree & Thayansin, 2013; Khamngae, Boonleaing, Bungchan, & Sakolnakorn, 2014; Sripana, 2014). First, there is a lack of integration from each government organisation, and secondly, they do not continually supervise at the policy and practice level - including policy's translation into practice (Khamngae et al., 2014). The resources of the central government are also not enough for both an operational budget and a personal budget (Khamngae et al., 2014). As a result, the outcomes of social welfare for older people are not as expected and social welfare does not meet the needs of older people. Importantly, it is not equally covering all geographical areas of the country, and this is particularly noticeable in rural areas which are where the majority of older persons are living (Khamngae et al., 2014). Additionally, older people still lack knowledge and understanding about their rights (Sripana, 2014). Their family and relatives are even less likely to be aware and maybe disrespecting older people. Significantly, many think older people create a high workload regarding caring and finding money to support them (Knodel et al., 2013).

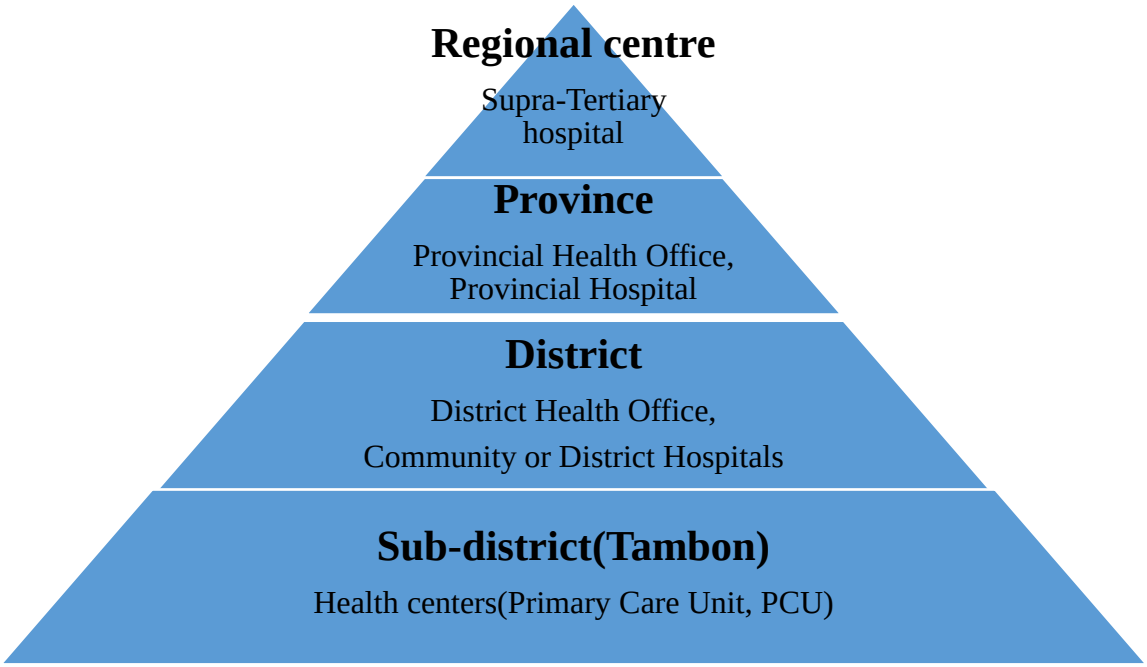
As a result of the above, older people living in rural areas are more likely to experience health problems and need more support than those who live in urban areas (Knodel et al., 2013; Weiangkham, Kerdmongkol, Amnatsatsue, Sasat, & Steckler, 2014). The health care system, therefore, needs to be well prepared to support older people in primary care units as they are the first health providers to respond when caring for older people living in the community (Weiangkham et al., 2014).

1.4.6 HEALTH SERVICE SYSTEMS IN THAILAND

The primary role of the Royal Thai Government's Ministry of Public Health (MoPH) is to provide public health services and implement health programmes throughout the country. The budget is shared for this and is mainly aimed at rural health activities. It also is responsible for setting the public health policies, and leading health-care delivery (Bureau of Policy and Strategy, 2011).

The healthcare system in Thailand is categorised into three main levels; namely, sub-district, district, and provincial hospitals (Thailand. Ministry of Public Health, 2013). For patients to get care from specialists, they must have severe symptoms, and they must be referred to a supra tertiary hospital in their regional centres. The healthcare system is presented in Figure 1-10, and the estimated numbers of public health services are shown in Table 1-4.

Figure 1-10: Health services hierarchy of Ministry of Public Health, Thailand



(Source: Kijsanayotin (2009). *Thailand primary health care information systems.*)

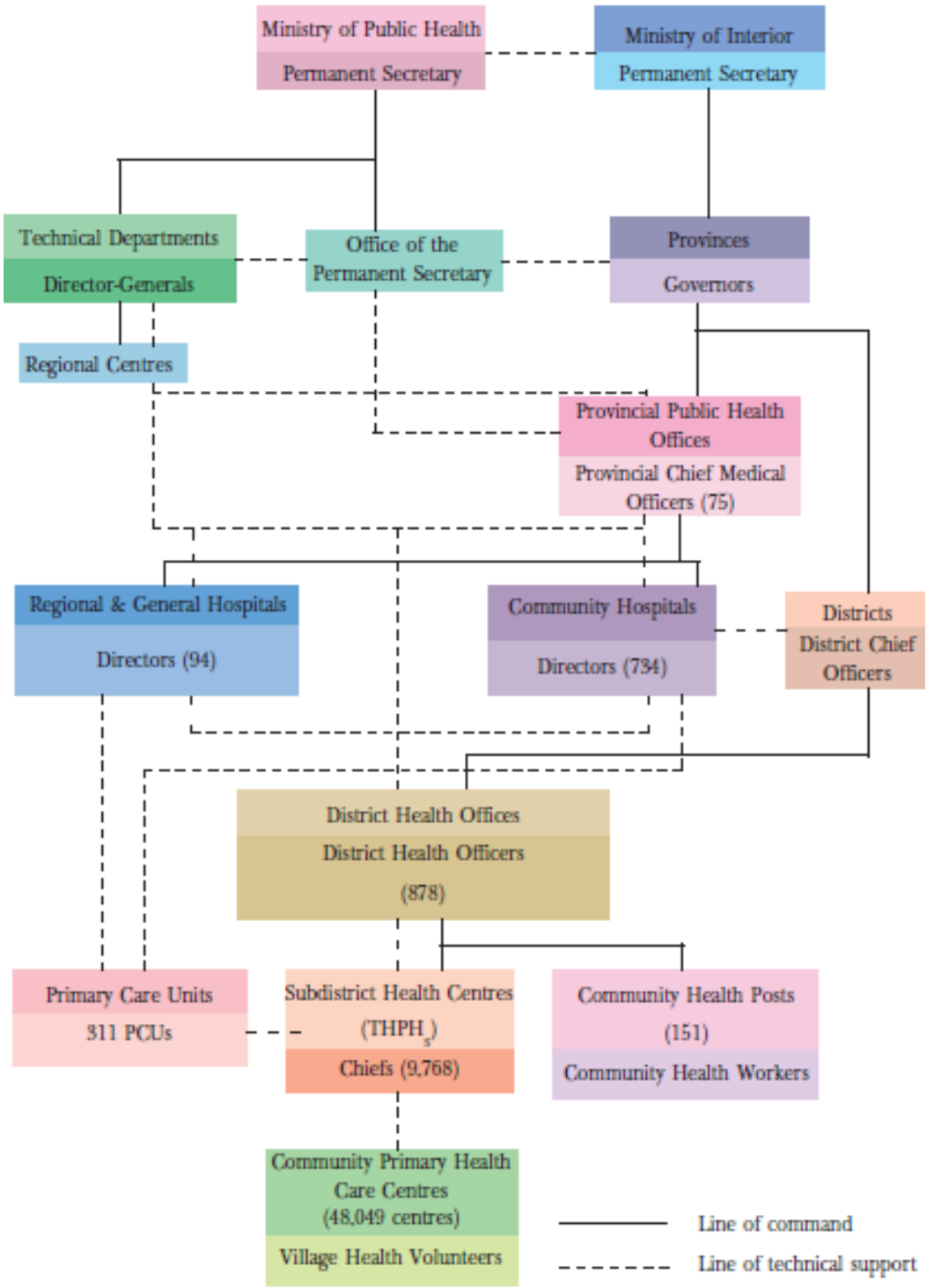
Table 1-4: The number of public health services under Ministry of Public Health, Thailand

Regions	Supra tertiary hospitals		Provincial hospitals		Community hospitals		Primary care units
	Number	Number of bed	Number	Number of bed	Number	Number of bed	Number
North	6	4,515	17	5,962	180	8,420	2,314
Central	9	6,010	32	10,197	169	8,133	2,482
Northeast	7	6,970	24	7,871	294	15,472	3,470
South	6	3,611	15	4,571	137	6,040	1,511
Total	**28**	**21,106**	**88**	**28,601**	**780**	**38,065**	**9,777**

(Source: Bureau of Health Policy and Strategy (2010). *Thailand health profile 2008-2010*)

Medical services at the district level for promotion of primary health care of MoPH has been established since 1973 (Kespichayawattana & Jitapunkul, 2008). The main objective is to provide the primary contact between people living in communities and the public health care system. Primary care units, Tambol health promoting hospitals, or community primary health care centres are mainly organised by Provincial Public Health Offices in each province - as can be seen from Figure 1-11: Organogram of provincial public health administration. These public health providers provide more than 90% of older persons with free services (Kespichayawattana & Jitapunkul, 2008). However, primary care providers face several issues in caring for community-dwelling older people. The main concern is how to enhance practice and support primary care providers to care for older people, particularly those older people who experience a mental health problem (Thailand. Ministry of Public Health & Thailand. Ministry of Social Development and Human Security, 2007; World Health Organization & Ministry of Public Health Thailand, 2006).

Figure 1-11: Organogram of provincial public health administration



(Source: Bureau of Policy and Strategy (2011, p. 337). *Thailand health profile 2008-2010*)

1.4.6.1 Health workforce in Thailand

The health workforce in Thailand provides care regarding health promotion, curative care, health prevention, and rehabilitation. The workforce consists of healthcare professionals, allied health professionals, Thai traditional medicine personnel, local health wisdom healers, alternative medicine personnel including village health volunteers and local health networks (Pagaiya & Noree, 2008).

In Thailand, inadequate numbers of physicians and other healthcare staff in rural areas are still the main issue (Wiwanitkit, 2011). Even though the distribution of health resources in Thailand has improved during the last decades, the number of healthcare staff in rural areas - in particular doctors, dentists, pharmacists, and registered nurses, remains less than in urban areas (Kespichayawattana & Jitapunkul, 2008). The distribution of health resources regarding health care providers (resource to population ratio) is outlined in Table 1-5.

Table 1-5: Distribution of health resources (resource to population ratio)

Type	All country	Bangkok	Yasothon
Doctors	1: 2,533	1: 886	1: 5,562
Dentists	1: 11,233	1: 6,477	1: 17,405
Pharmacists	1: 6,465	1: 3,206	1: 9,810
Nurses (Professional)	1: 495	1: 239	1: 734
Nurses (technical)	1: 15,430	1: 18,789	1: 21,582
Health centre staff	1 : 1,062	1: 897	1: 1,785

(Sources: Thailand. Ministry of Public Health (2013). *Health information.*)

The Ministry of Public Health is concerned with this and has the responsibility to produce more nurses and primary care workers, namely, health officers, assistant pharmacists, assistant dentists, assistant health officers, and physiotherapist assistants (Bureau of Health Policy and Strategy, 2010). There are 29 nursing colleges and public health

schools under the MoPH. All primary health workers and nurses that are educated and trained by the colleges and the schools under the MoPH and obtain some funding are required to sign a contract to work in the public health services of MoPH for four to eight years after graduating (Bureau of Health Policy and Strategy, 2010).

Health workers are first trained for two years in the public health schools. Then, they work as healthcare staff of MoPH in primary care units or district hospitals to provide health care for people living in the community. In this capacity, they work as a team member in preventive care and health promotion for individuals and communities. Primary care providers are a crucial role in the frontline care of Thai persons in primary care settings in rural areas and account for 57.2% of the healthcare workers (Pagaiya & Noree, 2008) as reported in Table 1-6.

Table 1-6: Distribution of doctors, nurses and primary care providers

Areas	Health services	Doctors (%)	Nurses (%)	Primary care providers (%)
Urban	Private hospitals	21.6	12.2	-
	Regional hospitals	12.6	12.7	22.5
	Provincial hospitals	12.4	17.7	-
Rural	District hospitals	16.5	28.0	20.4
	Primary care units	-	N/A	57.2
Others (Non-health services)		36.9	29.5	N/A

(Sources: . *Thailand's health workforce: a review of challenges and experiences.*)

The majority of primary care staff comprise registered nurses, health officers, assistant health officers, assistant pharmacists, and assistant dentists. The definition of each category of health worker and scope of their responsibility in primary care settings are described in Table 1-7.

Table 1-7: Primary care providers in Thai primary care units

Types	Definition based on educational qualification	Scope of work
Registered nurses	Health staff graduated four years from accredited institution education in the field of nursing and midwifery.	Planning, management, providing, and evaluation in terms of nursing care services for people affected by illnesses, injury, or other physical or mental impairment, or potential risks to health. They work autonomously or in teams with general practitioners and other health workers. They may supervise the implementation of nursing care plans, and conduct nursing health education activities.
Public health generalists or health officers	Health professionals graduated for four years in public health bachelor's degree from university education	Planning, management, providing, and evaluation in basic public health services for disease prevention and health promotion in population health. They manage environments for reducing determinant in health risks of the community.
Primary health workers or assistant health officers	Health professionals or Non-medical professionals graduated and trained with two years in public health or related fields from public schools of MoPH.	Planning, assessment, investigation, and implementation of programmes including regulations, monitor, and control environmental factors can potentially affect water, sanitation, foods hygiene, and food safety. They carry out disease investigation and prevention for people in the community. They can assist nurses or be able to provide basic treatment for clients.
Pharmacy technicians or assistant pharmacists	Health professionals or assistants pharmacists graduated with two years from public health schools of MoPH in the field of basic pharmacy.	Preparing and dispensing medications under the supervision of a pharmacist or other health professionals such as nurses or health officers.
Assistant dentists	Health professionals or assistants dentists graduated and trained from public health schools of MoPH in basic dental skills.	Providing basic dental care services about prevention and treatment of diseases including disorders of the teeth and mouth, as per care plans and procedures established by a dentist or other oral health professionals. They also provide health education regarding teeth.

(Source: Bureau of Health Policy and Strategy. (2010). *Human resources for health country profile Thailand.*)

Furthermore, each primary care unit has village health volunteers in each village for supporting primary care providers to care for people in the community. They are trained in basic health care, health promotion and in reporting health problems to primary care units - the managers of village health volunteers (Thailand. Ministry of Public Health, 2011). Volunteers receive some benefits from the government, namely free health services, and rewards for each episode of volunteering work. Some village health volunteers can be promoted to new positions in their primary care units after studying at institutes of the Ministry of Public Health (Thailand. Ministry of Public Health, 2011).

Identifying the health care needs of older persons is vital in ensuring they receive specialised health services from staff with expertise in geriatric medicine (Kespichayawattana & Jitapunkul, 2008). Unfortunately, most primary care units in Thailand experience inadequate resources, lack of training and supervision of staff (Ditton & Lehane, 2011).

1.4.6.2 Health promotion system in Thailand

The WHO launched the health promotion strategy in the late-1970s (WHO, 2008b) and since 1978 Thailand has adopted the strategy into the health care system as a national health policy (Bureau of Policy and Strategy, 2011; WHO, 2008b). Health promotion and health system development have been progressed together, by “the management of social and environmental determinants of health in a holistic manner through community participation” (Bureau of Policy and Strategy, 2011, p. 378). After the concept of health promotion had been adopted and developed along with the public health system during 1997 to 2006, a review showed lessons could be learned from this the journey and improvement made for the following phase. To summarise, Thai society has changed its health strategy from defensive to proactive by giving higher priority to health promotion

and disease prevention for all sectors in the society, at the individual, organisational, and policy levels (Bureau of Policy and Strategy, 2011). As a consequence, the national health system was reformed.

In 2007 the National Health Act health assembly was established to further improve the forward movement by reforming and turning the concepts of health promotion into the healthy living of Thai people. They believed that health promotion should be undertaken to encourage holistic well-being for all in Thai society, as noted in the policy, "health promotion comes before health repair" (Bureau of Policy and Strategy, 2011, p. 385).

Five strategies for health promotion were implemented at every level and are as follows (Bureau of Policy and Strategy, 2011, p. 385):

> *"1. Building healthy public policy,*
>
> *2. Creating supportive environments for health,*
>
> *3. Strengthen the community according to the principle of sufficiency economy with emphasis on participatory development,*
>
> *4. Developing health-related skills of the individual, family, and community,*
>
> *5. Reorienting public health services system to strengthen the public's health."*

The four objectives specified to achieve by 2020 are as follows (Bureau of Policy and Strategy, 2011, pp. 385-386):

> *"1. To put in place the development of a concrete and participatory health public policy for good health,*
>
> *2. To put in place the development and surroundings in a variety of tangible ways to facilitate the public's health,*

3. To put in place health promotion for the individual, family, community, and society in a balanced and interconnected manner in accordance with the principle of health promotion,

4. To put in place strong effort to cover 80 % of all the subdistricts in the country."

The health promotion system in Thailand has progressed well because the structure and systemic conditions have been designed to make improvements at national and local levels, such as the Health Promotion Fund, community health funds, and expanded roles of local government organisations (Bureau of Policy and Strategy, 2011). Nevertheless, health promotion may be affected by both crises and opportunities from changing social trends together with intensive globalisation.

The main role of primary care settings in Thailand is for health promotion for people living in the community. However, they are also the first place of contact in the public health service to promote, prevent, care for, and to rehabilitate people in their areas. This means that older people are not their only customer, rather all people who live in the community areas are clients of primary care units. It should be noted, however, that Thai older persons constitute more than half those living in the community that needs to be supported by primary care providers.

1.4.6.3 Thai primary care units

In Thailand, the majority of primary care units located in rural areas are public health services that have been organised by the Ministry of Public Health, the Royal Thai Government (Thailand. Ministry of Public Health, 2013), except some primary care settings and laboratories that are part of Thai universities. Thai primary care units have been developed in parallel with the concept of primary health care during the decade of 1992-2001 (International Health Policy Program, 2011). During 2007 to 2011 the

Ministry of Public Health launched a strategy to improve primary care units into "Health Promoting Hospital"[1] (International Health Policy Program, 2011). The primary care settings were then upgraded to be the Health Promoting Hospitals with approximately 9,762 units in 2011 (Thailand. Government Public Relations Department, 2011). These Health Promoting Hospitals can be divided into three sizes based on the number of people in their areas, namely, small < 3,000 people, medium 3,000 - ≤ 8,000 people, and large > 8,000 people (Health Focus, 2017). In addition, there are primary care units which are under the organisation of district hospitals, and these provide health care for people living nearby the hospitals (Sriwanitchakorn, Yana, Chawadet, & Boonboon, 2011). The main roles of the primary care units and health-promoting hospitals are health promotion, disease prevention, cure and care, rehabilitation and consumer protection (Bureau of Policy and Strategy, 2011; Kitreerawutiwong, Jordan, & Hughes, 2017). They are the front line healthcare providers locally for Thai people in the community. With regard to International Health Policy Program (2011), there are a variety of weaknesses and threats for primary care units in Thailand. For instance, most of the health services are similarly managed about looking after people in the community, but they are not all concerned with the health situations in their community. For example, in the role of primary care units in promoting health or curative diseases is not clear.

[1] Ministry of Public Health, Thailand has called Health Promoting Hospitals or primary care units that developed health services to a more integrated health promotion and prevention for people living in the community (Auamkul, Kanshana, & Phirangapaura, 1999).

According to the guidelines of primary care units for providing health services, older people have been divided into three groups, namely, the good elder, the homebound elder, and the bed-bound elder (Thailand. Department of Health Service Support, 2010). Older people who are experiencing chronic diseases are screened for depression disorders and the risk of suicide, probably because they are indicators of access to health services from the Ministry of Public Health, Department of Mental Health (Department of Mental Health, 2015b). However, older people without chronic diseases are not screened for mental illnesses from primary care providers.

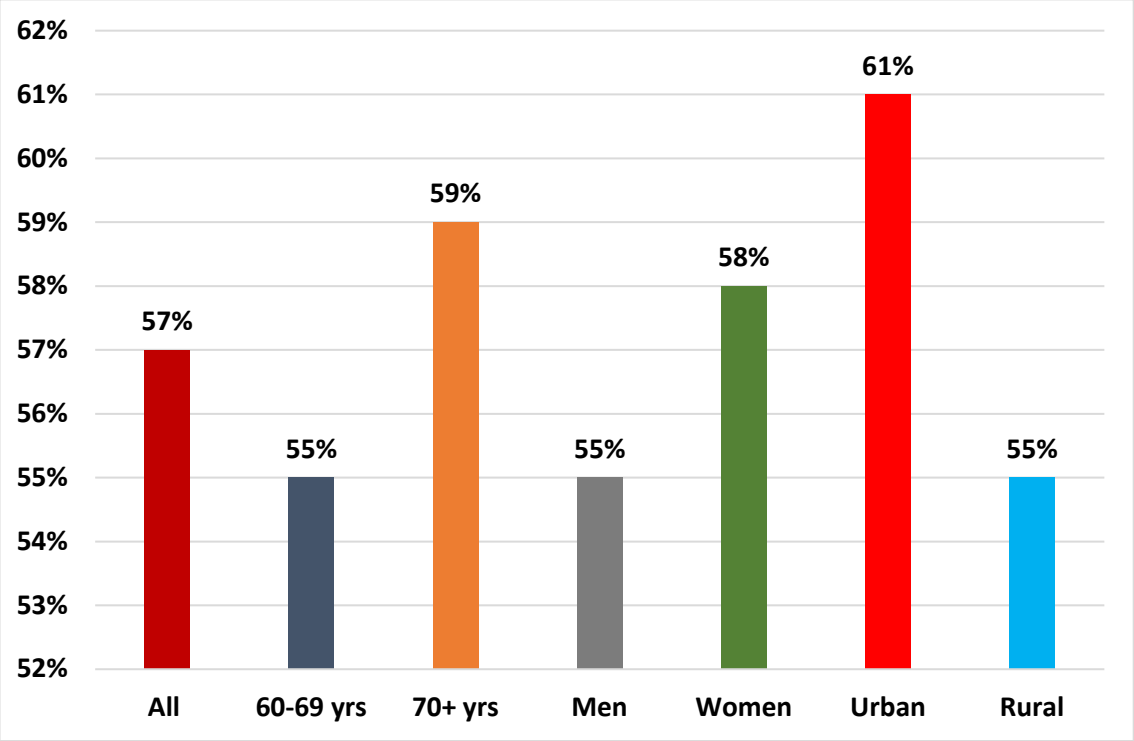
Unfortunately, the primary care providers have a heavy workload and large numbers of people to care for in their primary care units (Kitreerawutiwong et al., 2017). More importantly, the changing trends of health problems and lifestyles of Thai people living in the community make it very challenging for primary care staff to provide suitable health promotion, prevent disease and cure diseases (Knodel et al., 2013). Primary care units in Thailand still need to make improvements to their services to provide holistic care for their customers.

1.4.6.4 Mental health issues of older Thai persons

According to the National Survey of Older Persons of Thailand in 2011 (Knodel et al., 2013), people aged 60 and older living in rural areas were more likely to experience a health problem than those who live in urban areas. Furthermore, they were less likely to have had a general physical check-up in the past 12 months - as shown in Figure 1-12. Mental health problems and poor psychological well-being among persons 60 years and above were also found more in those who live in rural areas than those who live in urban areas - as presented in Table 1-8 (Knodel et al., 2013).

A recent study examined and predicted factors influencing the problems and needs of older persons living in remote areas of Thailand (Weiangkham et al.). The study found that they experienced health problem with more than one disease, had limited functional capabilities, and demonstrated poor behaviour related to health (Weiangkham et al., 2014). Additionally, cognitive ability, depression, income and psychological support were important problems of older people in rural areas (Weiangkham et al., 2014).

Figure 1-12: Percentage of persons 60 years or older who had a physical check-up in past 12 months unrelated to illness, 2011



(Source: Knodel et al. (2013, p. 82). *The changing well-being of Thai elderly: An update from the 2011 survey of older persons in Thailand.*)

Table 1-8: Indicators of psychological well-being among persons 60 years and older by age, gender, and area of residence, 2011

	Total	Age			Gender		Type of area	
		60-69	70-79	80+	Men	Women	Urban	Rural
Percentage of experiencing the following feelings at least sometimes during the past month								
Lack of appetite	52	48	57	65	48	55	48	54
Worry	40	38	40	47	36	42	38	40
Upset/mood	38	38	39	43	35	41	37	39
Lonely	33	30	37	40	29	36	31	34
Sad/unhappy	20	19	22	25	18	22	18	22
Hopeless	16	14	18	21	14	18	15	16
Worthless	12	11	15	17	11	14	11	13
Summary measures of overall psychological well-being								
Mean number the 7 negative feelings during past month	2.1	2.0	2.3	2.6	1.9	2.3	2.0	2.2
Mean self-assessed happiness score (0 to 10)	7.4	7.5	7.3	7.1	7.5	7.3	7.5	7.3

(Source: Knodel et al. (2013, p. 92). *The changing well-being of Thai elderly: An update from the 2011 survey of older persons in Thailand.*)

In Thailand, as in many other countries, the mental health of older people is a major issue for the government to address. The Department of Mental Health reported that the top five common mental health problems of older Thai persons were: anxiety disorder, depression, insomnia, dementia, and sexual dysfunction (Thailand. Department of Mental Health, 2015c). One-third of older people had poor mental health because they also suffered from chronic diseases and low self-esteem, and because of low respect to older adults in the changeable Thai culture (Thailand. Department of Mental Health, 2015c).

Department of Mental Health is an organisation under Ministry of Public Health, has responsibility for promoting, preventing, caring, and rehabilitating older Thai persons in term of mental health. Mental health promotion for older people is a priority of the World Federation for Mental Health. The federations objectives for older people are (World Federation for Mental Health, 2013, p. 33):

1. *"to enable older people to prepare for quality ageing,*
2. *to promote a positive attitude toward the elderly,*
3. *to promote and support the participation of older people in community activities."*

Since 2011, the Department of Mental Health has programmes of mental health promotion and prevention for mental health problems in older people (Thailand. Department of Mental Health, 2015c). These programmes have mainly been implemented in Health Promoting Hospitals or primary care units by integration into the senior clubs. The activities were to screen mental health problems and promote good mental health in older people. The programmes were further implemented into senior clinics of district hospitals and provincial hospitals in 2012. The principle of promotion and prevention in the mental health of older people living in the community was established in 2014 (Thailand. Department of Mental Health, 2015c). However, many primary health providers lack the understanding and skills necessary to support older people with mental health problems (Thailand. Department of Mental Health, 2015c).

1.5 SUMMARY

The discussion in this chapter outlined the issues relating to population ageing, WHO health policies for ageing populations including the situation of an ageing society, issues of ageing and health services systems in Thailand. The WHO has expressed concern about the plight of many older people who age with a myriad of health concerns and poor quality of life. Active ageing is important with WHO health policy is aiming to optimise the quality of life for older people. Primary care providers are a vital role in engaging older people to achieve active ageing, in particular, older people with mental health disorders living in the community.

The following Chapter provides an integrative review of the literature relating to active ageing in older people with mental disorders who are living in the community.

CHAPTER 2: ACTIVE AGEING AMONGST OLDER PEOPLE WITH MENTAL DISORDERS IN COMMUNITIES

2.1 INTRODUCTION

In Chapter One, the introduction and background to the study, the demographics of the ageing population in the world and Thailand are described along with the associated issues and concerns. Amongst the issues relating to population ageing is that many older people are living in the community face barriers in accessing health services mainly primary care settings. These may be because the primary care settings lack resources and support, but also because primary care providers in these settings have inadequate skills to care for older people especially older people with mental disorders who are living in the community.

The Active Ageing Framework was established by the WHO in 2002 to promote the engagement of activities for older people that focus on improving their health, security, and participation socially for optimising the quality of life in older people (WHO 2002). As noted in the previous chapter, healthy ageing, productive ageing, ageing well, optimal ageing, positive ageing and successful ageing are terms often used interchangeably with active ageing (Hutchison et al., 2006). However, the notion of active ageing is more comprehensive than those related concepts because it is a combination of all concepts and includes aspects of quality of life, a mental and physical health and well-being focus, promoting independence and enabling people to remain productive as they age (WHO, 2002). Active ageing in older people and older people with mental disorders, especially those who live in the community, has become an important area of research because the health policy needs to encourage older people living in their homes as they age (Provencher et al., 2014).

2.2 AIMS OF THE INTEGRATIVE REVIEW

The main aim of this integrative review was to critically synthesise the evidence from previous studies published in English and Thai about active ageing in older people, and older people with mental health disorders in communities.

2.3 METHODS

This study used an integrative review of the literature based on Whittemore and Knafl (2005)' five-stage approach – problem identification, literature search, data evaluation, data analysis, and presentation. The purpose of an integrative review is to review methods, theories, and/or empirical studies on a particular topic in order to present a comprehensive understanding of a phenomenon (Whittemore, 2005). An integrative review synthesises literature from both quantitative and qualitative research to develop new insights on an emerging topic (Torraco, 2005).

2.3.1 Search methods

A search comprising of a computerised search of the literature published in English and Thai languages from January 2002, which is the year the World Health Organization launched 'Active Ageing-A Policy Framework' (WHO, 2002), to February 2017 was undertaken. The inclusion criteria were research articles that defined active ageing and related concepts associated with mental disorders, the perspective of older people regarding active ageing, issues related to work with older people in communities, and the promotion of active ageing. The exclusion criteria were studies, which focused on acute health services, tertiary health care, private health services, and adolescent and adult health.

The search was limited to five databases; the CINAHL Complete, MEDLINE, EMBASE, PsycINFO, and Thai LIS. A manual search of reference lists was performed to identify studies which could not be found in the computer search. Index terms were used to describe relevant articles. Boolean operators with AND, and OR were used to combine words and phrases for narrowing and expanding of the search strategy. Then, all identified keywords and index terms were used to undertake an extensive search. During the last step, reference lists and bibliographies were searched to find further relevant articles. Finally, articles that contained insufficient information, discussion papers, systematic reviews, specific reviews, and poorly designed studies were excluded from the selected literature (Bettany-Saltikov, 2010; Kable, Pich, & Maslin-Prothero, 2012).

The search strategy used principal key terms in four broad domains:

1. Active ageing: including healthy ageing, successful ageing, productive ageing, ageing well, optimal ageing
2. Mental disorders: including mental illnesses, depression disorder, schizophrenia, cognitive impairment, dementia, anxiety disorder
3. Primary care providers: including doctors, dentists, nurses, social workers, primary care staff, pharmacists
4. Issues: including impact, effect, concern, influence, barriers, and facilitator.

2.3.2 Search outcome

A total of 734 records were retrieved that met the inclusion criteria, with the following distribution; CINAHL (158), MEDLINE (201), EMBASE (294), PsycINFO (76), and Thai LIS (5). Nineteen records were retrieved through manual searching. Only 295 papers remained after the removal of numerous duplicates. Two hundred and fifty-eight records were excluded at title and abstract stage, and the remaining 37 studies were assessed for

eligibility. Eleven full-text articles were excluded because they did not meet the inclusion criteria.

In all, the search yielded 26 relevant publications for critical appraisal. The empirical literature was represented internationally by the USA (5), Sweden (3), Australia (1), the UK (4), Scotland (1), Spain (2), Taiwan (1), Mexico (2), Korea (1), and Thailand (6). The PRISMA framework was used for searching and the selection process (Moher, Liberati, Tetzlaff, Altman, & Group, 2009) (see Figure 2-1).

2.3.3 Quality appraisal

Methodological quality was examined by the PhD student and the supervisors for the 26 studies selected before including them in this review. Critical appraisal was done independently and discussed until a consensus was reached on the strengths and limitations of each article.

Critical appraisal checklists for quantitative and qualitative studies which were developed by the Joanna Briggs Institute (Joanna Briggs Institute(JBI), 2016) were used to assess the methodological quality of the studies included. The JBI critical appraisal checklist for qualitative research was used to evaluate the qualitative articles consisting of ten items (Lockwood, Munn, & Porritt, 2015). An analytical cross-sectional study critical appraisal tool comprising of eight items was used to assess the methodological quality of cross-sectional studies, including the survey research (JBI, 2016). The JBI critical appraisal tool for quasi-experimental studies, or experimental studies without random allocation, was also used and includes nine items to examine the methodological quality of quasi-experimental research (JBI, 2016). In addition, the JBI critical appraisal checklist for randomized controlled trials, or RCTs, (individual participants in parallel groups) consisting of 13 items was used to explore the methodological quality of RCTs (JBI,

2016). Lastly, the mixed method appraisal tool (MMAT) was used to examine the methodological quality of mixed method studies (National Collaborating Centre for Methods and Tools, 2015).

Articles based on, qualitative, quantitative or mixed method studies that were poorly designed, inadequately explained, or those where the results were deemed to be biased were excluded (Kable et al., 2012). As a result, three studies were excluded after critical appraisal and quality assessment (see Table 2-1). Twenty-three studies were included in this integrative review.

2.3.4 Data abstraction and synthesis

All relevant articles were reviewed, and data were extracted from the primary studies as suggested by the Kable et al. (2012). The elements data abstraction followed author's last name (s) and year of publication, the aim of the study or phenomena of interest, methodology and methods used, participants and settings, main findings, and limitations. After each article was reviewed, relevant data were summarised in the appropriate table to facilitate synthesis (see Tables 2-2 and 2-3). The data abstraction and synthesis processes were independently reviewed by the research student and supervisors.

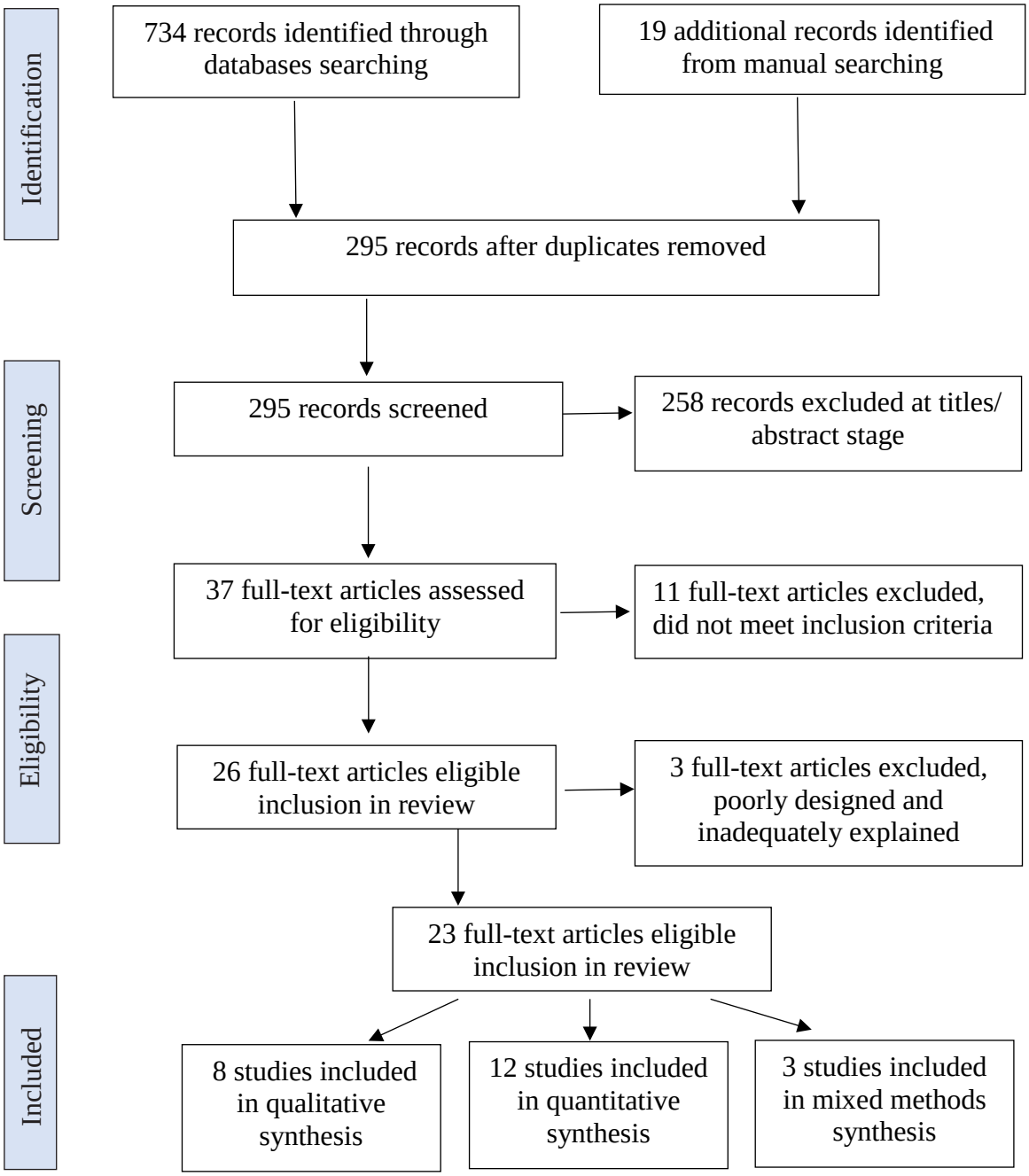


Figure 2-1: Adapted from PRISMA flow diagram (Moher et al., 2009, p. 3)

2.4 RESULTS

2.4.1 Characteristics of the studies

Twelve studies used quantitative research methods, eight studies used qualitative methods, and three articles used mixed methods design. Seven studies were conducted in Asian countries: including Thailand (5), Taiwan (1), and Korea (1). Three studies were conducted in the USA and Sweden. The remaining studies were conducted in Australia, the UK, Scotland, Mexico, and Spain.

2.4.2 The impact of mental disorders on active ageing and related concepts

Three studies looked at the impact of mental disorders on successful ageing. Successful ageing is one of the terms often used interchangeably with the concept of active ageing (Hutchison et al., 2006). Three studies indicated that older people with mental disorders were negatively associated with successful ageing (Ibrahim, Cohen, & Ramirez, 2010; Jeste et al., 2013; Vahia et al., 2010).

Vahia et al. (2010) compared successful ageing among non-depression people, and those with subthreshold depression, which was characterised by sadness and irritability, and depression disorder in older women living in a community of the USA. The findings found that older women with depression disorder had lower scores on measures of successful ageing (mean=6.7) than the subthreshold depression group of older women (mean=7.9). Furthermore, the subthreshold depression group of older women was lower than nondepressed persons (mean=8.5). This study used cross-sectional survey-based psychological assessments. Participants were 1,979 community-dwelling older women and were inclusive of a large sample size, to compare the different three groups. However, the crucial limitation of a cross-sectional analytic study is that they are unable to determine the stability of outcome measure over time (Carlson & Morrison, 2009).

Therefore, the findings are more likely to be different when being conducted at a different time.

Ibrahim examined rates of successful ageing between older adults with and without schizophrenia living in a community in the USA (Ibrahim et al., 2010). This was a cross-sectional analytic study, which it is unable to determine the stability over time (Sedgwick, 2014). Participants were 198 schizophrenia patients aged 55 years and over who developed the disease before age 45 years old and were recruited from outpatients' clinics, day programs, and supported community residence. People with cognitive impairment were excluded from the schizophrenia group. The comparison group was 113 people without schizophrenia aged 55 years and older, which were selected from the same area as the schizophrenia group. Successful ageing was compared between the groups. The findings showed that older adults with schizophrenia were less likely to achieve successful ageing compared with those without schizophrenia ($p<0.001$). Fewer negative symptoms and a higher quality of life index were two variables associated with successful ageing.

Jeste et al. (2013) used a structured multi-cohort design to examine the association between self-rated successful ageing and psychological and physical health factors among older people in a community in the USA. Participants were older adults aged between 50 and 99 years. There were 1,300 people who completed the telephone interview and 1,006 completed mail surveys. Most of the measures used self-report based assessments which are more likely to find information bias because participants may respond in a way that makes them look good (Althubaiti, 2016). Findings showed that well-being, resilience, optimism, and absence of depression, were related to successful ageing.

Overall, the findings from these studies suggest that older people who have mental disorders, namely, depression disorder and schizophrenia are less likely to successfully age compared with those who do not have mental illnesses.

2.4.3 The perspectives of older people regarding active ageing

Studies examining the perspectives of older people living in communities or institutions, note that older people want to be supported by health care providers in order to engage in active ageing to improve the quality of life (Buys et al., 2008; Grundberg, Ebbeskog, Gustafsson, & Religa, 2014; Kim, 2009).

Grundberg et al. (2014) used a qualitative descriptive design to explore health-promoting dialogues of older people who lived in Stockholm, Sweden. The lived experience of older people as this related to health-promoting dialogues was the phenomenon of interest. Thus, the methodology of this study is suitable to understand the participant's lived experienced with rich information from six women and one man, aged 83-96 years. Results showed that older people missed someone to talk to such as friends, relatives, health care and social service providers, about their mental health. Social support and dialogue were important to them.

In a cross-sectional, correlational study, Kim (2009) identified the influence of expectations of older people regarding ageing on physical and mental health status and examined the mediating effect of health-promoting behaviour. The methodology used a cross-sectional, correlational study. Participants were older people aged 60 years and older who were without cognitive impairment problems. The findings showed that older people who had higher expectations about ageing regarding health-promoting behaviour were more likely to maintain high levels of physical and mental health. However, participants were recruited by a convenience sample of 99 older people from three

community-based senior welfare centres in Korea. It may not be generalisable to all Korean older people.

Buys et al (2008) explored the experience of older people who are suffering from lifelong intellectual disability and have a high risk of mental health problems regarding active ageing. A descriptive qualitative study was used to explore the experience of 16 older people those who had been contacted by disability and aged care services in Australia. Participants were selected by purposive sampling. The method used face-to-face semi-structured interview, however, the interview guide contained quite broad topics. The study found that they had the same needs as those healthy ageing living in the community. They wanted to be empowered, be independent and have a meaningful role in society including achieving active ageing. However, they lacked appropriate support from health providers to achieve these goals.

2.4.4 The perspectives of primary care providers working in the community

There are several barriers and facilitators about active ageing activities or health promotion at the community level or in primary health care (Goodman, Davies, Dinan, Tai, & Iliffe, 2011; Runciman et al., 2006; Wilhelmsson & Lindberg, 2009).

According to Wilhelmsson and Lindberg (2009) who investigated nurses' working at the community level opinions regarding facilitators and barriers in their work with health promotion in Sweden. The methodology used a qualitative descriptive study. The method used a semi-structured interview with mainly open-ended questions with purpose sampling of 54 the nurses. The methodology and methods are suitable to explore opinions of the nurses. The findings indicated that the nurses were interested in health promotion and would like to promote activity. Facilitators working with health promotion in primary care were knowledgeable about health promotion, common goals, guideline, and

resources including the attitude of the staff. However, barriers to health promotion were: lack of coordination, the interest of staff in health promotion, and support from heads of primary care centres and colleagues. Mass media and society were also barriers working with health promotion in primary care settings.

Goodman et al. (2011) used a survey design and semi-structured questionnaire to explore the current level of nurse-led involvement in promotion activity for older people in the United Kingdom. The knowledge and attitudes of primary care nurses about health benefits of activity promotion were also explored. The questionnaire was sent to 971 primary care nurses and 521 persons indicating a 54% response rate. This may mean that primary care nurses who answered the survey may have a greater interest in activity promotion for older people resulting in a bias of the responses. The findings indicated that nurses considered the regular physical activity to be a crucial element for healthy ageing. Primary care staff, or nurses in primary care, are committed and interested in activity promotion for older people living in the community, and they had the opportunity to support older people to engage in physical activity. The barriers to activity promotion in primary care were: lack of time, organizational restrictions and limited opportunities for referring patients to suitable services. Recommendations suggested that primary care nurses need to be supported with specialist training relating to the activity of health promotion.

Runciman et al. (2006) used a questionnaire survey and follow-up telephone interviews with a sub-sample to identify how community nurses contribute to health promotion with older people in Scotland. The questionnaire was sent to 1062 community nurses from six Scottish National Health Services Boards, 373 responded, and 30 were follow-up with telephone interviews. The response rate of the survey was quite low at 35%. However,

some participants were interviewed to explore more information. The main findings stated that activities of health promotion such as mental health and positive ageing were given less priority and unrecognised by community nurses. They perceived they lacked skills regarding health promotion for older people. Evidence of activities in health promotion of older people was under-reported and limited in primary care.

2.4.5 The perspective of primary care providers in terms of mental disorders

Several previous studies explored the perspectives of primary care providers about caring for older people with mental disorders or people with mental disorders (Grundberg et al., 2016; Haddad et al., 2005; Lester, Tritter, & Sorohan, 2005; Murray et al., 2006).

Murray et al. (2006) explored the perceptions of primary care staff about depression in older people. Participants were general practitioners, practice nurses and practice counsellors working in primary care settings (n=18) in South London, the United of Kingdom. Individual in-depth interviews were used to examine their perspectives about late-life depression. This method was suitable to explore the perspective of participants. The findings reported that identification of late-life depression was complicated by comorbidity with physical illnesses. Older patients rarely complained about psychological difficulties, and they were too embarrassed to talk about non-medical problems. Primary care staff also noted that older people tended to perceive depression as a normal part of the ageing process and as a sign of weakness. The main source of both support and distress for older people were their families who could be a vital source to help identify and care for those with late-life depression. The findings of this study raise the important issues of supporting primary care providers to deal with depression in older people living in the community.

Furthermore, Haddad et al. (2005) used a three-area cross-sectional study for exploring how district nursing team members in the United Kingdom make contact with people with mental disorders living in the community and the attitude of the staff to common mental health problems such as depression. The experience of staff training and perception of training needs was also examined in this study. The questionnaires were sent to 331 staff with a 66% response rate. This is an acceptable response rate as suggested by National Collaborating Centre for Methods and Tools (2015). The results reported that approximately 16-17% of patients in the primary care suffered from mental health problems, most commonly dementia, and depression and anxiety disorders. The staff indicated that they lacked training in caring for people with mental health problems. They needed an education programme to improve their understanding and skills for detecting psychological problems, managing depression and anxiety, intervention in crises and increasing medication compliance.

Lester et al. (2005), using a qualitative descriptive study with focus groups interviews, explored perspectives of primary care providers caring for people with serious mental illnesses such as schizophrenia, bipolar disorder, recurrent depression, anxiety disorders. This study was conducted in six primary care trusts of the United Kingdom. Eighteen focus groups involved 45 patients with serious mental disorders, 39 general practitioners, and eight practice nurses. The participants included both patients and primary care providers, namely, doctors and nurses. The findings reported that most of the primary care staff felt the care of people with serious mental illnesses was too specialised for routine primary care. They also felt they lacked sufficient skills and knowledge. However, patients with mental disorders preferred to consult primary care staff rather than health professionals who are specialists in mental health. This study pointed out that primary care is a vitally important role in caring for people with serious mental illnesses living in

the community. Primary care providers should be concerned with patients' needs about treatment, continuity of care, and listening skills. Health policy may need to support primary care staff for improving their specialist skills in mental health.

A recent qualitative study also described the perspectives of district nurses who are primary care providers working in primary care settings and their ability to detect mental health problems and promote mental health amongst older people with multi-morbidity living in a community in Sweden (Grundberg et al., 2016). Participants were 25 district nurses from primary care centres in the Stockholm region of Sweden. Only seven participants preferred individual interviews, and the remaining 18 participants were assigned to one of three focus groups. This study used two methods to collect data, both individual interviews and focus groups, which can help get rich information. The findings showed that the district nurses focused on assessment, collaboration and social support and that there were methods to detect mental health problems and promote mental health in their patients. They mentioned that there were no guidelines or structured goals for mental health care in their settings. Some district nurses also needed more knowledge regarding interview techniques and the assessment instruments for mental health problems. They stated there was a lack of a structured forum for collaboration between health care providers for caring for their patients with mental health problems.

2.4.6 The promotion of active ageing and related concepts

Several studies have examined the effectiveness of policies and programmes in promoting active ageing and related concepts (Caprara, Fernández-Ballesteros, & Alessandri, 2016; Latorre et al., 2015; Lin et al., 2013; Mendoza-Ruvalcaba & Arias-Merino, 2015; Mendoza-Ruvalcaba & Fernández-Ballesteros, 2016). In studies using experimental designs, older people with mental disorders are commonly excluded from intervention

groups including studies designed to enhance mental health or to reduce depression symptoms (Latorre et al., 2015; Mendoza-Ruvalcaba & Arias-Merino, 2015).

Lin et al. (2013) investigated and evaluated the policies and practices adopted to promote active ageing in Taiwan. The study used a mixed method approach with mailed questionnaires and focus groups. The questionnaires were sent to 1,708 organisations and 525 responded resulting in a 30.74% response rate. The response rate was quite low however the return questionnaires came from across Taiwan. Some participants were also invited to discuss in focus groups, which gave more information. The findings show that the promotion of active ageing in non-profit organisations in Taiwan prioritised strategies relating to physical health, such as exercise activities and health education, mental health, such as family association, learning new things, for example, traditional skill classes engaging in volunteer work, being respected, and community participation respectively. The most popular of the active ageing activities for older people were leisure activities including tourism, neighbourhood friendship, health care study programmes, and both participating in and watching talent shows, health promotion, and lifelong education. The problems found with older people participating in active ageing activities was inconvenient transportation, a lack of related incentives, excessive distances for travel, a lack of companions to accompany them and concerns about the safety of activities. Barriers preventing service providers from providing promotion of active ageing were the lack of stable financial resources; few full-time staff; insufficient volunteer workers; a lack of transport; and older people being unwilling to attend. Lack of human and financial resources was the most significant factors in relation to the promotion of active ageing. The findings from this study are crucial information for health providers to provide promotion of active ageing, in particular, concerning the barriers of older people to participate in active ageing activities in communities.

Furthermore, a randomized controlled trial to evaluate the effectiveness of a programme promoting active ageing called “I am active” was conducted in Mexico (Mendoza-Ruvalcaba & Arias-Merino, 2015). The outcomes of this programme measuring improving physical activity, nutrition, and cognitive functioning, and quality of life in sixty-four healthy older people aged 60 years and older recruited from senior centres in Mexico. They were divided into 2 groups, the experimental group included 31 people and control group included 33 persons. Inclusion criteria were healthy older persons who can attend a session at least twice a week and were willing to participate in the programme and who were literate. Older people with depressive symptoms and cognitive impairment were excluded from the study after assessment with the Spanish version of the Geriatric Depression Scale and the Mini-Mental State Examination. The findings of the experimental group indicated significant improvement compared with the control group, namely, physical activity, nutrition, cognitive performance, and quality of life. The programme promoted improvement in domains of active ageing, mainly in self-efficacy beliefs as well as in the quality of life in healthy older persons. However, this study focused only on healthy older persons. Older people with mental disorders, namely, depression disorders and cognitive impairment were excluded from this research.

In a recent study, Mendoza-Ruvalcaba and Fernández-Ballesteros (2016) conducted a quasi-experimental design with two experimental conditions to determine the effectiveness of a programme for promoting active ageing. Participants were 76 older persons aged 60 years and older from a senior centre in Mexico. They were divided into three groups, namely, Vital Aging face-to-face (VA-FF) assigned to 35 persons, Vital Aging combined, VA-C (multimedia/face-to-face) assigned to 15 people, and a control group assigned to 26 persons. Primary outcomes were active life, the perception of aging, physical exercise, the frequency of social relationships, satisfaction with the social

relationship, life satisfaction, and self-efficacy. A trained psychologist applied the outcome assessments. Outcomes measures were measured as a pre-test, and then post-test after the intervention. The post-test was assessed at the end of the programme. The findings of experimental groups showed improvements in the active ageing outcome measures. Participants in VA-FF condition presented better memory performance, meta-memory, and a trend to report fewer memory problems. Participants in the VA-C condition indicated a trend to have better life satisfaction. Nevertheless, this study recruited only older people in the senior's centre. Older people with mental illnesses living in the community were not included in this study.

In addition, a previous study from Spain evaluated the effect of life review based on remembering specific positive events in active ageing in older adults living in the community (Latorre et al., 2015). The outcome measured pre-test and post-test in life satisfaction, depressive symptoms, experiencing the environment as rewarding, and autobiographical memory. The experimental group comprised life review and consisted of six sessions of individual training based on specific positive events. The control group or active control comprised a media workshop of six sessions focusing on learning journalistic techniques. Fifty-five older adults aged 53 to 89 years old in Spain were recruited into the study. Then, they were randomly assigned to a life review group (29 persons) and an active control (26 persons). The majority of participants had no physical illness, and none of the participants had been diagnosed with mental illness before starting the intervention. The findings found that life review intervention improved life satisfaction, increased specific memories, and reduced depressive symptoms. The effective component of life review can enhance emotional well-being of older adults in the active ageing program. Most subjects of this study were healthy older persons, and

only 27.3 % had a chronic illness. Again, older people with mental illnesses were not recruited into the programme of this study.

Lastly, Caprara et al. (2016) examined the effect of a psycho-educational multimedia programme designed to promote successful ageing in older adults from Spain. A quasi-experimental study with a pre-post intervention design compared with an experimental and a control group was used to test differential among the measured outcomes, namely, health and healthy habits, cognitive functioning, ageing self-efficacy, well-being, and social participation. A total of 115 older adults aged 54-82 years recruited from volunteers of the Autonomous University of Madrid participated in this study. They were divided into two groups. An intervention group comprised of 73 older adults and the other group consisted of 42 people who attended other regular courses for seniors at the same university. The findings revealed that the subjects in the experimental group mentioned better health, higher frequency of cultural, intellectual and social activities, higher physical exercise and healthier diets. They also pointed out the better functioning of their memory and felt fewer negative emotions. However, this study did not include older people experiencing mental health problems, and the participants were recruited from volunteers in the students of the University Programs for older adults. This programme may need to be adapted to many different contexts and population in particular older people with mental disorders.

2.4.7 Studies in relation to active ageing in Thailand

In Thailand, several studies of active ageing have been conducted, however, all of the studies focused on general older people or healthy older persons. Older people with serious chronic illness, disability or who are frail and who are experiencing mental health problems were usually excluded from the studies.

Nantsupawat, Kamnuansilapa, Sritanyarat, and Wongthanawasu (2010) using an ethnographic study explored family relationships, roles and the meaning of active ageing in Thai older people living in rural areas. Participants were 44 different family structures living in rural areas of Khon Kaen province, northeast of Thailand. They were divided into 58 older people aged 60 years old and older who served as key informants, and 45 family members who served as general informants. Data collection involved participant observation and in-depth interviews. The findings reported four types of family relationships, namely, one, two, three, and four generation living patterns based on the number of generations residing within a single household were found. Three and four-generation family patterns could promote active ageing for older people in the community. Nevertheless, only three and four-generation family patterns could enhance security and be sure someone would look after older people now and in the future. Earning a living and instructing children and grandchildren were important roles of family relationship. Active ageing from the perspective of Thai older people in this study was contributions and achieving happiness and which things made advantages for themselves, family, and society. Eight ways of living for being active ageing from the perspective of Thai older people were: working, looking after the next generations, getting loans, community participation, visits from relatives, respect from children, health, and pre-death preparation. The advantages of active ageing were having economic stability, remaining healthy, and having children who respect them. However, this study did not mention older people experiencing mental health problems.

Moreover, Thanakwang, Isaramalai, and Hattakit (2014) explored the meanings of active ageing in Thai older people living in the community. This was a descriptive qualitative study using focus groups and in-depth interviews to collect data. Participants were selected by purposive sampling from four regions of Thailand in one province from each

region, resulting in inclusions from four provinces. Inclusion criteria were Thai healthy older people aged 60 years and above, living in community-dwelling, without disabilities or severe dementia. The total of older adults were 64 participants. The results indicated that active ageing in the meaning of Thai older people comprised of six themes: being self-reliant, being actively engaged with society, growing spirituality, maintaining a healthy lifestyle, being active learners, and managing later life security. Perceptions of Thai older persons in term of active ageing involved health, social participation, and security in life. This study excluded older people with severe chronic illness, disability or who were frail from this study. Therefore, older people with chronic illness or disability and those who are experiencing mental health problems might have a different view in term of active ageing.

Furthermore, the concept of active ageing was used to develop a scale for measuring active ageing level in Thai older people (Thanakwang, Isaramalai, & Hatthakit, 2014). The scale of active ageing resulted in a 36-items instrument and indicated acceptable overall reliability and validity in a Thai context. The instrument consisted of seven components of active ageing; having self-reliant, engaging in society, improving spiritual wisdom, security in living, being a healthy lifestyle, being active learning, and support of family. The psychometric properties of the instrument were 0.95 of Cronbach's alpha and varied between 0.81 and 0.91. Concurrent validity and reliability were acceptable and confirmed. This study focused on active Thai older persons living in the community. Older people with mental disorders were not recruited into this study.

Recent studies of active ageing were researched by using secondary data from the 2011 Survey of Older Persons in Thailand aged 60 years and above (n=23,801; female=14,369 and male=9,432). The data was a nationally representative survey covering regions and

urban-rural areas. First of all, Haque, Soonthorndhada, Hunchangsith, and Kanchanachitra (2016) explored the data to find determinant factors of active ageing level in Thai older persons. Exploratory factor analysis was used to test factor structure of active ageing level. The finding showed that factor structure of active ageing level was different between female and male. Females had higher active ageing levels than male. This study mentioned health policy should focus on older people to promote active ageing, namely, health, longer working lives, a lifelong learning programme, and financial security. Haque (2016) also examined active ageing levels of Thai older persons and compared with each region of Thailand. The findings indicated that the active ageing level of Thai older persons is not high and there are differences between male and female. The average active ageing index in the Central region of Thailand is lower than the North, Northeast, and South regions but there are no mean differences among North, Northeast, and South regions. This study suggested that Thai policies should implement strategies to improve health and economic security, to promote participants in social groups and longer working lives and learning programmes. Thai older persons should be supported to increase active ageing particularly in the Central region of Thailand.

2.5 DISCUSSION OF LITERATURE REVIEW

The findings of this integrative review indicated that older people with mental disorders were less likely to achieve active ageing and well-being compared with those who were without mental disorders (Ibrahim et al., 2010; Jeste et al., 2013; Vahia et al., 2010). Older people, in particular, older people with mental disorders, need support from health care providers in order to promote their physical and mental health and to empower them to achieve active ageing (Buys et al., 2008; Grundberg et al., 2014; Kim, 2009).

However, several barriers were identified in relation to caring or working with older people and older people with mental disorders at the community level or in primary care. For example, primary care providers need to improve mental health knowledge and skills in relation to mental disorders, namely, detecting and treating, anxiety management, crisis intervention, communication, and medication management including resources (Haddad et al., 2005; Lester et al., 2005; Murray et al., 2006). They also lack awareness of the mental health problems of older people (Grundberg et al., 2016; Murray et al., 2006). Primary care providers are vitally important roles when caring for older people, in particular, older people with mental illnesses living in the community. For this area to improve health policy may need to support resources and knowledge in relation to mental health for primary care staff.

While previous studies developed and examined effective programmes for promoting active ageing, or health promotion activities for older people living in the community, older people with mental disorders were not included as participants (Mendoza-Ruvalcaba & Arias-Merino, 2015; Mendoza-Ruvalcaba & Fernández-Ballesteros, 2016). For example, a previous study was outcomes measured in relation to reduced depressive symptoms and life satisfaction, however, the participants were healthy older people without mental illnesses (Latorre et al., 2015). These maybe imply that older people with mental disorders are more likely to be ignored by healthcare professionals, or even researchers, than other members of the community.

Previous research based on the concept of active ageing was conducted in Thailand (Haque et al., 2016; Nantsupawat et al., 2010; Thanakwang, Isaramalai, & Hattakit, 2014). Unfortunately, none of the studies conducted used a sample which included older people who have mental disorders living in the community, including studies related to

primary care or primary care staff. The only study that used the concept of active ageing was to develop a scale for measuring active ageing levels in Thai healthy older people (Thanakwang, Isaramalai, & Hatthakit, 2014). Whilst the concept of active ageing, promoting active ageing, and enhancing the well-being of older people, was launched by WHO in 2002 (WHO, 2002), there is little research currently available explaining how to promote active ageing. Promoting active ageing in older people with mental disorders, therefore, still lacks evidence - as can be found from this integrative review.

Further research is needed to develop an instrument for measuring the level of promoting active ageing among older people with mental disorders living in the community, and to identify factors that influence the promotion of active ageing in this group. Evidence to demonstrate how primary care providers promote active ageing in older people with mental disorders living in the community, and how primary care can be supported whilst doing this, is also urgently needed for these emerging issues. The health policy should provide resources such as suitable training program, guidelines, and increase the budget allowing more funding to support the necessary mental health tasks for primary care units.

2.6 REVIEW LIMITATIONS

This review includes studies in English and Thai languages from five databases. The CINAHL Complete, MEDLINE, PsycINFO, and EMBASE are important databases which focus on studies related to nursing, allied health, alternative and complementary medicine or medicine, public health, and behaviour science and mental health. Thai LIS, or Thai Digital Collection, is a database which includes all full papers and dissertation from universities in Thailand. Relevant studies published in other languages and databases may have been missed in this review.

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Jeste et al. (2013)	Kim (2009)	Ibrahim et al. (2010)	Goodman et al. (2011)	Vahia et al. (2010)
JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies					
1.Were the criteria for inclusion in the sample clearly defined?	Yes	Yes	Yes	Yes	Yes
2.Were the study subjects and the settings described in detail?	Yes	Yes	Yes	Yes	Yes
3.Was the exposure measured in a valid and reliable way?	Yes	Yes	Yes	Unclear	Yes
4.Were objective, standard criteria used for measurement of the condition?	Yes	Yes	Yes	Yes	Yes
5.Were confounding factors identified?	Yes	Yes	Unclear	N/A	Unclear
6.Were strategies to deal with confounding factors stated?	Yes	Yes	Unclear	N/A	Unclear
7.Were the outcomes measured in a valid and reliable?	Yes	Yes	Yes	Unclear	Yes
8.Was appropriate statistical analysis used?	Yes	Yes	Yes	Yes	Yes
Overall appraisal	**☑ Include**	**☑ Include**	**☑ Include**	**☑ Include**	**☑ Include**

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Chansarn (2012)	Haque (2016)	Haque et al. (2016)	Haddad et al. (2005)
JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies				
1.Were the criteria for inclusion in the sample clearly defined?	Yes	Yes	Yes	Yes
2.Were the study subjects and the settings described in detail?	Unclear	Yes	Yes	Yes
3.Was the exposure measured in a valid and reliable way?	N/A	Yes	Yes	Unclear
4.Were objective, standard criteria used for measurement of the condition?	N/A	Yes	Yes	Unclear
5.Were confounding factors identified?	No	Unclear	Unclear	No
6.Were strategies to deal with confounding factors stated?	No	Unclear	Unclear	Unclear
7.Were the outcomes measured in a valid and reliable?	N/A	Yes	Yes	Yes
8.Was appropriate statistical analysis used?	N/A	Yes	Yes	Yes
Overall appraisal	**☑ Exclude**	**☑ Include**	**☑ Include**	**☑ Include**

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Mendoza-Ruvalcaba and Fernández-Ballesteros (2016)	Caprara et al. (2016)	Wilcox et al. (2008)
JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)			
1.Is it clear in the study what is the "cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	Yes	Yes	Yes
2.Were the participants included in any comparisons similar?	Yes	Yes	Unclear
3.Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	Unclear	Yes	Unclear
4.Was there a control group?	Yes	Yes	No
5.Were there multiple measurements of the outcome both pre and post the intervention/exposure?	Yes	Yes	Yes
6.Was follow-up complete, and if not, was follow-up adequately reported and strategies to deal with loss to follow-up employed?	Unclear	No	Unclear
7.Were the outcome of participants included in any comparisons measured in the same way?	Yes	Yes	Unclear
8.Were outcomes measured in a reliable way?	Yes	Yes	No
9.Was appropriate statistical analysis used?	Yes	Yes	Yes
Overall appraisal	**☑ Include**	**☑ Include**	**☑ Exclude**

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Mendoza-Ruvalcaba and Arias-Merino (2015)	Latorre et al. (2015)
JBI Critical Appraisal Checklist for Randomized Controlled Trials		
1.Was true randomization used for assignment of participants to treatment groups	Unclear	Unclear
2.Was allocation to treatment groups concealed?	Unclear	Unclear
3.Were treatment groups similar at the baseline?	Yes	Yes
4.Were participants blind to treatment assignment?	Unclear	Yes
5.Were those delivering treatment blind to treatment assignment?	Unclear	Yes
6.Were outcomes assessors blind to treatment?	Unclear	Yes
7.Were treatments groups treated identically other than the intervention of interest?	Yes	Yes
8.Was follow-up complete, and if not, were strategies to address incomplete follow-up utilized?	Yes	No
9.Were participants analysed in the groups to which they were randomized?	Yes	Yes
10.Were outcomes measured in the same way for treatment groups?	Yes	Yes
11.Were outcomes measured in a reliable way?	Yes	Yes
12.Was appropriate statistical analysis used?	Yes	Yes
13.Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conducted and analysis of the trial?	Yes	Yes
Overall appraisal	**☑ Include**	**☑ Include**

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Grundberg et al. (2014)	Buys et al. (2008)	Wilhelmsson and Lindberg (2009)	Grundberg et al. (2016)	Murray et al. (2006)
JBI Critical Appraisal Checklist for Qualitative Research					
1.Is there congruity between the stated philosophical perspective and the research methodology?	Yes	Yes	Yes	Yes	Yes
2.Is there congruity between the research methodology and the research question or objectives?	Yes	Yes	Yes	Yes	Yes
3.Is there congruity between the research methodology and the methods used to collect data?	Yes	Yes	Yes	Yes	Yes
4.Is there congruity between the research methodology and the representation and analysis of data?	Yes	Yes	Yes	Yes	Yes
5.Is there congruity between the research methodology and the interpretation of results?	Yes	Yes	Yes	Yes	Yes
6.Is there a statement locating the researcher culturally or theoretically?	Unclear	Unclear	Yes	Unclear	Unclear
7.Is the influence of the researcher on the research, and vice-versa, addressed?	Yes	Unclear	Unclear	No	Unclear
8.Are participants, and their voices, adequately represented?	Yes	Yes	Yes	Yes	Yes
9.Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	No	Yes	Yes	Yes	No
10.Do the conclusion draw in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Yes	Yes
Overall appraisal	**☑ Include**	**☑ Include**	**☑ Include**	**☑ Include**	**☑ Include**

Table 2-1: Methodological quality of the reviewed studies

Item/articles	Russ (2012)	Nantsupawat et al. (2010)	Thanakwang, Isaramalai, and Hattakit (2014)	Lester et al. (2005)
JBI Critical Appraisal Checklist for Qualitative Research				
1.Is there congruity between the stated philosophical perspective and the research methodology?	Unclear	Yes	Yes	Yes
2.Is there congruity between the research methodology and the research question or objectives?	No	Yes	Yes	Yes
3.Is there congruity between the research methodology and the methods used to collect data?	No	Yes	Yes	Yes
4.Is there congruity between the research methodology and the representation and analysis of data?	No	Yes	Yes	Yes
5.Is there congruity between the research methodology and the interpretation of results?	No	Yes	Yes	Yes
6.Is there a statement locating the researcher culturally or theoretically?	No	Yes	Unclear	Unclear
7.Is the influence of the researcher on the research, and vice-versa, addressed?	No	Unclear	Unclear	Unclear
8.Are participants, and their voices, adequately represented?	Yes	Yes	Yes	Yes
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	No	Yes	Yes	Yes
10.Do the conclusion draw in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Yes
Overall appraisal	**☑ Exclude**	**☑ Include**	**☑ Include**	**☑ Include**

Table 2-1: Methodological quality of the review studies

Types of mixed methods study components or primary studies	Methodological quality criteria	Lin et al. (2013)	Runciman et al. (2006)	Thanakwang, Isaramalai, and Hatthakit (2014)
Screening questions (for all types)	*Are there clear qualitative and quantitative research questions (or objectives), or a clear mixed methods question (or objective)?	Yes	Yes	Yes
	*Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components)	Yes	Yes	Yes
	Further appraisal may be not feasible or appropriate when the answer is *'No' or Can't tell'* to one or both screening questions.			
1.Qualitative	1.1 Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Yes	Yes	Yes
	1.2 Is the process for analysing qualitative data relevant to address the research question (objective)?	Can't tell	Yes	Yes
	1.3 Is appropriate consideration given to how findings relate to the context, e.g., the settings in which the data were collected?	Yes	Yes	Yes
	1.4 Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	Can't tell	Yes	Yes
2.Quantitative randomized controlled(trials)	2.1 Is there a clear description of the randomization (or an appropriate sequence generation)?	N/A	N/A	N/A
	2.2 Is there a clear description of the allocation concealment(or blinding when applicable)	N/A	N/A	N/A
	2.3 Are there complete outcome data (80 % or above)?	N/A	N/A	N/A
	2.4 Are there low withdrawal/drop-out (below 20%)?	N/A	N/A	N/A

Table 2-1: Methodological quality of the review studies

Types of mixed methods study components or primary studies	Methodological quality criteria	Lin et al. (2013)	Runciman et al. (2006)	Thanakwang, Isaramalai, and Hatthakit (2014)
3.Quantitative non-randomized	3.1 Are participants (organizations) recruited in a way that minimizes selection bias?	N/A	N/A	N/A
	3.2 Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	N/A	N/A	N/A
	3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	N/A	N/A	N/A
	3.4 Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	N/A	N/A	N/A
4.Quantitative descriptive	4.1 Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Yes	Yes	Yes
	4.2 Is the sample representative of the population under study?	Yes	Yes	Yes
	4.3 Are measurements appropriate (clear origin, or validity known, or standard instrument)?	Can't tell	Yes	Yes
	4.4 Is there an acceptable response rate (60 % or above)?	No	No	Yes
5.Mixed methods	5.1 Is the mixed methods research design relevant to address the qualitative and qualitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objectively)	Yes	Yes	Yes
	5.2 Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	Can't tell	Yes	Yes
	5.3 Is appropriate consideration given to the limitation associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	No	Yes	Yes
	Overall appraisal	**☑ Include**	**☑ Include**	**☑ Include**

Table 2-2: Summary of quantitative studies and mixed methods studies included in the literature review

Author(year)	Aims	Methodology/methods	Participants/settings	Main findings	Limitations
Goodman et al. (2011)	- To discover the current level of nurse-led involvement in activity promotion for older people. - To explore the knowledge and attitudes of primary care nurses in term of health benefits of activity promotion for older people.	- A survey design used to mail out a semi-structured questionnaire. - The questionnaire covered; current involvement in promoting activity and awareness of local initiatives for older people, training, and knowledge of activity promotion methods, attitudes towards activity promotion for older people, personal activity levels, and demographic information. - Twenty closed questions and at the end of the questionnaire was an open question for comments and observations about nursing involvement. - Descriptive analysis used to interpret data.	- Primary care nurses; practice nurse, district nurse, and health visitors from five primary care trusts in Britain. - The questionnaire was posted out to all primary care nurses (n=971), but the response rate was 54% (n=521).	- Regular physical activity is crucial for healthy ageing. - Nurses had commitment, interest, and opportunities to support older people for practising physical exercise. - Lack of time, organisational constraints and limited opportunities to refer patients to suitable services were barriers to the activity of promotion in primary care. - Primary care nurses need access to specialist training and formal links with services for older people with complex need about the promotion of physical activity.	- The response rate was 54%, and those who responded had a greater interest in activity promotion for older people than those who did not. - Specialist community nurses working with particular older patients groups were excluded from this study, so the involvement of nurses in promoting physical activity was underestimated in this study. - The study conducted inner city environment, patterns of work, access to specialist services and training provision would differ from those in more suburban or rural areas.

Ibrahim, F., Cohen, C. I., & Ramirez, P. M.(2010)	- To examine rates of successful aging comparison between older adult with and without schizophrenia.	- A cross-sectional analytic study - Measurement of successful ageing consisted of the summed score (range 0 to 6) of three domains comprising six indices (Cronbach's alpha ≥0.60, ICC=0.79 to 0.99). - T-test, Chi-square, Pearson correlations, and regression analysis were used to analyze data.	Participants were divided into two groups: - 198 schizophrenia patients aged 55 years and older who developed the disease before age 45, they were selected from the community and excluded cognitive impairment too severe - Comparison group those without schizophrenia about 113 aged 55 years and above were recruited from the primary sampling using randomly selected block groups and then knocking on doors for an interview. - Written informed consent on all subjects. - Living in community in the USA	- Older adults with schizophrenia living in the community rarely achieved successful aging compared with people without schizophrenia. - Older adults with schizophrenia met all six criteria of successful ageing only 2 % whereas older adults without met 19%. - Fewer negative symptoms and a higher quality of life index were associated with successful ageing within the schizophrenia group.	- A cross-sectional study is unable to determine the stability of outcome measure over time. - The sample selected from only urban area. - The sample of schizophrenia recruited from outpatients and supported residence which excluded persons who are no longer in treatment or living in institutions.
Vahia et al. (2010)	- To compare successful ageing among non-depressed persons, subthreshold depression, and depression disorder.	- A cross-sectional survey - Depression was measured by the Center for Epidemiological Studies Scale for Depression (CESD.) - Non-depressed persons were defined as CESD score below 8, sub-threshold depression as score	- Participants were recruited from the San Diego centre for the Women's Health Initiative study. - 1,979 women aged 60 years and over returned the survey.	- Depression associated with successful ageing; older women with depression disorder have worsened scores on measures of successful ageing than sub-threshold depression,	- It was a cross-sectional study conducting with only Caucasian women and the median level of education was high.

		between 8 and 15, and CESD Depression as a score of 16 or above. - The survey questionnaire on successful ageing used a self-rated of successful ageing on a 10-point Likert scale, with 1 being least successful and 10 most successful. - History of diagnosis or management of mental health problem used self-report. - The statistic used F-test for continuous data and chi-square tests for categorical data. - Univariate ANOVAs and Mann-Whitney U tests used to explore differences in successful ageing and depression disorder.	- Living in community of the USA	sub-threshold depression has worsened scores than non-depressed persons.	- Cross-sectional design maybe difficult interpret to make causal inference. - Measured successful ageing with self-report maybe occurs recall bias.
Jeste et al. (2013)	- To examine self-rated successful ageing and psychological factors.	- A structured multi-cohort design - List-assisted random digit dialing procedures - A 25-minute structured telephone interview with demographic characteristics, general health, depression and anxiety, and cognitive functioning	Inclusion criteria; age between 50 and 99 years, a telephone in their home, physical and mental ability to participate in a telephone interview and to complete mail survey, English fluency - 1,300 community-dwelling residents of San Diego	- Psychological factors; resilience, optimism, well-being, an absence of depression had an important role in enhancing successful ageing in older adults. - The potential for enhancing successful ageing was promoting resilience and	- Used self-report based assessment may find information bias. - Used telephones interview may get information bias. - Excluded people in the nursing home and other institutions.

		- The two-item Personal Health Questionnaire used to assess depression. - The 12-item modified version of the Telephone Interview for evaluating cognitive status - Screening instrument for cognitive impairment - neuropsychological screening - Mail survey used to 36-Item Short-Form Health Survey, the Cognitive Failure Questionnaire, the 9-item version of the Patient Health Questionnaire, the Like Orientation Test-Revised for optimism, the 10-item version of the Connor-Davidson Resilience Scale, a 10-point Likert-type scale ranging from 1 (least successful) to 10 (most successful). - Bivariate correlational analysis - Multivariate analysis	completed the telephone interview. - 1,006 of them completed mail survey. - 294 participants completed the only telephone interview. - Community- based in the United States of America	treating or preventing depression.	
Kim (2009)	- To identify the influence of expectations about ageing on physical and mental health status.	- A cross-sectional, correlational study - A self-administered questionnaire, a short version of Expectations Regarding Aging was used to measure expectations about ageing.	- A convenience sample of 99 older people recruited from 3 community-based senior welfare centres in Korea. - Inclusion criteria were aged 60 years and older, no	- Higher expectations regarding ageing associated with physical and mental health status in older people. - Health-promoting behaviour was enhanced if older people	- The cross-sectional design cannot conclude causal inferences.

	- To examine the mediating effect of health-promoting behaviour.	- The Health-Promoting Lifestyle Profile II, a Korean version was measured regarding health-promoting behaviour. - The Korean version of Medical Outcomes Study 12-item Short Form was evaluated physical and mental health status. - Descriptive statistics and multiple regression analysis were used to calculate the data.	cognitive impairment problems, willing to participate in the study. - All participants gave informed consent. - Community in Korean	had expectations regarding ageing toward physical and mental health.	
Lin, W.-I., Chen, M.-L., & Cheng, J.-C. (2013)	- To investigate and evaluate the policies and practices adopted in Taiwan to promote active ageing.	- Mixed method design - Used questionnaires and focus group to collect data. - Active ageing activities were measured by activity program, frequency, participants' perception, assessment, and difficulties encountered by an agency conducting activities of active ageing. - Focus group for finding opinions and suggestions based on providers' experience from a representative of local government, communities, and non-profit-making organisation.	- 1,688 senior citizen centres and ten community health centres were main sources of data. - 1,708 questionnaires by mail and recovered 525. - Conducted in the non-profit-making organisation (NPOs) and community organisations (COs) in Taiwan.	- The most important content of active ageing was physical health, mental health, learning new things, engaging in volunteer work, being respected, and community participation, respectively. - Inconvenient transportation, lack of related incentives, excessive distance, lack of companions to accompany them, and activity being unsafe were an obstacle to participating active ageing activities.	- Low response rated 30.74%, but the data reflected the regional variations across Taiwan.

Runciman et al. (2006)	- To survey community nurses' health promotion work with people aged 50 years and older. - To identify health promotion initiatives.	- Mixed method design - A questionnaire survey, with follow-up telephone interviews with a sub-sample - The questionnaire was developed and tested; Cohen's Kappa values used to calculate for 155 variables, 50% of items achieved very well (values: 0.61-0.9), and 36% of items achieved a moderate level (0.4-0.6). - Telephone interviews used an audio-recorded discussion about 15 to 45 minutes. - Questionnaire data used descriptive analysis. - Interview transcripts used a two-stage content analysis.	- 1062 community nurses were selected by a 50% stratified random sample from six Scottish National Health Services Boards. - 373 (35%) responded, and 30 of whom were interviewed by telephone. - Community in Scotland	- Community nurses' health promotion with older people was wide-ranging. - Biomedical policy priorities dominated working with community nurses. - Heart health, diet, exercise, mental health, and positive ageing were less often reported. - There was embedded in health promotion, but it was not visible. - Evidence of audit, evaluation, and active involvement of older people in planning health promotion was limited.	- The response rate was quite low, but the authors used telephone interview of some sample.
Mendoza-Ruvalcaba and Arias-Merino (2015)	-To assess the effectiveness of a program to promote active ageing.	- Randomized controlled trial - Intervention is a program designed to promote active ageing by stimulating and improving physical activity, nutrition, and cognitive functioning, quality of life. - All participants were evaluated at baseline, post-test, and after 6 months of follow-up. - The experimental group received the program total 16 sessions in 2	-Sixty-four healthy older people aged 60 years and older recruited from senior centres in Mexico. - They were divided into 2 groups; the experimental group included 31 people and control group included 33 persons. **Inclusion criteria**	-The experimental group indicated significant improvement compared with the control group, namely, physical activity, nutrition, cognitive performance, and quality of life. - The program promotes improvement in domains of active ageing, mainly in self-efficacy beliefs as well as in	- This study used self-reported measures which may bias regarding social desirability and acquiescence. - The sample size is quite small. -The inclusion criteria may limit the generalization of the findings.

		months and consisted of 2-hour group sections, held twice a week. -The control group participated in weekly social activities of the senior centre and received the program after the program completed. -Chi-squared test, the Student's t-test, and repeated measures analysis of variance was used to analysis the data.	-They can attend a session at least twice a week. - They were willing to participate in the program, and being literate **Exclusion criteria** -Older people with depressive symptoms measured with the Spanish version of the Geriatric Depression Scale and cognitive impairment measured with the Mini-Mental State Examination.	quality of life in healthy older persons	
Mendoza-Ruvalcaba and Fernández-Ballesteros (2016)	-To test the effectiveness of the Vital Aging program to promote active ageing.	- A quasi-experimental design with two experimental conditions - It is a semi-randomized study. - Outcome measures were conducted as a pretest, and then intervention was managed during ten weeks. The post-test was conducted at the end of the program. -Primary outcomes were active life, the perception of aging, physical exercise, the frequency of social relationships, satisfaction with the	- Seventy-six older persons aged 60 years and older from a senior centre in Mexico. - They were divided into three groups: 1.Thirty-five persons were assigned to Vital Aging face-to-face(VA-FF). 2.Fifteen older people were assigned to Vital Aging combined, VA-C (multimedia/face-to-face). 3.Twenty-six persons were assigned to a control group.	- Experimental groups found improvements in the active ageing outcome measures. - Participants in VA-FF condition presented better memory performance, meta-memory, and a trend to report fewer memory problems. - Participants in the VA-C condition indicated a trend to have better life satisfaction.	- The sample size is quite small. -The generalization of the results limited with conclusion criteria and characteristics of the subjects.

		social relationship, life satisfaction, and self-efficacy. -A trained psychologist applied the assessment battery. - One-way analysis of variance and a repeated-measure ANOVA with a Greenhouse-Geisser correction were used to analyze the data.			
Latorre et al. (2015)	-To examine the effectiveness of life review in specific positive events in older adults living in the community.	- A randomised control trial - The outcome measured pre-test and post-test in life satisfaction, depressive symptoms, experiencing the environment as rewarding, and autobiographical memory. - Experimental group or life review consisted of six sessions individual training based on specific positive events. -Control group or active control comprised a media workshop of six sessions focused on learning journalistic techniques. -Statistical analysis used an ANOVA for repeated measures.	- Fifty-five older adults aged 53 to 89 years old in Spain. - They were randomly assigned to a life review group (29 persons) and an active control (26 persons). - The majority of participants had no physical illness. - None of the participants got mental illness before starting intervention.	-Life review intervention improved life satisfaction, increased specific memories, and reduced depressive symptoms. - The effective component of life review can enhance emotional well-being in the active ageing program.	- The follow-up did not organise in this study. - The sample size is quite small.
Caprara et al. (2016)	-To test the effectiveness of Vital Ageing-Multimedia (a psycho-educational	- A quasi-experimental study was a pre-post intervention design with an experimental and a control group.	- A total of 115 older adults aged 54-82 years participated in this study.	- Participants in the intervention group showed higher scores in subject health, general activities, the frequency of	- This study was not follow-up measurement both two groups.

	multimedia program), the program of promoting successful ageing.	- Variables and measures were health and healthy habits, cognitive functioning, ageing self-efficacy, well-being, and social participation. - $\chi 2$ analysis and one-way ANOVA and ANCOVA were used to analyze the data.	- They were recruited from volunteers of the Autonomous University of Madrid, Spain. - 73 subjects were assigned the intervention group, and the control group was other 42 people attending another regular course for seniors at the same university, and the waiting list to attend the program later.	physical exercise, diet quality, subjective memory, use of memonics help, less negative affect and higher hedonic balance compared with subjects in the control group.	
Haque (2016)	-To test the validity of active ageing determinant factors model and active ageing level in Thai older adults. -To examine the similarity of active ageing level in each region of Thailand.	- This study used secondary data from the Survey of Older Persons in Thailand, 2011. -Variables used to validate the active ageing determinant factors structure; age, happiness level, psychological distress status, smoking, drinking alcohol, activities of daily living, subjective health, illness, visibility, hearing, education, community participation, work, income, saving. - Confirmation factor analysis was used to examine active ageing for determinant factors structure model.	-Older persons aged 60 years and above (n=23,801; female=14,369 and male=9,432). - The data is a nationally representative survey covering all regions and urban-rural areas of Thailand.	-The active ageing level of Thai older persons is not high. -There are mean differences of active ageing level between male and female. -The average of the active ageing index in Central region is lower than North, Northeast, and South regions. - There are no mean differences among North, Northeast, and South regions.	- Not reported

Haque et al. (2016)	-To find determinant factors of active ageing level in Thai older persons. -To test the similarity factors of active ageing in female and male older persons. -To estimate the active ageing in Thai older persons. -To examine the association of indicators with active ageing level.	- Data of this study used the 2011 Survey of Older Persons in Thailand - Exploratory factor analysis used to test factor structure of active ageing. -Variables based on WHO's theoretical determinant factors.	- This study analysed older persons aged 60 years and above (n=23,801; female=14,369 and male=9,432). - The data is a nationally representative survey covering all regions and urban-rural areas of Thailand.	-Factor structure of active ageing levels was different between female and male. -The findings indicated six determinant factors of active ageing in each gender of Thailand. - The average of active ageing level for female reported as 0.66 and male found 0.62.	-The data of the 2011 Survey of Older Persons in Thailand did not cover all indicator variables based on the WHO's model. - The data set used a self-rated indicator and may not be the actual situation.
Haddad et al. (2005)	-To understand how district nursing team members make contact with people with mental health problems. -To explore attitude of the staff for common mental health problems, depression. -To examine the type of intervention for	-A cross-sectional study -A questionnaire consisted of 40 items; demographic data, workload information about mental disorders, mental health interventions used, training experience and needs of mental health problems. -Data were analyzed by factor analysis and linear regression.	- The questionnaires were sent to 331 staff of all district nursing team members (district nurses, community staff nurses, health care advisors, home care assistants). - Settings located in Jersey, Lewisham, and Hertfordshire in the United Kingdom.	- Response rate reported 66%. - 16-17 % of patients in the primary care experienced mental health problems, most commonly dementia, depression and anxiety disorders. - Psychological care activities used in practice. - The staff noted lack of training for caring mental health problems.	- not reported

	mental health problems. -To explore the experience of staff training and perception of training needs.			- They need education programs to improve their understanding and skills for detecting psychological problems, managing depression and anxiety, intervention in crises and increasing medication compliance.	
Thanakwang, Isaramalai, and Hatthakit (2014)	-To develop a scale of active ageing for Thai older persons. -To test reliability and validity of the active ageing scale.	-A mixed methods study comprised of eight steps. -The first step was a descriptive qualitative study with focus groups and in-depth interviews. This step was to explore the meanings of active ageing from the perspective of older Thai persons. -The second and third steps were to develop initial the scale of active ageing. -The fourth step was to test content validity by reviewing from a panel of experts. -The fifth step was to conduct cognitive interviews. -The sixth step was to test pilot the study.	- Participants in the qualitative phase were 64 Thai older people living in their homes both in rural and urban areas. - Participants in quantitative phase were 540 older people. - Participants of the expert panel were seven specialists in Thailand. - Settings conducted in all regions of Thailand.	- The scale of active ageing resulted in a final 36-items and indicated acceptable overall reliability and validity in a Thai context. -The instrument consisted of seven components of active ageing; having self-reliant, engaging in the community, improving spiritual wisdom, security in living, being a healthy lifestyle, being active learning, and support of family. -The psychometric properties of the instrument were 0.95 of Cronbach's alpha and varied between 0.81 and 0.91. -Concurrent validity and reliability were acceptable and confirmed.	-Participants were responding desirable manner to express a positive light. - This instrument was developed based on Thai cultural which may be different from other countries.

		-The seventh and eighth steps were to test the psychometric properties of the active ageing scale.			

Table 2-3: Summary of qualitative studies included in the literature review

Authors/ Year	Phenomena of interest/ Methodology	Methods	Participants/setting	Main findings	Limitation
Buys, Boulton-Lewis, Tedman-Jones, Edwards, Knox, Bigby (2008)	- The issue of active ageing by focusing on the comments and perceptions of older people. - A descriptive qualitative research	- A face-to-face semi-structured interview -Duration of the interview was 60-90 minutes. - Audio-taped and transcribed verbatim were used for data management. - Data analysis used the constant comparative methods following an inductive process. - A process of coding, developing categories and constantly comparing and regrouping these categories were involved in exploring the meaning of active ageing.	- Sixteen older persons with a lifelong intellectual disability aged 50 and older. - They were selected by using purposive sampling. - Ethical considerations were undertaken from both the sample and someone who knew them. - Disability and aged care services in Australia	- Older people with a lifelong disability had similar wants and needs as healthy older people. - Empowerment, relationships, activity, safety, health and fitness, living arrangement, learning, and security were determinants of active ageing. - They lack appropriate support – lack of the controlling influence of others to achieve what they desire of their lives.	- not reported
Grundberg et al. (2014)	- Experience of health-promoting dialogues from perspectives of older people	- Qualitative interviews with semi-structured, in-depth interviews were used to collect data.	- Seven older people with multi-morbidity aged 83-92 years were selected by a	- The seniors with multi-morbidity lack someone to talk about their mental health issues,	- Participants were a small number of informative and only one male participant.

	- A qualitative descriptive design	- The latent content analysis was used to identify the phenomenon.	convenience and purposeful sample. - Living in community in a suburb of Stockholm, Sweden	for example, friends, relatives and especially health care and social service providers for health-promoting dialogues. - Social support and dialogues could promote mental health.	
Wilhelmsson and Lindberg (2009)	- Facilitators and barriers for district nurses working with health promotion - A qualitative descriptive design	- Semi-structured interviews with mainly open-ended questions - The questions covered; factors are facilitating health promotion work, the experience of facilitators and barriers in work, what they should do to reach good results, and how different professions collaborate. - The interview took time between 35 to 90 min and audiotaped. - Each author performed half of the interviews and also transcribed the same interviews verbatim. - Data were analysed by inductive content analysis and latent analysis.	- 54 district nurses from all 21 health-care regions in Sweden. - They were selected by purposeful sampling. - Primary care centres in Sweden.	- The district nurses were very interested in health promotion and would like to work with it. - **Facilitators were**; 1) Knowledge in term of specialisation in nursing activities, deeper knowledge about health promotion, systematic exploration regarding public health in the area of primary care centres. 2) Prerequisites regarding common goals, guidelines, and resource for working with health promotion. 3) Distinctive features regarding attitude, characteristics, and freedom of choice for health promotion. - **Barriers were**; 1) Lack of co-ordinator, resources of the organisation, interest in health promotion, and support	- Informants who agree to participate in this study had a special interest in health promotion and were recruited by purposeful sampling.

				from management in particular Head of Primary Care Centres and colleagues. 2) Indistinctness in term of functions of district nurses, priorities of prevention and health promotion were given low priority as primary care managers, counselling about health promotion; it was aggravating because of influence from mass media and society.	
Lester et al. (2005)	-Perspectives of primary care providers for caring for people with serious mental illnesses. -Views of patients with serious mental illness on primary care. - A descriptive qualitative study.	- Focus groups consisted of six health staff groups, six patient's groups, and six combined among health professionals and patient's groups. - The topic guide developed from a literature review and then was piloted with six patients and six health professionals. - Data were analyzed by using NVivo 2.0.	- This study conducted focus groups in 55 patients with serious mental disorders, 39 general practitioners, and eight practice nurses. - This study was carried out in six primary care trusts in the West Midland, the UK.	- The perspective of primary care staff was that caring for people with serious mental illnesses was too specialised for routine primary care. - They also felt the lack of sufficient skills and knowledge. - Patients' preferred to consult their primary care providers rather than other health professionals including those who specialise in mental health.	-No health staff graduated a post-graduation in mental health in this study. -Participants were six mental health lead nurses who had an interest in mental health.
Murray et al. (2006)	- Perception of primary care staff regarding depression in older people.	- Data collection involved with individual in-depth interviews.	- Participants were 18 general practitioners, seven practice nurses and five practice	- Perception of primary care staff felt identification of late-life depression was complicated by	

	- A descriptive qualitative study.	- An initial interview guide was developed based on the literature review. - Interview process took one and a half hours. - Data were processed from transcripts to coded themes, and to explore the correlation between them.	counsellors working in 18 primary care settings in South London, the United Kingdom. - They were recruited using purposive sampling in different centres.	co-morbidity with physical illnesses. -The general practitioners said older patients rarely complained about psychological difficulties. - Practice nurses felt older patients were too embarrassed to tell about non-medical problems. -Participants though older people tended to perceive depression as a normal part of the ageing process and as a sign of weakness. - They also felt that stigma of mental illness was broadly known as a barrier to seeking help. -The main source of both support and distress for older people were their families which could be vital for detecting and caring late-life depression.	
Nantsupawat et al. (2010)	- Exploring family relationships, roles and the meaning of active ageing in Thai older people living in rural areas. - An ethnographic design.	- Data collection involved by using methods for participant observation and in-depth interviews. - Participant observation organised in health settings, temples, grocery stores, rice	- Key informants were 58 older people living in rural areas of Khon Kaen, in northeast Thailand. - General informants were 45 family members.	-There were four types of family relationships; one, two, three, and four generation living patterns. -There were two roles of family relationship; earning a living and instructing children and grandchildren.	-Older people in a rural village from one province cannot be generalized to other older persons elsewhere. -The principle researcher was born

		farms, festivals and funeral ceremonies. In-depth interviews with participants home and took time about 30 -60 minutes. - The researcher used a constructed interview guide. - Data were analysed by methods of latent content analysis.	- They were purposively selected and from 44 different family structures.	-Active ageing for older people meant contributing and achieving happiness which they saw as an advantage for themselves, family, and society. - Working, looking after next generations, getting loans, community participation, visiting relatives, respect from children, health, and pre-death preparation were eight ways of life for being active ageing. - Three and four-generation family patterns could promote active ageing because they made older people feel secure in the knowledge that someone would look after them now, and in the future.	in the village used in this study.
Thanakwang, Isaramalai, and Hattakit (2014)	-The meanings of active ageing from the perspective of Thai older persons. -A descriptive qualitative study.	-Focus groups and in-depth interviews were methods to collect data. -Each focus groups took from 60-90 minutes. -Two participants from focus groups were invited for an in-depth interview later.	-Participants were selected by purposive sampling from four regions of Thailand. -The settings were one province from each region, resulting in four provinces. **Inclusion criteria:** -Thai older people aged 60 years and above;	-Active ageing in the meaning of Thai older people comprised of six themes: being self-reliant, being actively engaged with society, growing spirituality, maintaining a healthy lifestyle, being active learners, and managing later life security.	The participants were selected using convenience sampling. So, it could not be representative of all Thai older people. -Older people with serious chronic

		-Interviews varied from 30-60 minutes, and semi-structured interviews were used for data collection. -Data were analysed by content analysis.	-living in community-dwelling; -without disabilities or severe dementia. -Total 64 older adults were participants.	-Perception of Thai older persons in term of active ageing involved health, social participation, and security in life.	illness, disability or who are frail were excluded from this study.
Grundberg et al. (2016)	-The perspective of district nurses on detecting mental health problems and promoting mental health amongst older people with multi-morbidity living in the community. -A descriptive qualitative design.	-Individual interview and focus groups were methods to collect data. -The latent content analysis was used to analyze the data.	- Participants were 25 district nurses from primary care centres in Stockholm region of Sweden. - Seven participants preferred individual interviews. - 18 participants were assigned to one of three focus groups.	-The district nurses focused on assessment, collaboration and social support to ensure that there were methods to detect mental health problems and promote mental health in their patients. -They mentioned no guidelines or structured goals for mental health care in their settings. - Some district nurses needed more knowledge regarding interview techniques and assessment instrument of mental health problems. - They stated they lacked a structured forum for collaboration between healthcare providers.	-This study used two methods of data collection; interview and focus groups. Interview conducted by the participants who were very interested in and shared their experience. The finding must be interpreted with caution.

2.7 JUSTIFICATION OF THE STUDY

As mentioned in Chapter One, the main aims of the study were to a) develop and test a new survey instrument designed to measure the promotion of active ageing in older people with mental disorders living in the community of Thailand, and b) identify factors that influence the promotion of active ageing in this group.

An ageing society poses significant problems globally, including in Thailand (TGRI, 2013; Kinsell & He, 2009). Older people need support from health care providers to promote physical and mental health and to be empowered to achieve active ageing (Buys et al., 2008; Grundberg et al., 2014). Moreover, there are several barriers to caring and working with older people, and older people with mental disorders living in the community (Muir-Cochrane et al., 2014; Runciman et al., 2006). For example, primary care providers need more support, such as support to increase skills and knowledge, and more resources about health promotion for older people (Runciman et al., 2006; Wilhelmsson & Lindberg, 2009). They also lack awareness of mental health problems in older people (Muir-Cochrane et al., 2014). Moreover, service provision focuses on physical health rather than mental health problems (Muir-Cochrane et al., 2014). Most importantly, it is known that mental disorders affect successful ageing (Ibrahim et al., 2010; Jeste et al., 2013; Vahia et al., 2010).

After WHO launched the concept of active ageing in 2002 (WHO, 2002), there were a number of countries, including Thailand, that adopted and implemented this concept into their health policies and aimed to promote active ageing in their countries (Hutchison et al., 2006; Jitapunkul & Wivatvanit, 2008). Promoting active ageing in communities presented several issues. For example, health care providers lacked skills, and resources (Lin et al., 2013), and the programs of promoting active ageing mainly focused on older

people in general, or healthy older persons (Caprara et al., 2016; Latorre et al., 2015; Mendoza-Ruvalcaba & Arias-Merino, 2015; Wang, Chen, Lai, Chen, & Chen, 2014).

The evidence from this literature review shows that promoting active ageing in older people with mental disorders living in the community is an under researched area. Most importantly, there have been no attempts to develop an instrument for measuring the level of promotional activity among older people with mental disorders living in the community or identifying factors that influence the promotion of active ageing on this group. The evidence about how primary care providers promote active ageing in older people with mental disorders and how they can support primary care for promoting active ageing in this group are also understudied.

In order to develop and test an instrument for measuring the promotion of active ageing in older people with mental disorders living in the community of Thailand, and to identify factors that influence the promotion of active ageing in this group, a mixed methods methodology and design research study was warranted. The following Chapter describes the study methodology - a sequential, exploratory, mixed-methods methodology, which was used to address the aims of this study, to answer the research questions and to meet the objectives of this study.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

The previous chapter reported on an integrative literature review that explored active ageing amongst older people with mental disorders in the community. The review concluded that older people with mental disorders need support from health care providers to promote their physical and mental health and to empower them to achieve active ageing. The review also concluded that promoting active ageing in older people with mental disorders is an under-researched area.

This chapter describes the methodology used for this study. As noted in the introduction to this PhD research, mixed methods methodology with an exploratory sequential design was used. In addition to the overall plan for the study, this chapter outlines the research aims, objectives and research questions followed by the rationale for adopting the mixed methods exploratory design. It also addresses the methodological challenges of developing and testing a new instrument, establishing the validity and reliability of a new survey instrument, including establishing an adequate sample size to test the psychometric properties of the new instrument.

3.2 AIMS, OBJECTIVES, AND RESEARCH QUESTIONS OF THE STUDY

The aims of the study were to develop and test a new survey instrument designed to: a) measure the promotion of active ageing in older people with mental disorders living in the community of Thailand, and b) identify factors that influence the promotion of active ageing in this group.

The objectives of the study were:

1. To explore how primary care providers understand the concept of active ageing.

2. To explore how primary care providers use/apply the concept of active ageing.

3. To examine the perspectives of primary care providers regarding the promotion of active ageing.

4. To identify the perspectives of primary care providers regarding factors that influence the promotion of active ageing.

5. To develop an instrument for measuring the promotion of active ageing and identifying factors that influence the promotion of active ageing.

6. To psychometrically test an instrument for measuring the promotion of active ageing and identifying factors that influence promotion active ageing in this group.

The research questions were:

1. What are the perspectives of primary care providers about promoting active ageing in older people with mental disorders living in a Thai community?

1.1 What do they understand the concept 'active ageing'?

1.2 How do they use/apply the concept of active ageing?

1.3 What is the promotion of active ageing in this group?

1.4 What are the factors that influence the promotion of active ageing in this group?

2. What are the main components of an instrument designed to measure the promotion of active ageing in older people with mental disorders living in a Thai community and that identifies factors that influence the promotion of active ageing in this group?

3. What are the psychometric properties of the new survey instrument?

3.1 What is the content validity?

3.2 What is the face validity?

3.3 What are the internal and external reliability?

3.4 What is the construct validity?

3.3 MIXED METHODS DESIGN APPROACH

This research project is based on mixed methods research which has been referred to as "the third major research approach or research paradigm", along with qualitative and quantitative designs (Johnson, Onwuegbuzie, & Turner, 2007, p. 112). In general, there are three worldviews or paradigms used in research of social and behavioural sciences, namely, postpositivism, constructivism, and pragmatism (Teddlie & Tashakkori, 2009). Postpositivism is related to quantitative approaches, which is based on determinism thinking, reductionism by narrowing and focusing on select variables to interrelate, empirical observation and measurement, and theory verification (Creswell & Clark, 2011). Constructivism is often associated with qualitative approaches which hold the worldview of understanding or finding the meaning of phenomena, formed through participants and their subjective perspectives (Creswell & Clark, 2011; Teddlie & Tashakkori, 2009). The research in this form of inquiry is shaped from the bottom up, from individual perspectives to broad patterns, and then, to theory (Creswell & Clark, 2011). Pragmatism is typically associated with mixed methods research which focuses on the results of research, the problem centred or research questions rather than the methods, and a variety of methods for collecting data to inform the problem in a study (Creswell & Clark, 2011). The concept of pragmatism is that qualitative and quantitative methods are compatible (Teddlie & Tashakkori, 2009). Therefore, it is pluralistic and real-world practice-oriented (Creswell & Clark, 2011).

Mixed methods research has been defined by different experts (Hamed & Patrycja HĄ, 2016) as follow:

A recent definition from Johnson et al. (2007, p. 123) defined mixed methods research as;

> *"...the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration."*

According to Creswell and Clark, at present, the definition relies on the core components of mixed methods research and mixed methods design, and the researcher should (Creswell & Clark, 2011, p. 5);

1. *"collect and analyze persuasively and rigorously both qualitative and quantitative data (based on the research questions);*
2. *mix (or integrate or link) the two forms of data concurrently by combining them (or merging them) sequentially by having one build on the other, or embedding one within the other;*
3. *give priority to one or to both forms of data (in terms of what the research emphasizes);*
4. *use these procedures in a single study or in multiple phases of a program of study;*
5. *frame these procedures within philosophical worldviews and theoretical lenses; and;*

6. *combine the procedures into specific research designs that direct the plan for conducting the study."*

To summarises, mixed methods design means research that involves both quantitative and qualitative data regarding collecting, analysing, and interpreting in only one study or in a series of studies that examine the phenomenon in the same way (Leech & Onwuegbuzie, 2009).

Mixed methods designs can be divided into four basic types reflecting the interaction between research methods and data sets, the priority of qualitative or quantitative designs, timing, and mixing research methods. These mixed methods types are known as the convergent parallel design, the explanatory sequential design, the exploratory sequential design, and the embedded design (Creswell & Clark, 2011). Each design is described as follows:

1. The exploratory sequential design also referred to as the exploratory design, begins with a qualitative approach in the first phase, and prioritises the collection and analysis of qualitative data. The second phase, the quantitative approach, is built on the exploratory results to confirm or generalise the initial qualitative findings (Pluye & Hong, 2014). Then, the researcher interprets how the quantitative findings construct on the initial qualitative results (Creswell & Clark, 2011).

2. The explanatory sequential design, also referred to as explanatory design, starts the first phase of collection and analysis of the quantitative study, which prioritises addressing the research's questions. This is followed by the second phase, the qualitative study, which is developed to follow on from the findings of the quantitative first phase of the study. Then, the researcher interprets how the results of the qualitative phase can assist to explain the initial quantitative findings (Creswell & Clark, 2011).

3. The convergent parallel design also referred to as the convergent design, is when the researcher studies concurrently to implement both the qualitative and qualitative approach at the same time. It prioritises equally both qualitative and quantitative methods and keeps the approaches independent during collection and analysis of data. Then, the researcher mixes the findings of qualitative and quantitative designs during the overall interpretation (Creswell & Clark, 2011).

4. The embedded design takes place when the researcher collects and analyses data from qualitative or quantitative studies within a traditional qualitative or quantitative study. This type of mixed methods design may add a qualitative stand within a quantitative design, such as an experimental design. On the other hand, the researcher may add a quantitative stand within a qualitative study, such as within a case study. The supplement strand is added to the traditional qualitative, or quantitative designs to enhance the quality of the overall design in some way (Creswell & Clark, 2011).

The research undertaken for this PhD study used the exploratory sequential design to answer the research's questions. The rationale for this type of mixed method design as is described as follows.

3.4 RATIONALE FOR A MIXED METHODS APPROACH

Mixed methods studies provide depth and insight into research problems (Creswell & Clark, 2011) and are suitable for studying complex nursing and health care research issues (Halcomb, Andrew, & Brannen, 2009).

The overall aims of this PhD research were to develop and test an instrument for measuring the promotion of active ageing in older people with mental disorders living in the Thai community, and for identifying factors that influence the promotion of active ageing in this group. One method alone was not sufficient to address the aims and

objectives of the study. A mixed method exploratory sequential design was considered appropriate in the light of the importance of understanding the construct; active ageing in Thailand, and how this is used or applied, and the need to develop an instrument to measure and evaluate this in the future. In addition, an exploratory sequential design is appropriate when instruments of measure are not available (Creswell & Clark, 2011).

3.5 THE EXPLORATORY SEQUENTIAL DESIGN

A mixed method exploratory sequential design is divided into two phases (Creswell & Clark, 2011). The first phase begins by conducting a qualitative exploration of the topic before constructing the second phase using a quantitative approach (Creswell & Clark, 2011; Kroll & Neri, 2009). The initial purpose of exploratory sequential design is to generalise the findings from a qualitative approach to a large sample collected during the second phase (Creswell & Clark, 2011). This design has often been called the instrument development approach (Creswell & Clark, 2011) or the quantitative follow-up approach (Kroll & Neri, 2009).

Philosophical assumptions of the exploratory design work from constructivist principles during the first phase (the qualitative strand) and have greater priority within the design (Creswell & Clark, 2011). The first step of the exploratory design involves the collection of qualitative data, its analysis, and then use the information gathered to develop a quantitative follow-up phase of data collection (Creswell & Clark, 2011). The quantitative phase builds on the qualitative study. For example, the purpose of the qualitative study in this research was to identify barriers and facilitators primary care providers experience when using/applying the concept of active ageing in older people with mental disorders living in a Thai community. Then, the fundamental assumptions of the second phase of this research (the quantitative study) shift to postpositivism to develop

an instrument to measure variables using statistical methods (Creswell & Clark, 2011). The mixed method research design is presented with multiple worldviews as one-phase shifts into the other phase.

There were three important steps in the exploratory sequential design for developing the new instrument as recommended by Creswell and Clark (2011):

1. Step one involves using aspects of the findings from the qualitative phase to help develop an instrument in the quantitative phase. The exploratory design is intended to develop and test the instrument. An important step is determining what information from the initial qualitative phase can be most helpful for developing the instrument in the quantitative phase. Qualitative data analysis is used to identify important/ relevant data relating to subsequent or developmental phases of the study. Significant statements, quotes from the data, or relevant sentences are highlighted, coded into segments of information, and the codes are grouped into broad categories or themes identified.

2. Step two involves determining the type of participants to recruit, and how many to recruit, for the quantitative phase. The participants in the quantitative phase are typically not the same participants who are recruited into the qualitative phase because the purpose of the quantitative study is to generalise the findings to a population. Moreover, the quantitative phase requires a large sample size so that the researcher can analyse data with statistical methods for testing the psychometric properties of the new instrument.

3. Step three involves developing the instrument. A good instrument must have strong psychometric properties. Instruments may use the themes or phases from the initial qualitative phase and published instruments or a literature review to help develop the best match for the different qualitative themes. On the other hand, the development of the instrument can build on the findings of the qualitative phase alone.

Procedures of scale development can rigorously assist in the development of the best instrument.

There are eight general approaches recommended by Creswell and Clark (2011), and (DeVillis, 2012). These are:

1. Determine clearly what you want to measure, based on theory, literature review, and the findings from the qualitative study.
2. Generate an item pool, using short items, the level of respondent reading ability, and questions. The participant's language should also be identified if possible.
3. Determine the items in the scale of measurement and construction of the instrument.
4. Review the item pools by an expert panel.
5. Consider the inclusion of validated items from other instruments if possible.
6. Administer the instrument to test validation in a pilot sample of respondents.
7. Evaluate each item and the total items (e.g., item-scale correlations, validity, and reliability of the instrument).
8. Optimize scale length based on validity and reliability of the new instrument.

The strengths of the exploratory sequential design according to Creswell and Clark (2011) include:

1. The exploratory sequential design is divided into two different phases that can make it easy to describe, implement, and report.
2. A quantitative approach can make the findings from the qualitative component more acceptable regarding a quantitative-biased audience.
3. The findings from the qualitative phase can help generate the quantitative component.

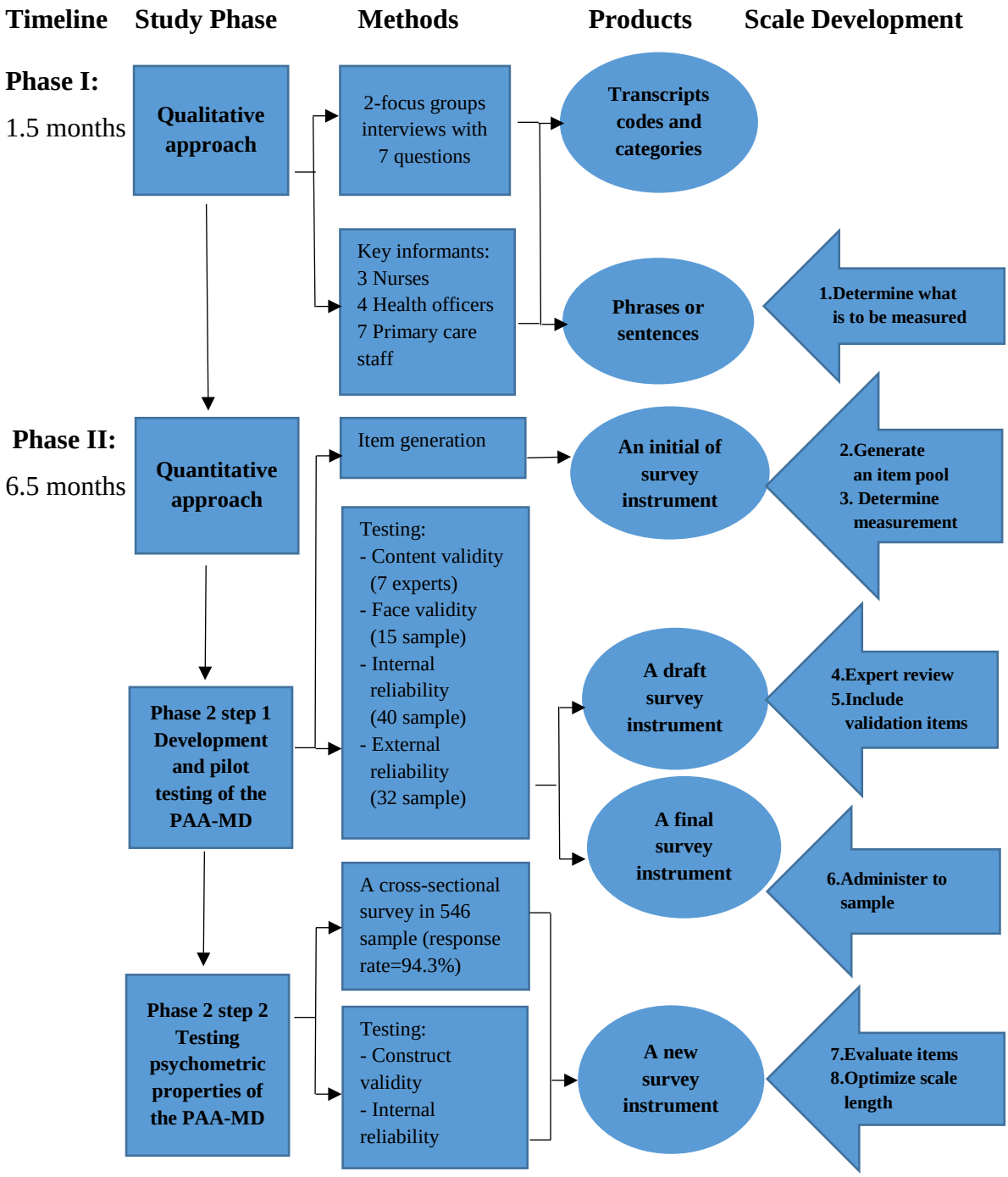
4. One of the potential products of the research process from the exploratory design is a new instrument, as demonstrated in the research study reported in this PhD.

According to Creswell and Clark, there are inherent challenges in using the exploratory sequential design (Creswell & Clark, 2011) and the researcher must consider some challenges before deciding to use this design. These are:

1. The two-phase approach is time-consuming. It can take considerable time to conduct this type of research, including time to develop a new instrument. Researchers should recognise this factor and build time into the study plan;
2. It is difficult to specify the procedures of the quantitative phase when applying for initial ethics approval for this design;
3. In the qualitative phase, researchers should consider using a small, purposeful sample. A large sample of different participants in the second phase is recruited to avoid questions of bias in the quantitative phase;
4. The researcher needs to decide which of the findings from the qualitative phase should assist in the development of the instrument and how to use these results to generate quantitative measures;
5. Procedures should be undertaken to ensure that the scores developed for the new instrument are valid and reliable.

The present study comprised two main phases, which was time-consuming taking approximately eight months to collect data because primary care providers were very busy. Phase one was a descriptive qualitative study designed to develop the initial draft of a new instrument. Phase two was divided into two steps - step one for development and pilot testing a new instrument, and step two for testing psychometric properties of the new instrument. The summary of each of the two phases is described in the Figure 3-1.

Figure 3-1: Summary Procedures of this Exploratory Instrument Design Mixed Methods Study



(Source: Adapted from Creswell and Clark (2011, p. 191). *Designing and conducting mixed methods research (2nd ed.).* California: SAGE Publications.)

The study design, plan, and methods used for the qualitative and quantitative phases of this PhD research, including the focus group meetings, development and pilot testing of a new instrument, testing psychometric properties of a new instrument from a cross-sectional study, recruitment of participants, data collection, data analysis, the rigor of this study, are detailed in the following chapter, Chapter four: Research design, plan, and methods.

Findings of the first phase were used to help develop the initial Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD) and are described in Chapter five Phase one- Focus group interviews and findings.

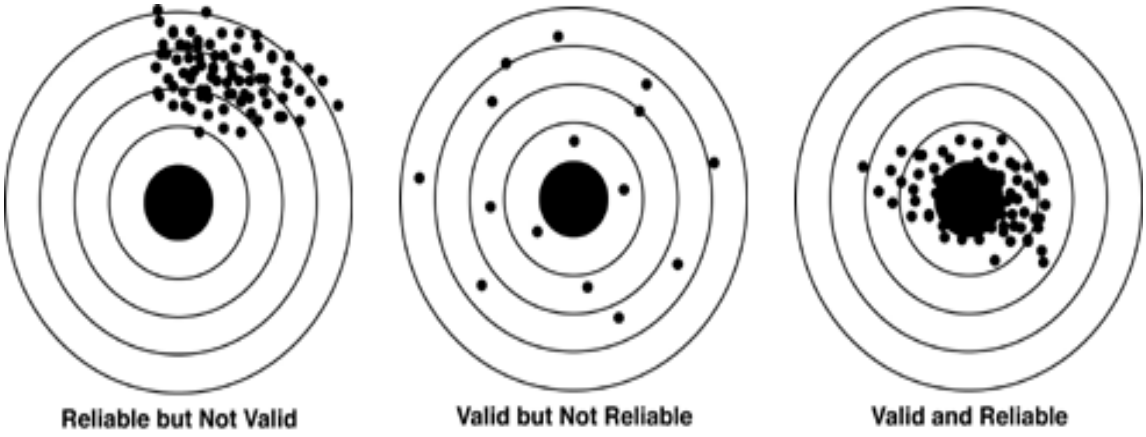
The findings from Phase two were divided into two steps, Chapter six Phase two step one - The development and pilot testing of a new survey instrument -PAA-MD, and Chapter seven Phase two step two - Testing the psychometric properties of a new instrument from a cross-sectional study.

3.6 METHODOLOGICAL CHALLENGES IN DEVELOPING AND TESTING A NEW INSTRUMENT

The validity and reliability of measures are two key indicators of the quality of a measuring instrument. The development and testing of a new instrument are, in large part, focused on reducing error in the measurement process (Kimberlin & Winterstein, 2008). Properties of instruments are called psychometrics which is the construction and validation of measurement tools and are used for assessing and testing reliable and valid forms of measurement (Gellman & Turner, 2013). According to the Encyclopedia of Behavioral Medicine (Gellman & Turner, 2013, p. 1563), psychometric properties are defined as, *"…the construction and validation of measurement instruments and assessing*

if these instruments are reliable and valid forms of measurement." At best, each measurement should be both valid and reliable. However, the instruments may be valid but they are not always reliable.

Figure 3-2: Illustrated the relationship between validity and reliability



(Source: Center for Teaching and Learning (2016). *"The quantitative method in the social sciences e-lessons."* Retrieved 21st November 2016, from http:// ccnmtl. columbia.edu/projects/qmss/home.html.)

As shown in the Figure 3-2, the picture on the left-hand side indicates reliability without validity. The middle picture represents validity without reliability. The best instrument should be the picture on the right-hand side, which means it has both high validity and high reliability. This study aims to achieve both high validity and high reliability as in the picture on the right-hand side.

3.6.1 The concept of validity

Cohen, Swerdlik, and Sturman (2013, p. 181) stated: "validity, as applied to a test, is a judgment or estimate of how well a test measures what it purports to measure in a particular context". Words like "acceptable" or "weak" are frequently used in the element of the validity of instruments and scores of measurement (Cohen et al., 2013). These terms

define, regarding a judgment, how adequately the test measures what it purports to measure. Validity refers to the evidence presented to support or refute the meaning or interpretation assigned to assessment results (DeVillis, 2012) . All assessments require validity evidence, and nearly all topics in assessment involve validity in some way (Downing, 2003). Content validity, criterion-related validity, and construct validity are traditionally three categories using in conceptualise validity (Cohen et al., 2013; DeVellis, 2003).

1. Content validity

Content validity is a measure of validity to evaluate the subjects, topics, or content which is covered by the items in the instrument (Cohen et al., 2013). Polit and Beck (2004, p. 423) define content validity as, “the degree to which an instrument has an appropriate sample of items for the construct being measured”. Experts opinion in the field are usually used to test content validity (Kimberlin & Winterstein, 2008).

In this PhD research, the ideas and initial development of the PAA-MD used several sources including the findings of focus group interviews, the concept of active ageing from WHO (2002), and previous studies (Chansarn, 2012; Lin et al., 2013; Nantsupawat et al., 2010; Thailand. Department of Mental Health, 2015a; Thanakwang, Isaramalai, & Hattakit, 2014). Two practitioner nurses who are proposed respondents and key informants from the primary care units who participated in the FGs be asked to give suggestions on the initial survey instrument. Finally, content validity was tested using opinions from a panel of experts relevant to areas under study. The initial PAA-MD was further refined after testing this process.

2. Criterion-related, or criterion validity

Criterion validity is a judgment on the new measure correlate with other measures of the same or very similar constructs that are related to theory (Kimberlin & Winterstein, 2008). Concurrent and predictive validity are two types of criterion validity (Cohen et al., 2013). These types of validity can test the validity coefficient which is a correlation coefficient providing a measure of the relationship between test scores and scores on the criterion measure (Cohen et al., 2013).

This PhD research, however, does not utilise criterion validity. This is because there is no gold standard or instrument measuring the same concept available in term of the promotion of active ageing amongst older people with mental disorders.

3. Construct validity

Construct validity is based on the gathering of evidence from numerous previous studies to use a specific measuring instrument (Kimberlin & Winterstein, 2008). Factor analysis is a method for establishing construct validity (Cohen et al., 2013). Factor analysis consists of an exploratory or a confirmatory basis. Exploratory factor analysis involves "estimating, or extracting, factors; deciding how many factors to retain; and rotating factors to an interpretable orientation" (Floyd & Widaman, 1995, p. 287). In contrast, confirmatory factor analysis tests the degree to which a hypothetical model, includes factors and fits the actual data (Cohen et al., 2013). Factor loading, a sort of metaphor, is a term used in factor analysis to convey information which the factor determines the instrument scores (Cohen et al., 2013). A new instrument development should identify significant factor loading based on sample size as you can see in Table 3-1 (Hair, Black, Babib, & Andrson, 2014).

Table 3-1: Guidelines for identifying significant factor loading based on sample size

Factor Loading	Sample Size Needed for Significance
0.30	350
0.35	250
0.40	200
0.45	150
0.50	120
0.55	100
0.60	85
0.65	70
0.70	60
0.75	50

[a] Significance is based on a.05 significance level(α), a power level of 80 percent, and standard errors assumed to be twice those of conventional correlation coefficients.

Furthermore, Hair et al. (2014), suggested the criteria about the number of factors to retain when applying exploratory factor analysis. An eigenvalue higher than one (1), the scree plot characteristics, and interpretability are the crucial components which the researchers should consider to retain the number of factors (Hair et al., 2014). Then, consideration is given to the loading on each variable being significant, the community score is greater than 0.50, and the item contributes to factor interpretability (Hair et al., 2014). Finally, consideration is given to variables, where the cross-loading shows relatively high loadings on more than one factor are commonly deleted unless theoretically justified, or the objective of the study is strictly reduced to data (Hair et al., 2014).

In this PhD research, validation of construct validity used exploratory factor analysis for summarising and grouping closely connected items in a large sample. This process created a new composite factor representing each group of items (DeVillis, 2012). The number of factors to retain, when applying exploratory factor analysis, was adapted from suggestions based on Hair et al. (2014). The components are having an eigenvalue greater than 1, the scree plot characteristics, and interpretability (Hair et al., 2014) were adopted. The criteria used in this study in determining the retention of each item was that the item-

factor loading is greater than 0.40, with a sample size of more than 350 respondents (Hair et al., 2014) to ensure the factor loading of the new survey instrument. Then, to ensure the loading on each variable is significant, the community score needed to be greater than 0.50, - thus the item contributed to factor interpretability (Hair et al., 2014).

4. Face validity

Face validity has been well described by Cohen et al. (2013, p. 183) and "…relates more to what a test appears to measure to the person being tested than to what the test actually measures. Ultimately, face validity may be more a matter of public relations than psychometric soundness, but it seems important nonetheless" (Cohen et al., 2013, p. 184). The purpose is to establish an instrument's ease of use, clarity, and readability (Burton & Mazerolle, 2011). There are many methods to help improve face validity, namely; cognitive interviewing, a panel of professionals using a team-based approach, the technique of readability score appropriateness (Banna, Buchthal, & Tauyan, 2015; Haeger, Lambert, Kinzie, & Gieser, 2012; Huang et al., 2012). The cognitive interviewing technique is a form of structured interviewing designed to enhance face validity of a survey or evaluation instrument (Banna, Becerra, Kaiser, & Townsend, 2010). It has three strategies; the concurrence think-aloud technique, the use of paraphrasing, and the use of probes or a set of questions the interviewer uses for improving face validity developed by Willis (1994).

In this PhD research, ten primary care staff from a primary care setting in Ubonratchathani Province were invited and asked for their feedback on the PAA-MD in term of appropriate wording. More importantly, the instruction aspects of the PAA-MD were also conducted, namely; instructions, response options, item words, and examples of active ageing activities in their settings. Furthermore, five older people with mental disorders, such as anxiety disorder or depressive disorder, who were otherwise of stable health, and with

good cognition, were invited to comment and suggest amendments to the PAA-MD. The research student interviewed and asked them to give feedback on the PAA-MD with regard to appropriate wording. They were also asked to give examples of activity about the promotion of active ageing in their communities.

The PAA-MD was further refined after testing this process. Furthermore, in the process of the pilot study to test reliability, forty primary care workers were asked the questions, "What, in your opinion, are the best and worst questions?" and, "How easy are the questions to understand and answer"? and "Are there any other issues or problems you notice?". This process helped to improve the face validity of the PAA-MD. Summary of the methods used for survey instrument validation are shown in Table 3-2.

Table 3-2: Summary of the methods used for survey validation

Type	Description	Purpose
Face validity	Evaluation of the appearance of an instrument by a group of experts and/or potential participants	Establishing an instrument s ease of use, clarity, and readability
Content validity	Evaluation of an instrument representativeness of the topic to be studied by a group of experts.	Establishing an instruments credibility, accuracy, relevance, and breadth of knowledge regarding the domain.
Criterion validity	Evaluation of an instrument correlation to another that is deemed unquestionable or identified as the gold standard.	Establishing an instruments selection over another or establishing the predictability of the measure for a future criterion.
Construct validity	Evaluation of an instrument ability to relate to other variables or the degree to which it follows a pattern predicted by theory.	Establishing an instruments ability to evaluate the construct it was developed to measure.

(Source: Burton and Mazerolle (2011, p. 29). Survey instrument validity part I: Principles of survey instrument development and validation in athletic training education research. *Athletic Training Education Journal, 6*(1), 27-35.)

5. Cross-language validity

According to Squires (2008), the validity of the translation process in this study should be examined to ensure cross-language validity because data collection was undertaken in Thailand using the Thai language and analyses using English. The research student and participants are Thai people who use the native Thai language in everyday life. The documents, consisting of the seven questions of the FG interviews, the Information Statement, the Informed Consent form for all participants, and the research proposal were translated from English to the Thai language. The document translated from Thai to the English language was the PAA-MD (Appendix 20 and 21) developed in Thai language and to be responded to by Thai participants.

The approaches used in this PhD research to ensure cross-language validity were as follows. Firstly, the English versions of the Information Statement, the Informed Consent Form, and the seven questions of the Focus group interview schedule, including the final survey instrument, were reviewed and edited by the research student's supervisors. Secondly, the research student initially translated all documents from English to the Thai language and Thai to the English language in the case of the final survey instrument. Then, a qualified bilingual validator (Appendix 18) checked the translated documents against the original English and Thai documents to ensure the accuracy of the translation. The documents were then reviewed, discussed and clarified for changes to the translation as needed and in conjunction with the research student and the qualified bilingual validator until both reached an agreement.

According to Savignon (1997), translators for research purposes should hold sociolinguistic competence to a minimum. Further, as defined by Squires (2008, p. 266), they should be able to function on a sophisticated level using their oral and written

communication skills, integrate an understanding of cultural norms into communication process, know how and when, for example, to be polite and show respect in social situations.

The research student, whose native language is Thai, was the initial translator. She has developed sociolinguistic language competence in English since pursuing her Masters of Applied Gerontology at Flinders University, Australia in 2012, and then PhD studies in 2014. The qualified bilingual validator who verified the initial translation is a lecturer of Department of English Language and Literature, Faculty of Liberal Arts, Ubon Ratchathani University, Thailand. He received his Bachelor of Arts majoring in English from Khon Khaen University, Thailand, in 1996. He then earned his Masters of Arts in English Language Teaching from University of Canberra, Australia, in 2003. Through this process, the translated documents should contain minimum errors (Jandt, 2015).

3.6.2 The concept of reliability

Reliability is of fundamental importance in psychological measurement. Scale reliability is the proportion of variance attributable to the true score of the latent variable (DeVillis, 2012). There is a variety of methods for calculating reliability, and these are explained in the following sections.

Internal consistency reliability is used to calculate the homogeneity of the items within a scale or estimate the equivalence of sets of items from the same instrument (Kimberlin & Winterstein, 2008). The coefficient of internal consistency provides an estimate of the reliability of measurement and is based on the assumption that items measuring the same construct should correlate (Kimberlin & Winterstein, 2008). Internal consistency reliability is different methods to estimate scores of the reliability. Cronbach's coefficient alpha is one of the most widely used methods for estimating internal consistency

(DeVellis, 2006). Its function is to calculate the average intercorrelations of items and the number of items in the tool (Kimberlin & Winterstein, 2008). Acceptable and unacceptable levels of the Cronbach's Alpha coefficient were demonstrated in Table 3-3.

Table 3-3: Acceptable and unacceptable levels of the Cronbach's Alpha Coefficient

Alpha coefficient (α)	Implied reliability
< .50	Unacceptable
> .50	Poor
> .60	Questionable
> .70	Acceptable
> .80	Good
> .90	Excellent

(Source: George and Mallery (2000, p. 279) *SPSS for Windows step by step: A simple guide and reference 9.0 update* (2nd ed.). Boston: Allyn & Bacon.)

Sufficient internal consistency reliability of a new instrument should indicate a Cronbach's alpha value of 0.70 and above, and a minimum corrected item-total correlation coefficient as 0.30 (Ferketich, 1991; Nunnally & Bernstein, 1994).

Test-retest reliability or stability of instrument is an estimate of reliability to obtain a correlation pairs of scores from the same participants who are administrated of the same test on two different time (Cohen et al., 2013), or a measure of how constant scores remain from one occasion to another (DeVellis, 2003). The coefficient of stability can be interpreted by using the strength of association from statistics with Pearson's and Spearman's correlation coefficient as demonstrated in Table 3-4 (Smarandache, 2008).

Table 3-4: Strength of association from Pearson's and Spearman's Correlation Coefficient

Coefficient Value(*r*)	Strength of Association
- 0.5 to 0.5	Weak relationship
0.5 to 0.8 or - 0.8 to -0.5	Moderate relationship
0.8 to 1 or - 1 to -0.8	Strong relationship

(Source: Smarandache (2008, p. 2) Alternatives to Pearson's and Spearman's correlation coefficients. *arXiv preprint arXiv:0805.0383*.)

Moreover, there are different types of reliability which can measure a new instrument dependent on purpose, type, uses, sources of error variance, and statistic procedures, as can be seen in Table 3-5 (Cohen et al., 2013).

Table 3-5: Summary of reliability types

Type of reliability	Purpose	Typical uses	Sources of error variance	Statistical procedures
Test-retest	To evaluate the stability of a measure	When assessing the stability of various personality traits	Administration	Pearson *r* or Spearman rho
Alternate-forms	To evaluate the relationship between different forms of a measure	When there is a need for different forms of a test (e.g., makeup tests)	Test construction or administration	Pearson *r* or Spearman rho
Internal consistency	To evaluate the extent to which items on a scale relate to one another	When evaluating the homogeneity of a measure	Test construction	Pearson *r* between equivalent test halves with Spearman-Brown correction or Kuder-Richardson for dichotomous items, or coefficient alpha for multipoint items or APD
Inter-scorer	To evaluate the level of agreement between raters on a measure	Interviews or coding of behaviour. Used when researchers need to show that there is consensus in the way that different raters view a particular behaviour pattern (and hence no observer bias)	Scoring and interpretation	Cohen's kappa, Pearson *r* or Spearman rho

(Source: Cohen et al. (2013, p. 161). *Psychological testing and assessment: An introduction to tests and measurement* (8th ed.). New York: McGraw-Hill.)

In this PhD research, the PAA-MD was tested using both internal reliability and external reliability in the pilot study. The PAA-MD was also examined to find internal reliability using a cross-sectional study. Moreover, each item of the PAA-MD was tested to measure a minimum corrected item-total correlation coefficient for retaining the items of scale.

Overall, internal consistency reliability of the PAA-MD from the pilot testing and the cross-sectional study were either higher than an acceptable level or had sufficient reliability. All items have greater a minimum corrected item-total correlation coefficient. Furthermore, the PAA-MD had stability reliability over time even when tested in the same group two weeks later of pilot testing.

3.6.3 Establishing sample size adequacy for testing psychometric properties of the new survey instrument

The recommended sample size for testing psychometric properties of a new instrument is a minimum of five to ten samples per item (DeVellis, 2003; Nunnally & Bernstein, 1994). According to De Villis, a sample size of greater than 300 subjects will assist to make a good estimation of the final sample needed to test psychometric properties of the new instrument (DeVillis, 2012).

To ensure the sample size is large enough for testing the psychometric properties of the PAA-MD with exploratory factor analysis, all health care providers working in primary care units of Yasothon Province, northeast of Thailand, accounting for 122 units from nine districts and approximately 579 staff, were recruited into this survey study. These settings are different from the primary care units from both phase one and phase two step one.

The PhD researcher distributed the PAA-MD into the mailbox of the staff in Public Health Administrative of each district to test psychometric properties in a large sample. McLaren

(2013) concludes the advantage of this method is that a large volume of data can be collected from different geographical areas. In addition, interview bias is avoided, respondent convenience is ensured, and anonymity is safeguarded which is similar to the benefits of postal questionnaires (Curtis & Redmond, 2009). Moreover, structured questionnaires are easy to code and analyse with computer programs. Reliability is then easy to evaluate in terms of predetermined responses.

However, the challenge of this process is the possibility of a low response rate. Lack of supervision from the researcher may lead to some questions being missed because of a lack of understanding of a question. A Cochrane Review of methods used to increase response to postal and electronic questionnaires was undertaken by Edwards et al. (2009). Edwards noted with regards to postal questionnaires that monetary incentives, use of recorded delivery, envelope teasers with the level of interest, use of pre-notification, follow-up contact, shorter questionnaires, unconditional incentives, obligations to respond, use of stamped addressed envelopes and assurances on confidentiality could all increase response rate. In Thailand, a large mail based national cohort study reported the methods used for increasing response rate in several strategies, namely; pre-notification letter, guarantee of confidentiality, frequent contact with telephone and feedback, update of contact details, informative cover letters, and the use of incentives and small rewards (Seubsman et al., 2011). As a result, the final response rate of this study was 71.3 % (Seubsman et al., 2011).

This PhD research achieved a high response rate with a large enough sample size for testing psychometric properties of the PAA-MD with exploratory factor analysis. Strategies utilised to address the possibility of low response rate included:

1. The use of pre-notification to the Heads of Public Health District in monthly meetings at Yasothon Provincial Health Office. The heads then gave information about this research to the heads of primary care settings in their district;

2. Coordination with Public Health District in Yasothon Province. Health officers who were not line managers of the participants in each district helped to distribute the information package including the information statement and the PAA-MD into the mailbox of staff. This ensured the distribution of the PAA-MD including the information statement to all primary care providers of their district;

3. Assuring confidentiality of the information in the information statement;

4. Providing a pen in the information package;

5. The research student reminded participants four times after sending the PAA-MD. This occurred fortnightly by sending a message to the health officers. The purpose was to remind the staff in the primary care units to respond to the PAA-MD.

Finally, the response rate of this survey study was 94.3% accounting for 546 participants. The sample size was greater than the 300 subjects required, according to DeVellis, to test the psychometric properties of the final survey instrument with exploratory factor analysis (DeVellis, 2003). This is reported in more detail in Chapter seven Phase two step two - Testing psychometric properties of a new instrument.

3.7 SUMMARY

The methodology of sequential exploratory mixed methods for this PhD research has been outlined and discussed in detail. Each phase of this PhD research has been described along with its relationship to the study design and methodology. The methodological challenges of developing and testing a new instrument are also described. Establishing the validity and reliability of a new survey instrument is examined, including establishing an adequate sample size to test the psychometric properties of the new instrument.

The following Chapter presents research design, plan, and methods used for this PhD research. In this chapter, research methods will be reported by phases; phase one, phases two-step one, and phase two-step two. Ethical considerations and researcher's background are also described in detail.

CHAPTER 4: RESEARCH DESIGN, PLAN, AND METHODS

4.1 INTRODUCTION

In the previous chapter, the study methodology; sequential exploratory mixed methods were discussed along with the methodological challenges in developing and testing the new instrument.

This chapter reports research methods used describing both phase one - the qualitative descriptive study with focus group interviews and phase two - step one - the development and pilot testing of a new survey instrument; the "Promoting Active Ageing in Older People with Mental Disorders Scale" (PAA-MD) and phase two - step two - testing psychometric properties of a new instrument. Ethical considerations and the researcher's background are also described.

4.2 PHASE 1: STUDY DESIGN, PLAN AND METHODS

4.2.1 Study design

As noted previously in Chapter three, this PhD research used a mixed method research approach, specifically, an exploratory sequential design comprising two phases. The first phase of a sequential design begins by exploring a topic, in this instance how primary care providers use the WHO model of active ageing in older people with mental disorders living in a Thai community. The second phase of design in this PhD research involves a quantitative approach which includes developing and testing psychometric properties of a new instrument.

A descriptive qualitative study is based on the general premise of naturalistic inquiry which implies a commitment to studying a phenomenon as it naturally is (Sandelowski, 2000). This PhD research approach does not relate to specific disciplinary or

methodological roots (Polit & Beck, 2010). It also involves no pre-selection of variables to study and no manipulation of variables (Sandelowski, 2000, 2010). In general, descriptive qualitative research shows comprehensive summaries of the phenomenon in everyday language, but it does not seek to pierce in any interpretive depth.

The first phase of this PhD research was a qualitative descriptive study using focus groups (FGs) with an interview guide, which consisted of seven questions. There are numerous reasons why FGs were chosen to address the aims of this descriptive study. FGs thoroughly provide explanations or alternative interpretations of qualitative data (Goodman & Evans, 2015) allowing the researcher to explore perspectives of some participants on a specific issue with one interview (Holloway & Wheeler, 2010). FGs make the participants feel a sense of safety in the environment in contrast to an individual interview because they are not singled out to respond to the questions (Grove, Gray, & Burns, 2015; Milne & Oberle, 2005). Consequently, the participants could express their opinions, in relation to ideas or experiences without feeling pressure to respond to all the questions all the time.

The FGs methods are suitable for the first phase of this PhD research because FGs allow information to be gathered efficiently in a short period which is desirable for primary care providers who are short of time because of their busy workload (Krueger & Casey, 2015; WHO, 2004). The nature of the interaction of the focus group allowed participants to comment and build on to the emerging issues (Acocella, 2012) which helped to obtain a comprehensive picture from their diverse perceptions and experiences in relation to the concept of active ageing for older people with mental disorders living in their communities.

The Human Research Ethics Committee of the University of Newcastle approved this PhD research. The Ubonratchathani Provincial Health Officer who is head of all primary care units in Ubonratchathani Province also reviewed this study proposal. Further, the Provincial Chief Medical Officer Ubonratchathani gave permission to conduct this study. Consistent with the ethical principles described later in this chapter, participants were given a pseudonym in order to protect their identity.

4.2.2 Methods: Focus groups

This process took place over 1.5 months from mid-December 2015 to January 2016.

4.2.2.1 Recruitment of participants for the Focus Groups

Packaged information letters with the research student contact details, consent forms, and reply paid envelopes, were given to the Head of the Primary Care Units within the Ubonratchathani Province. The Head of each Primary Care Unit was asked to distribute these to all of their primary care staff who were to become the research participants. The primary care staff, (the participants) were asked to respond within three weeks. During this time, the research student was available by phone to answer questions about the study. Upon receipt of the letters of consent, the research student made contact with the participant to answer any questions relating to the study and to arrange the Focus Group meeting.

4.2.2.2 Participants and Setting of the study

There were 14 primary care providers who participated in phase one. In this PhD research, two focus groups were conducted with participants from the two primary care units under the Ministry of Public Health, which located in Detudom District, Ubonratchathani Province, Thailand. Krueger and Casey (2015) suggest that sufficient numbers of participants in each focus group are usually between five and eight participants and no

more than ten. The first FG consisted of six primary care staff and the second FG comprised of eight primary care providers. In Thailand, the majority of public primary care units have village health volunteers who support primary care providers in caring for people in communities. The village health volunteers are trained regarding basic healthcare, health promotion and reporting health problems to staff in primary care units who are usually the heads of the village health volunteers (Thailand. Ministry of Public Health, 2011). These volunteers get some benefits for their voluntary work from the government, such as free health services, and rewards for their volunteer works (Thailand. Ministry of Public Health, 2011). However, this PhD research did not recruit the village health volunteers because the nature of their work is unpaid and nonprofessional and that their training focuses on awareness, encouragement and social support.

4.2.3 Data collection methods

The FGs were conducted in the afternoon at 3.00 pm because the participants were willing to meet at this time as because fewer patients visit the primary care units in the afternoon. The FGs met in a private meeting room of the primary care units. The rooms were well ventilated and had minimal noise interruptions from the primary care units.

The research student facilitated both focus groups. The focus groups commenced with the research student inviting introductions from all group members followed by a reminder of the purposes of the focus group interview and the need for confidentiality and anonymity within the group. The research student then stated the questions to the group, ensuring that everyone had heard and understood the questions clearly and had an opportunity to respond. The questions progressed from broad topics to specific, depending on the participants' response. For example, when the research student asked the primary care providers about their experience in promoting active ageing in their

communities, the primary care providers said they had a variety of experiences. Then, the research student asked them for tangible examples of how they promoted active ageing and then, more specifically, by how they focused in particular on older people with mental disorders.

The duration of the focus groups was between one to 1.5 hours. Each session was audiotaped on a voice tracer by the research student and later transcribed verbatim. Transcription of the interviews was conducted by the research student. The interview transcripts were reviewed and verified against the audio file as they were completed. In addition, field notes were written by the research student at the time of each interview. During the focus group meetings, the participants were provided with refreshments such as tea, coffee, orange juice, water, and Thai dessert.

All participants were encouraged to speak freely about their perceptions and experiences. The questions were often repeated gently to ensure understanding and prompts were provided for the participants in order to take the lead and respond. The research student also welcomed any further topics the participants wished to discuss. Most participants were able to relate to the questions and to describe their experiences. The focus group meetings ended when participants had nothing more to say.

The main questions during the focus group

1. Can you tell me what you understand by the term active ageing? Can you give some examples of this in your community?
2. What are your perceptions or experiences about promoting active ageing with older people with mental disorders?

3. Do you use any methods for promoting/engaging older people with mental disorders using the WHO active ageing model or any other model? What programs/activities do you currently use and how are these applied?
4. What helps you to promote or engage with active ageing?
5. What gets in the way of this or prevents you from engaging in active ageing?
6. What resources/support do you need to promote and implement WHO active ageing?
7. Please give some examples of the knowledge and skills you think you need to promote active ageing amongst older people with mental disorders in rural Thailand?

4.2.4 Data analysis

Directed content analysis, as described by Hsieh and Shannon (2005), was used to analyse the data from the FGs. The directed content analysis is used to validate or extend a theoretical framework or theory (Hsieh & Shannon, 2005; Zhang & Wildemuth, 2016). Creswell and Clark (2011), recommended procedures for scale development to determine what is to be measured by using the products from the qualitative study, namely significant statements, quotes from the data, or relevant sentences are highlighted, coded into segments of information, and the codes are grouped into broad categories or themes identified. Moreover, new instruments may use the findings from the initial qualitative phase and published instruments or a literature review to help develop the best match for generating an item pool (Creswell & Clark, 2011).

In the case of this PhD research, the aims were to develop and test a new survey instrument based on the findings from this qualitative study, the WHO model, and previous studies relevant to the study. Therefore, the concept of active ageing from the

WHO model and previous studies relevant to this research were used to guide the exploration and analysis of participants' experiences. Significant statements, quotes from the data, or relevant phrases and sentences were highlighted, and then codes were grouped into broad categories identified. The findings of this qualitative study were used to help develop an initial survey instrument.

4.2.5 Trustworthiness

To ensure rigour, Lincoln and Guba's Criteria (Lincoln & Guba, 1985); credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985) were applied. Establishing trustworthiness relating to focus group data was also applied. These strategies were as suggested by Morrison-Beedy, Côté-Arsenault, and Feinstein (2001).

4.2.5.1 Credibility

The strategies used in this phase of the study to ensure the credibility of the findings were:

1. Researcher credibility

Patton (2002) suggests that personal and professional experience might affect data collection, analysis, and interpretation. In this PhD research, the research student has 18 years of experience as a psychiatric nurse in a public psychiatric hospital in Thailand. She also has experience facilitating group meetings with psychiatric patients and healthcare staff. In or to ensure credibility in this research, the research student regularly debriefed during the process of data collection and analysis with her supervisors who both have extensive expertise in both qualitative research and research approaches.

2. Methodological coherence

Methodological coherence means congruence between the research question and the method strategies which ensure rigour in qualitative research credibility (Milne & Oberle, 2005; Morse, Barrett, Mayan, Olson, & Spiers, 2002). The credibility of qualitative

studies must be linked to their purposes and study designs (Milne & Oberle, 2005; Whittemore, Chase, & Mandle, 2001). The first phase of this PhD research was qualitative descriptive study using FGs to explore the experiences and perspectives of primary care staff regarding the promotion of active ageing in older people with mental disorders living in their communities. In general, descriptive qualitative research shows comprehensive summaries of the phenomenon in everyday language, but it does not seek to pierce in any interpretive depth (Sandelowski, 2010). It also involves no pre-selection of variables to study and no manipulation of variables (Sandelowski, 2000, 2010). Therefore, the findings from FGs are more likely to reflect perspective or experience of the participants.

3. Appropriate sample

A suitable sample of participants who are likely to represent or have knowledge relating to the research topic ensures efficient and effective saturation of categories in term of credibility of the findings (Morse et al., 2002). In this PhD research, the participants were recruited using purposive sampling. Participants worked in primary care settings in Thailand as described in methods of this Chapter (Chapter Four). Each focus group comprised of primary care staff working in the same workplace. They had understanding and experience in caring for older people with mental disorders in their community. Therefore, the findings of this PhD research are more likely to represent the topic areas.

4. Member checking

Member checking means that the findings of qualitative studies are sent back to the original participants to confirm findings accurately reflect their thoughts (Holloway & Wheeler, 2010). This method can ensure the credibility of the study by confirming the accuracy of the results, completeness of interpretation, and reasonable representative of their perspectives (Holloway & Wheeler, 2010; Rebar & Gersch, 2015). In this PhD research, two nurse practitioners who are key informants from each primary care units

were asked to give comment on the findings of the FGs and make suggestions on initial drafts of the PAA-MD. They could give ideas to enhance the content validity of the initial PAA-MD.

4.2.5.2 Dependability

According to Polit, Beck, and Hungler (2012), dependability refers to the stability of data over time or reliability in which the findings are credible and stable over time (Morrison-Beedy et al., 2001). In qualitative studies, research procedures including researchers and methods need to be explicit so that other researchers can audit and replicate the study (Holloway & Wheeler, 2010). The detailed research processes and methods used in this PhD research are described in Chapter three and this Chapter (Chapter four), including study design, recruitment participants, methods, and data analysis.

4.2.5.3 Confirmability

Confirmability refers to the extent to which the findings of qualitative research which are shaped by the participants' perspective and not by researchers bias, motivation, or interest (Cohen & Crabtree, 2006). The principle of confirmability means that the researchers focus on the objectivity of the study (Shenton, 2004). This PhD research used a variety of strategies to ensure confirmability of the findings. First of all, the detailed outline of study design, plan, and methods including data analysis were clearly explained in Chapter three and four. Next, extracts of interview transcripts explored following the perspectives and experiences of participants relating to the research question were provided to support the findings of this research. Furthermore, the research student used a reflective journal during the qualitative approach to ensure she was conducting the FGs, data analysis and presenting the findings honestly and openly.

4.2.5.4 Transferability

Transferability refers to whether particular findings are a stable representation of meaning into other contexts or the generalisability of the results into a different population (Shenton, 2004). The participants, setting, and procedure of the study should be thoroughly described for other researchers to be able to make decisions regarding transferability (Creswell, 2013; Lincoln & Guba, 1985). This PhD research provided information on the context, procedures, recruitment of participants, methods and processes used during the focus group meetings and the process for data analysis in this Chapter (Chapter Four). This information will assist readers to determine if the findings can be transferred to others part of Thailand or internationally.

4.3 PHASE 2 STEP 1: STUDY DESIGN, PLAN, AND METHODS

Phase 2 step 1 describes the development and pilot testing of the PAA-MD. The settings for pilot testing the PAA-MD took place in nine primary care units from Muang District, Warinchamrap District, and Khamarath District of Ubonratchathani Province, northeast of Thailand. Different units were used for each part of the process designed to test preliminary results of the PAA-MD. The staff from these primary care units were not involved in phase one of this PhD research; the focus groups.

This PhD research was approved by the Human Research Ethics Committee of the University of Newcastle. The Ubonratchathani Provincial Health Officer, who heads up all of the primary care units in Ubonratchathani Province, also reviewed the study proposal. The Provincial Chief Medical Officer Ubonratchathani permitted to conduct this PhD research. Consistent with the ethical principles described later in this chapter.

4.3.1 Methods: The development and pilot testing of the PAA-MD

This process took place over 3.5 months from February to mid-May 2016 and was divided into four processes as follows:

4.3.1.1 Item generation

The item-development process is the first step of a robust survey instrument. This step is both important and time-consuming. However, investment of time in conceptualising the domains of interest and generating items contributes to the validity of the instrument. Pertaining to the time spent in developing the instrument, Haladyna (Haladyna, 2004), suggests that during the development of the instrument, thought should be given to which tests and which test items to measure.

In this PhD research, the PAA-MD was developed based on the Thai language and utilised the findings from the first phase of the study; the FG interviews with primary care providers. This indicated three key issues; unfamiliarity with the concept of active ageing, promoting active ageing in communities, and factors that influence the promotion of active ageing. The initial of PAA-MD was also influenced by a recent study about the promotion of active ageing in Taiwan (Lin et al., 2013). Furthermore, previous studies from Thailand were assisted in generating the item pool for the instrument (Chansarn, 2012; Nantsupawat et al., 2010; Thailand. Department of Mental Health, 2015a; Thanakwang, Isaramalai, & Hattakit, 2014). The model of active ageing from WHO also was used to guide the development of the PAA-MD (WHO, 2002). Furthermore, the two practitioner nurses who were key informants from the primary care units in the phase one of the focus group interviews were asked to review items in the PAA-MD to check credibility of the findings in the descriptive qualitative study and to ensure internal consistency of the content (Mastaglia, Toye, & Kristjanson, 2003). A five-point Likert

scale which is commonly used in instruments measuring opinions, beliefs, and attitudes (DeVellis, 2003) was used to rate the score in each item of the PAA-MD. Usefully, the Likert scale can be used to analyse parametric statistics from the study results in many ways (Hartley, 2014). This type of scale is suitable for the PAA-MD because this instrument measures opinions of primary care providers about the promotion of active ageing.

4.3.1.2 Content validity testing

Content validity is that of validity for assessing the principle of concepts, theory, or content relevant to items in the instrument (Cohen et al., 2013). Content validity commonly depends on experts opinion in the field because there is no statistics to determine how much a measure adequately covers a content topic or represents a construct (Kimberlin & Winterstein, 2008). Waltz, Strickland, and Lenz (2005), recommend a panel of specialists to calculate agreement of item relevance with a minimum of three experts required, however, more than ten is likely to be unnecessary (Lynn, 1986).

In this PhD research, the PAA-MD was sent to a panel of nine experts specialising in multidisciplinary areas relevant to the study. The expert panel consisted of two psychiatric nurses, two psychiatrists, a community nurse, a gerontological nurse, a geriatrician, an expert in linguistics and culture, and an expert in instrument development who specialised in ageing persons.

Each expert was asked to rate their agreement regarding the relevance of each survey item on a 4-point scale: 1 = not relevant; 2 = somewhat relevant; 3 = quite relevant; to 4 = very relevant (Polit & Beck, 2006). The expert advocated using a 4-point scale because it can avoid a neutral and ambivalent midpoint (Lynn, 1986). Relevance ratings were used

to calculate the content validity index for individual items (I-CVI) and the content validity index for the overall survey (S-CVI).

I-CVI was calculated by using the formula as follows;

$$\text{I-CVI} = \frac{\text{the number of experts giving a rating of either 3 or 4 for each item}}{\text{The number of experts}}$$

According to Lynn's criteria (1986), the values of I-CVI should be at least 0.78 when six to ten experts are used, and a value of S-CVI 0.80 or higher is considered acceptable (Polit & Beck, 2006). Items which did not reach minimum agreement were deleted or revised. Furthermore, the panel was asked to assess the clarity and conciseness of the close-ended items in the initial of PAA-MD with a "yes" or "no" response to each item. In addition, they were invited to make recommendations around the wording in any items that were likely to be ambiguous, unclear, or inappropriate.

4.3.1.3 Face validity

The term of face validity is used to describe a set of items that evaluate what they appear to measure at their face value (DeVellis, 2003). All in all, face validity is a complex multidimensional construct which is used to evaluate how the items of instrument appear for respondents and others (Thomas, Hathaway, & Arheart, 1992).

In this PhD research, the PAA-MD was conducted to examine face validity with ten primary care providers who are working in the primary care unit in Ubonratchathani Province, Ban Dam Pra Health Promoting Hospital. They were asked to provide their opinion and suggestions about the PAA-MD. They were also invited to review wording in any item that was ambiguous, unclear, or inappropriate. Additionally, they were also asked to give feedback about response sets of PAA-MD.

Moreover, five older people with mental disorders, such as anxiety disorder or depressive disorder, that was otherwise stable health wise and with good cognition, were invited to comment on any item that was difficult to understand and asked to suggest some activities promoting active ageing in their community to the PAA-MD.

4.3.1.4 Pilot study

Hertzog (2008), argues that the purpose of a pilot study is to assess feasibility, adequacy of instrumentation, proposed methods and identify issues with data collection. It may also assist to answer methodological questions when planning a larger study. Recommended samples for a pilot study can be estimated ranging in size from ten to forty per group (Hertzog, 2008).

In this PhD research, the PAA-MD was circulated to a convenience sample of 40 primary care providers in Ubonratchathani Province, Muang, Khemmarat and Warinchamrap Districts. The PAA-MD has tested both internal and external reliability with the pilot study to ensure internal consistency reliability and stability over time. It was tested to examine internal consistency reliability utilising Cronbach's alpha coefficient. Sufficient internal consistency reliability for a new instrument should indicate the Cronbach's alpha value of 0.70 and above, a range of inter-item correlations between 0.30 to 0.70 and a minimum corrected item-total correlation coefficient as 0.30 (Ferketich, 1991; Nunnally & Bernstein, 1994). These criteria were used to examine internal consistency reliability for retaining the items in this PhD research.

Moreover, external reliability, or test-retest reliability, within a 2-week interval in the same group of pilot participants was tested for evaluating the stability over the time of the PAA-MD. Spearman's rank correlation coefficient was used to analyse the correlation between the mean score of the PAA-MD during test-retest reliability because of the small

sample size (Cohen et al., 2013). The acceptable external reliability is 0.7 and above (DeVellis, 2003).

4.3.2 Recruitment of study participants

The process of recruiting participants in the phase 2 step 1 of this PhD research comprised of four components as follows:

4.3.2.1 Panel of experts for testing content validity:

The nine experts were recruited using purposive sampling from Thai universities or colleges based on background and experience in relation to the topic of the research project and who were specialists in their fields. The research student checked websites of universities and colleges for information based on the inclusion criteria. In Thailand, it is culturally appropriate to make informal contact by phone or email to ascertain their interest in being an expert for this study. Individuals who agreed to participate received the recruitment materials and the draft of PAA-MD from the research student. The research student was available by phone or email to answer questions about the study. Experts were invited to send the signed Informed Consent Form and the draft of PAA-MD back to the research student in a pre-addressed reply paid envelope. In this study, some experts were willing to be contacted by email and returned the draft of PAA-MD by email as well.

4.3.2.2 Recruitment of primary care providers for testing face validity:

Ten participants in this process were recruited using convenience sampling. The research student contacted the Head of Primary Care Unit, Ban Dam Pra from the Health Promoting Hospital in Ubonratchathani Province which is a different unit from that used in the settings of the pilot study and phase one. The information packages included the PAA-MD, consent form, and information statement and these were distributed to staff.

The research student was available by phone or email to answer any questions about the study. Upon receipt of consent forms, the research student made an appointment to meet in order to collect the data for this phase. At the meeting, the research student provided a copy of the PAA-MD and asked for feedback about the instrument. Participants were asked questions about what was written in the PAA-MD, such as, we would like your opinion on the wording, what is your opinion on the response sets, which are the best and worst questions, how easy are the questions to understand, and are there any other issues or problems you notice. The research student then collected the PAA-MD along with the suggested changes from the participants.

4.3.2.3 Recruitment of older participants for testing face validity:

Five participants in this process were recruited using convenience sampling. The research student contacted the Head of the Primary Care Unit, Ban Dam Pra from the Health Promoting Hospital in Ubonratchathani Province. The primary care provider, who is a registered nurse, was asked to identify suitable participants (depending on their health status and ability to read) for the study and gave them the Information Statement, consent form and reply paid envelope for the return of the research student. The research student was available by phone to answer any questions that may arise about the study. Upon receipt of the signed Informed Consent form, the research student made contact with the older person participants, to meet with and give them the PAA-MD. The research student then waited with the participants to answer any questions and to collect the PAA-MD at the completion of the meeting.

4.3.2.4 Recruitment of primary care providers for the pilot testing:

Forty participants in this process were recruited using purposive sampling. The research student contacted the heads of primary care units from each district in Ubonratchathani

Province, which were different units from the settings for testing face validity and phase one. The information packages included information statement, the PAA-MD, and the consent forms were distributed to staff. The research student was available by phone or email to answer any questions about the study. Upon receipt of consent forms, the research student made an appointment for a meeting to collect the data for this phase. At the primary care units, the research student provided a copy of the PAA-MD and gave background important information about the reason for collecting the data twice for testing internal and external reliability or test-retest reliability. The research student remained in the primary care units to answer any question about the PAA-MD if needed. The research student then collected the PAA-MD from the participants twice. The time between the first and second collection was approximately two weeks.

4.4 PHASE 2 STEP 2: STUDY DESIGN, PLAN, AND METHODS

4.4.1 Study design

In phase 2 step 2, the cross-sectional survey design was used to evaluate the psychometric properties of the PAA-MD from a large sample. It also assisted in generating information to examine the perspectives of primary care providers regarding the promotion of active ageing in older people with mental disorders living in the community and identifying factors that influence the promotion of active ageing. Familiarity with the concept of active ageing and other related concepts were also examined in this cross-sectional study.

The cross-sectional surveys, or survey designs, have traditionally been used for quantitative, descriptive and correlational studies. They can be used either to describe and classify phenomena or to test links between variables of interest (McLaren, 2013). Whittaker (2009, p. 61), describes survey design with a quantitative research approach as

surveys that are *'used to study large groups or populations usually using a standardized quantitative approach to identify beliefs, attitudes, behaviours and other characteristics'*.

This phase of the PhD research was carried out in Yasothon Province, northeast of Thailand, which is a different province to that used in the study processes discussed in phase one and phase two-step one.

This PhD research was approved by the Human Research Ethics Committee of the University of Newcastle. The Yasothon Provincial Health Office who is the Head of all Primary Care Units in Yasothon Province also reviewed this study proposal. The Yasothon Provincial Chief Executive Medical Officer gave permission to conduct this PhD research. Consistent with the ethical principles described later in this chapter.

4.4.2 Sample size

The recommended sample size for the psychometric evaluation of a new instrument is a minimum of five to ten samples per item (DeVellis, 2003; Nunnally & Bernstein, 1994). A sample size greater than 300 subjects helps make a good estimation (DeVillis, 2012).

In this PhD research, the target population was people employed by the Ministry of Public Health, the Royal Thai Government. The sample comprised all health care providers working in primary care units in Yasothon Province, northeast of Thailand, which were recruited by a convenience sampling. This is made up of 122 units of 9 districts with approximately 579 staff. Therefore, the targeted participant numbers were considered adequate for making a reliable evaluation of the new instrument.

4.4.3 Recruitment of study participants

An information package containing the information statement, the PAA-MD, and a pen were forwarded to all primary care workers in Yasothon Province. The health officers who were not line managers of the participants in each of the Public Health District distributed the information package into staff mailboxes in the Primary Care Units. The research student was available by phone to answer questions about the study. The health officers then retrieved the completed surveys from the boxes on a weekly basis. The participant's privacy was protected as the instrument package was closed with glue tape by the participant and none were seen to be tampered with upon return to the research student. This meant only the participant and the research student read what was inside. The returned and completed PAA-MD was taken as consent for this part of the research.

4.4.4 Data collection

Data collection took place over approximately three months, from mid-May to mid-August 2016. The data collection procedure was organised as follows:

1. Data collection was undertaken after getting ethics approval from the Human Research Ethics Committee, the University of Newcastle and permission from the Yasothon Provincial Chief Executive Medical Officer, Yasothon Province;

2. The research student presented the research project to the Heads of Public Health District in monthly meetings at Yasothon Provincial Health Office;

3. The health officers in each Public Health District distributed the package of research information into staff mailboxes at the Primary Care Units;

4. The research student reminded participants to reply four times after sending the package of research information. This occurred each fortnight by sending a message to the health officers in each district. The purpose was to remind the staff in the primary care units to respond to the PAA-MD.

4.4.5 Data analysis

Data from the cross-sectional survey was analysed based on the type of variable. The statistical significance of 0.05 was used to when determining statistical significance. The PAA-MD was checked the missing data before entry into the computer program. Prior to data analysis, the PAA-MD was coded and checked for accuracy in the process of data entry by using SPSS program to ensure consistency of analysis. Then, it was analysed with descriptive statistics to check the accuracy of data entry. According to Hair et al. (2014), under 10% of missing data for an individual case or observation can generally be ignored, except when the missing data occurs in a specific set of questions or as attrition at the end of the questionnaire. The Kolmogorov-Smirnov test was used to test the normality of distribution from the responses of the PAA-MD.

The data were analysed using IBM SPSS Statistics version 24 (SPSS Inc., Chicago, IL). The detail of the data analysis is as follows:

1. Descriptive statistics were used to describe the characteristics of the sample, namely; frequency, mean, standard derivation, and percentage.

2. The psychometric properties of the PAA-MD were tested. Only section II and III of the PAA-MD could be analysed to examine psychometric properties because they have continuous variables and the normal distribution is based on assumptions of the parametric statistics for calculating using exploratory factor analysis and Cronbach's Alpha (Hair et al., 2014; Suhr, 2017). Internal consistency reliability was tested by using Cronbach's alpha coefficient which indicates sufficient internal consistency for a new instrument as having a value of 0.70 and above (Hair et al., 2014; Nunnally & Bernstein, 1994). Construct validity was tested by using exploratory factor analysis for summarising and to group closely connected items together. This process created a new composite factor representing each group of items (DeVellis, 2003).

Prior to conducting exploratory factor analysis, the Kaiser-Meyer-Olkin (KMO) value was obtained to decide if the sample was adequate for factor analysis (Hair et al., 2014). Bartlett's test of sphericity tests that sufficient correlations exist among the variables to proceed, and should be statistically significant ($P<0.05$) (Hair et al., 2014). Hair et al. (2014), also provides the criteria for the number of factors to retain when applying exploratory factor analysis. These are an eigenvalue greater than 1, characteristics of the scree plot, and the interpretability (Hair et al., 2014). The criteria to retain each item within this PhD research is an item-factor loading of greater than 0.40, even though the sample size is more than 350 respondents (Hair et al., 2014). The results show the loading on each variable is significant, the community score is greater than 0.50, and the item contributes to factor interpretability (Hair et al., 2014). In line with Hair et al, for this research, variables, where the cross-loading presents relatively high loadings on more than one factor, were removed unless theoretically justified or, the objective is strictly data reduction (Hair et al., 2014). The PAA-MD was refined after testing the psychometric properties.

4.5 ETHICAL CONSIDERATIONS

Guidelines and principles for conducting research with humans from the National Health Medical Research Council were adhered to throughout the research process of this research. Ethical approval was sought from the Human Ethics Committee of the University of Newcastle, reference number H-2015-0379 (Appendix1). The Ubonratchathani Provincial Health Office and Yasothon Provincial Health Office who are responsible for the primary care units in Ubonratchathani and Yasothon provinces also reviewed the research proposal. The Provincial Chief Medical Officer

Ubonratchathani and Yasothon Provinces gave permission to conduct this PhD research (Appendix 2 and 3).

According to National Health and Medical Research Council (2015) in Australia, human research is conducted based on the relationship between researchers and the participants of the research, and the ethical principles of the research must have the following *"respect for human beings, research merit and integrity, justice, and beneficence"*. The details of ethical principles for this PhD research are reported as follows:

4.5.1 Informed consent

The information statement (Appendix 4-9 and 11-16) includes details of the research methods, the process of data collection and interview, the risks and benefits of participating, and protection of privacy. Potential participants for all phases of the research, including the focus groups, the expert panel, the process used to check face validity, the pilot study, and the cross-sectional survey, were provided with detailed information about the study and the opportunity to have any questions or concerns about the study and its processes answered. Any questions were answered before potential participants completed the consent form (Appendix 10 and 17). Potential participants were made aware, and reminded, that they could decline to take part in this research and withdraw from this PhD research at any time without penalty.

4.5.2 Privacy, confidentiality, and disclosure of information

1. Phase one: Focus group interview

The participants were not asked about personal or identifying information during the focus group. If they wanted to use a false name during the discussion they could. The focus group discussion was recorded and parts were transcribed (typed up), by the research student, for analysis later. The participants were asked to maintain the

confidentiality of the focus group discussion. This means that they were asked not to reveal any names of people, places, services etc. is discussed in the focus group. They could also ask for anything that they say in the group to be edited or deleted. With regard, the audio recordings of focus groups, all focus group transcripts were de-identified using pseudonyms for participants' name to protect participants' identity and maintain privacy at all times. During data collection in Thailand, the data were securely stored in the research student's office, which could only be accessed by the research student herself. On the completion of data collection, all data were kept in a password-protected computer or in locked cabinets that could only be accessed by the research student and the supervisors.

2. Phase two-step one, content validity, face validity, and pilot testing

The participants were given a coded identification number on all the researched related forms. During face to face meetings for testing the face validity of the PAA-MD, the participants were not asked about personal or identifying information during the meeting. They were given a coded identification number on all the forms. During data collection in Thailand, the collected data were securely stored in the research student's office that could only be accessed by the research student when in Thailand. All the study information was kept on a password-protected computer or in locked cabinets that could only be accessed by the research student whilst in Thailand. On the completion of data collection, all data were kept in a password-protected computer or in locked cabinets that could only be accessed by the research student and the supervisors.

3. Phase two-step two, a cross-sectional study of the PAA-MD

The participant's name and any personal information were not needed to participate in the survey. The survey instrument was allocated a coded identification number which was

not linked to the participants' name. During data collection in Thailand, the collected data were securely stored in the research student's office that could be accessed only by the research student whilst in Thailand. All the study information was kept on a password-protected computer or in locked cabinets only accessed by the research student whilst in Thailand. On the completion of data collection, all data were kept on a password-protected computer or in locked cabinets that could only be accessed by the research student and the supervisors.

4.5.3 Potential risks

This PhD research posed minimal risk to participants who were staff employed by the Ministry of Public Health, Royal Thai Government. For the participants who were older people with mental disorders, there were minimal risks to participation in this PhD research. Suitable participants depending on their health status and ability to read for the study were identified by a registered nurse of the primary care units who gave them the Information Statement and consent form. The research student made contact with the older person participants, to meet with and give them the PAA-MD after receipt of the signed Informed Consent form. The research student then waited with the participants to answer any questions and to collect the PAA-MD at the completion of the data collection. In the light of this, participants were reminded that they could withdraw from the research at any time.

In the first phase of this PhD research - the focus group meetings - participants were invited to talk about promoting active ageing amongst older people with mental disorders in primary care units. It was, therefore, possible that some of the conversations regarding a participant's situation may have resulted in emotional discomfort. In the light of this, participants were reminded that they could withdraw from the focus groups at any time.

Participants were also reminded that if they became distressed, support from the Health Provincial of Ubonratchathani (+6645-262-692) was available. Prior to commencement of focus groups, all participants were informed of these support measures. Participants were able to choose to continue the focus groups after a short break or reschedule a time for participation. Participants were also able to withdraw completely from the study at any time.

The participants of the cross-sectional study were free to participate in testing psychometric properties of the final survey instrument. The line managers of the participants were not aware of participation to ensure strict confidentiality. This cross-sectional survey was supported administratively for the distribution the information packages about the study with the final survey instrument from the Public Health Provincial of Yasothon Province. The health officers who helped administratively were not line managers of participants. The health officers in the Public Health Administration in each district help distributed the information packages of the PAA-MD and information statement into the staff mailboxes of the primary care units in the districts. The health officers retrieved unidentified and completed surveys enclosed in sealed envelopes from the boxes on a weekly basis.

4.6 THE RESEARCHER'S BACKGROUND

Kedsaraporn is an experienced mental health nurse and a researcher in the Research and Development Centre of Prasrimahabhodi Psychiatric Hospital, Department of Mental Health, Ministry of Public Health in Thailand since 2005. She graduated with a Bachelor Degree in Nursing from Boromratchachonnani Nursing College, Thailand in 1996. She graduated with a Masters Degree in Epidemiology from Mahidol University in 2001 and then trained in mental health and psychiatric nursing from Khon Kaen University,

Thailand in 2005. She also completed a Master of Applied Gerontology from Flinders University, Australia in 2012. In her role as a researcher at the research centre, she developed expertise in nursing and medical research, using both qualitative and quantitative methodologies, including instrument development. She also has experience with facilitating groups of psychiatric patients.

The research student worked as a mental health nurse and researcher in Prasrimahabodi Psychiatric Hospital under Department of Mental Health. The primary care settings are organised by the Public Health Provincial of Ubonratchathani and Yasothon Provinces, Department of Health Service Support. Therefore, the research student does not have any affiliation with either of the nominated sites.

4.7 SUMMARY

The research methods used in this PhD research for phase one- descriptive study with FGs, phase two-step one development and pilot testing of a new instrument including phase two-step two testing of psychometric properties of a new instrument have been outlined and discussed in detail. Each phase of this research has been described along with recruitment of participants, sample size, data collection and data analysis in this Chapter. Ethical considerations and the researcher's background were also reported.

The following Chapter presents the findings of focus group interviews. In this chapter, discussion, strengths and limitations, and summary are also reported.

CHAPTER 5: PHASE 1: FOCUS GROUP INTERVIEWS AND FINDINGS

5.1 INTRODUCTION

In the previous chapter, the overall study design, plan and the research methods used in this PhD research were reported.

This chapter, chapter five, reports the findings of phase one - the qualitative descriptive study from the focus group (FG) interviews of primary care providers from primary care units in Ubonratchathani Province, Thailand. A discussion of the findings, the strengths and limitations, and summary of this descriptive qualitative study are also described.

5.2 OBJECTIVES AND RESEARCH QUESTIONS

The objectives of phase 1 were:

1. To explore how primary care providers understand the concept of active ageing.
2. To explore how primary care providers use/apply the concept of active ageing.
3. To examine the perspectives of primary care providers regarding the promotion of active ageing.
4. To identify the perspectives of primary care providers regarding factors that influence the promotion of active ageing.

The research questions of phase 1:

What are the perspectives of primary care providers about promoting active ageing in older people with mental disorders living in a Thai community?

1. What do they understand by the concept ‘active ageing’?
2. How do they use/apply the concept of active ageing?
3. What is the promotion of active ageing in this group?

4. What are the factors that influence the promotion of active ageing in this group?

The research methods of the phase one were reported in previous chapter-Chapter four: Research design, plan, and methods.

5.3 RESULTS

5.3.1 Participants' characteristics

Fourteen primary care providers participated in FGs. Their demographic characteristics are presented in Table 5-1. Their age ranged from 24-52 years (mean=37.07, standard deviation (SD)=9.32). All participants had at least one year working in primary care units. The majority of participants were female. They had on average 12 years (SD=8.91, range 3-30) of working experience in the primary care units. The roles of participants in the primary care units included registered nurses, public health officers, public health administrators, dental assistant, aides, and workers.

Table 5-1: Overall characteristics of primary care provider participants (n=14)

Characteristics	Number
Sex	
Female	11
Male	3
Age in years, means (range, SD)	37.07 (24-52, 9.32)
Age in working (years), means (range, SD)	11.93 (3-30, 8.91)
Position	
Nurse practitioners	2
Registered Nurse	1
Public health officers	2
Public health administrators	2
Dental assistants	4
Aides	1
Workers	2

Content analysis revealed three major categories. The categories identified were: unfamiliarity with the concept of active ageing, promotion activities in communities, and factors that influence the promotion of active ageing. The following discussion presents the main categories that emerged from the analysis of the interview data.

5.3.2 Unfamiliarity with the concept of active ageing

Whilst the Thai Government health authorities had embraced the WHO Active Ageing model in primary care units, the majority of participants in this part of the study were unfamiliar with the term of active ageing. Being unfamiliar with the concept of active ageing meant that health care providers had either not ever heard of the concept or the

idea, had not heard the term used or they were not sure about how it was defined. Unfamiliarity also meant that some health care workers simply could not understand the concept even after the terms was described to them as per the WHO pillars and others suggested that there may be an alternative term used in accordance with the Thai language. When asked what they knew some said:

> *"Umm, I have never heard about the concept of active ageing"*. [Primary care provider (PCP) for 20 years]
>
> *"Ohh, I do not know about this word."* [PCP for 23 years]
>
> *"Well, I don't know what does it mean?"* [PCP for 17 years]
>
> *"I have never known the term of active ageing."* [PCP for 30]
>
> *"I am not sure what the definition of this concept."* [PCP for 20 years]

The research student then explained the meaning of active ageing as per the WHO model (2002) with reference to the three pillars of the concept; participation, health, and security. Some primary care providers said they did not understand what these terms meant to them or in terms of the care, they provided including those who had worked in primary care for 30 years. There were others, however, who recognised some of the elements of the WHO model in their everyday work as the following exemplars show. They said:

> *"Ohh, thanks for giving us the meaning. But, I clearly do not understand the concept.* [PCP for 23 years]
>
> *"Well, thanks for your explanation of the meaning of active ageing. I am still not sure about the definition of this concept"* [PCP for 20 years]

Other participants also said:

> *"Maybe, we used a different technical term or word."* [PCP for 20 years]
>
> *"I think sometimes, formal Thai language is quite difficult to understand."* [PCP for 20 years]

5.3.3 Promotion activities in communities

Despite not being fully aware of the concept "active ageing" and the meaning according to the WHO model, the participants described activities that might promote active ageing. These related to health promotion, education and training, participation in the community, and security. Whilst these did not cover all components of the WHO model, they were nevertheless promotion activities with a focus on older people.

5.3.3.1 Health promotion activities

The participants' descriptions of health promotion activities largely related to health examinations to assess physical health for older people in their communities annually and some activities relating to health promotion. The annualised health examinations were linked to a significant annual cultural event, with older people with mental illnesses screened initially by volunteers from the village. Health examination of all older people living in the community every year include monitoring body weight and blood pressure, dental check-ups, screening for diabetes mellitus, depression symptoms and suicidal ideation.

In the following, participants described what they do for older people and they show the link to Thai cultural events. Notably, however, is that older people with mental disorders do not receive special attention necessarily however, there is widespread screening for depression along with health examinations and attention to those older people who cannot leave their home.

"Generally, we have organised health examination for all older people in Songkran Festival (the national older people celebration on 13th April) but it is not specific for older people with mental disorders" [PCP for 23 years]

"We are currently not providing activities of promoting active ageing specifically for older people with mental disorders but we set up some activities for all older people" [PCP for 3 years]

"We set up a home visit for older people who are bedridden or cannot get outside their house at least once a year" [PCP for 4 years]

Notably, local village volunteers have trained prior the annual check-up associated with the annual cultural event and activities to help with basic health assessment and screening for depression symptoms. The questions the volunteers ask relating to the depression screening are: "Do you feel sad or hopeless? and Do you feel bored or loss of pleasure?". The village volunteers reported the older person's response and health care concerns to the primary care staff in their village. As one participant said;

"*We have health volunteers in each village for help us to care older people for basic assessment and record document for reporting health activities every month"* [PCP for 23 years]

The participant also managed assessments of mental health with screening for depression symptoms with the 2-question screening tool described above and another 9-question screening tool used with older people living chronic diseases such as diabetes, heart disease, and chronic renal failure.

"Older people who are experiencing chronic disease were being assessed for the risk of depressive disorders with 2-questions and 9-questions tools at least one a year" [PCP for 23 years]

5.3.3.2 Education and training

The primary care providers have educated and trained both older people and caregivers in order to care for themselves and their relatives. For example, older people are instructed on observing for warning signs relating to their specific diseases and the side effects of medications they are on, and they were educated about wound cleaning, protection from falling, and appropriate nutrition. As two participants said:

"We are also trained on how to care for older people who suffer from chronic diseases both older people and caregivers" [PCP for 23 years]

"We trained caregivers to clean wound for older people" [PCP for 8 years]

5.3.3.3 Security

The meaning of security in the concept of active ageing consists of financial security and living safety (WHO, 2002). The participants described that older people in their responsibilities received an allowance every month from the central government. They also built corridor hand railing in the primary care units for protecting older people from fall accidents. Moreover, older people with mental disorders or disability in the community were supported with equipment including a walker and wheelchair from the local government to enhance living safety at their home. As two participants mentioned:

"Exactly, all older people in our communities receive an allowance every month" [PCP for 23 years]

"We are preparing rail corridor or railing along the health services for older people who are visiting in our primary care. Older people with mental disorders or disability about 6 persons in our responsibility are protected to be living safety by renting equipment such as wheelchair or walker in living safety from the local government"" [PCP for 8 years]

5.3.3.4 Participation

Older people should be supported to participate in family, community, and society in relation to socioeconomic stability, culturally and spiritually, which under their basic human rights, their needs, preferences, and capacities (WHO, 2002). The findings of this phase reported that older people living in the community organize senior clubs[1] to facilitate their activities associated with the concept of active ageing.

Activities of the senior clubs are normally linked to culturally and spiritually religion for Buddhist such as making merit and producing baskets. However, only some villages could manage the senior clubs and the activities for older people were not providing all essential components for them and all year. As participants said:

"Some village has managed senior clubs for promoting activities which older people can participate in their group. Older club normally consists of religious activities such as making merit in the temple of the Buddha or in the national day However, the clubs are not providing all essential activities for older people" [PCP for 23 years]

"In some villages, there are activities in order to produce baskets but they are not running the activities all year" [PCP for 23 years]

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[1] *Mosby's Medical Dictionary, 8th edition.* (2009). Senior centres mean "community agencies for older adults. The centres offer nutritional, recreational, educational, health, and legal services"

5.3.4 Factors that influence the promotion of active ageing

The results from focus groups indicated that there were several factors influencing the promotion of active ageing in older people with mental disorders living in communities. The primary care providers pointed out that facilitators, barriers, resources and support, knowledge, and skills are important factors for promoting active ageing in this group.

5.3.4.1 Facilitators

Adequate supervision from mental health services was a crucial facilitator that influenced the promotion of active ageing in communities. The participants of this research mentioned that they needed help from the staff of the mental health service to supervise or train them in relation to regularly promote active ageing in older people with mental disorders. For example, on the job training and supervision such as how to deal with the emergency mental health crisis in primary care are needed for this type of support.

> *"Well, for me, mental health service should support and supervision. We need the mental health service help us anytime whenever we need urgent support to deal with emergency mental health crisis"* [PCP for 20 years]

> "*If Psychiatric Hospital or district hospital supported and trained our healthcare professionals. We are really happy to promote active ageing in all older people in our communities"* [PCP for 23 years]

Cooperation from local government, politicians, teachers, police, and people in communities was also an important key factor to help primary care workers promote active ageing in communities. Some participants in this research said that they could not promote active ageing in older people with a mental disorder by themselves. Local government or city councils, police, teachers, and politicians such as village leaders, who are key informants in each community, should also play a role to support primary care

staff with motivating or encouraging people in their community to participate in promoting activities.

> *"People in communities should help us whenever we promote active ageing. We need also to cooperate with another organisation such as local government, police, teacher, politics"* [PCP for 20 years]

In addition, one participant mentioned that the leader of a community was an important person to help promote activities of active ageing for older people. He can motivate and encourage people in their community to join the health promotion activities.

> *"I think it depends on the strength of communities. I mean that the leader is important key informant to motivate people in villages for promoting every activity"* [PCP for 4 years]

Furthermore, older people and their family also play a crucial role in promoting active ageing. A participant pointed out that she needed older people and their family to participate in promotional activities. One participant also said that the families of those who were educated and had worked in a government organisation were more likely to participate in promotional activities than other families.

> *"I think everyone in our primary care happy to promote active ageing. However, we need cooperation with other organisation such as politics, teacher, police, local government including older people and their family"* [PCP for 23 years]

> *"For me, family background is an important factor to work with people in our communities. I mean that some families are willing to participate in any activities, in particular, those families that have education and a retirement person from the government organisation"* [PCP for 17 years]

5.3.4.2 Barriers

The primary care providers in this research fade several barriers to promote active ageing in older people with mental disorders living in communities, namely, lack of knowledge and skills, heavy workload, lack of budget, and lack of support network.

Lack of knowledge and skills how to deal with people who are experiencing mental illnesses is one vital barrier of primary care workers. For example, a participant expressed that she was uncomfortable with caring or dealing with people with mental disorders.

> *"Well, I think working regarding mental health is abstract and quite difficult to understand compared with physical health"* [PCP for 20 years]

Furthermore, two participants complained that they lack knowledge and skills about mental illnesses to care for people with mental disorders. The mental health training courses from mental health service focus only on nurses in primary care units and provide education only once a time in each year. They were also concerned that these training courses were not good quality and did not cover what they need for working with mental health issues in primary care.

> *"Well, I think the healthcare professionals still lack knowledge about mental health. I want to train in the knowledge of mental health"* [PCP for 8 years]

> *"Training course about mental health is not effective. I think the psychiatric hospital should train all healthcare professionals in my primary care unit, is not just nurses. I cannot work this task by myself, and I need to be supported by our team"* [PCP for 23 years]

A heavy workload in Thai primary care units is one of barrier in working with primary care workers. Two participants complained that they have a variety of work

responsibilities to deal with every day. Specifically, the primary care units have only a few staff to do all tasks associated with the physical and mental health of older people.

> *"In our primary care units, health care professionals are few in numbers and cannot manage the mental health tasks"* [PCP for 3 years]

> *"Well, we have many responsibilities and tasks including a heavy workload but we could not work enough quality"* [PCP for 10 years]

Lack of budget is an important barrier in Thai primary care units. One participant pointed out that the funding from the central government; the Ministry of Public Health was not enough for working in primary care. A participant also said that primary care unit is less staff but they must have worked for many people living in the community.

> *"The budget is so important for us to work in every task. But, you may know our government support money; it is not enough for working both physical and mental health"* [PCP for 20 years]

> *"We have to do many things such as treatment for all people in our communities about 70,000 people both physical and mental health and have older people about 700 people. But, we have only 7 health officers"* [PCP for 3 years]

In addition, one participant who has worked in Thai primary care for 23 years complained that the funding and health policy from the Thai government was not direct for supporting mental health tasks, which is one of the critical barriers for working in the primary care unit.

> *Well, the budget for supporting mental health tasks is indirect in another part. It is not budget for developing mental health. The government should give more*

money and pay directly to promote active ageing in older people with mental disorders" [PCP for 23 years]

They also complained that there was no specific mental health policy to guide them. For example, they suggested that a mental health policy with key performance indicators should be compulsory for primary care units.

"Department of Mental Health is not a specific policy about mental health task. We have to follow the policy of the central government" [PCP for 20 years]

"The policy should scope what we need to do in urgent. Sometimes, we do not know what should be our priority for mental health tasks. Now, physical health is the main priority because the government give the main policy and report key performance indicators, support resources including more money" [PCP for 23 years]

Lack of support from network health services; in particular mental health services is one barrier for Thai primary care units to care people with mental disorders living in the community. One participant mentioned that working in primary care was not specific, in particular with reference to mental health tasks, such as mental health promotion.

"Umm, I also think the role of working is unclear role especially mental health tasks" [PCP for 17 years]

One participant also said that the mental health service does not assist them to deal with people who have mental illnesses.

"I think health service system about mental health is not supporting our staff in working. It is not clear what we have to do" [PCP for 23 years]

Two participants complained that they did not know the channels to refer psychiatric patients to the psychiatric hospital. They did not know which department should contact to urgently consult in terms of emergency care for people with mental illnesses. For example, they did not know how to deal with people with aggression or those threatening suicide or homicide.

> *"Umm, we need to be supported by the Psychiatric Hospital. Now, we do not know the channel to refer psychiatric patients"* [PCP for 3 years]

> *"We need to know how to contact or ask for help from the psychiatric hospital. What is the service we have to cooperate? Sometimes, we got problems in our communities such as aggressive behaviours, suicide or homicide. At that time, I need to consult specialist in mental illness for managing the problem in urgent"* [PCP for 20 years]

5.3.4.3 Resources and support

Resources and support were important factors that influenced the promotion of active ageing in communities. Two participants said that they needed better media and technological support to use for promoting active ageing or mental health promotion. The resources should be suitable for older people with mental illnesses such as the large size poster.

> *"We want the big size of poster about promoting mental health and active ageing if they are small, older people cannot read them"* [PCP for 20 years]

> *"Umm, I think the Department of Mental Health should support resources such as video, poster, and innovation to promote active ageing in older people suffer from mental health problems"* [PCP for 23 years]

As reported in barriers, primary care workers said that they need to be supported by mental health services to deal with mental health problems in their community. This means that support is one crucial factor to promote active ageing in older people with mental disorders.

5.3.4.4 Knowledge and skills

Knowledge and skills of primary care providers in terms of mental illness were crucial factors that influence promoting active ageing in older people with mental disorders. The participants in this research expressed that they lack knowledge and skills in relation to concepts of active ageing, methods of promoting active ageing, the severity of psychiatric symptoms, management of psychiatric patients, caring for older people with mental disorders, medications, counselling, and communication between health providers and psychiatric patients.

> *"Also, the knowledge is important for caring for older people with mental disorders and methods to promote active ageing"* [PCP for 23 years]

> *"Well, I want to know and have skills about the signs and symptoms and level of psychiatric disorders"* [PCP for 17 years]

> *"Also, I need to know about caring for people with mental disorders, especially in older people. I think I would then help people in our communities more than in the past"* [PCP for 17 years]

> *"Ahh, I think basic counselling and how to communicate with psychiatric patients are important skills for us. They come to our primary care for ventilation rather than need medicine. That is my experience"* [PCP for 20 years]

"Umm, I think our health officers need to train regarding mental health such as psychiatric disorders, medication, side effect of medicine" [PCP for 23 years]

One participant also complained that the psychiatric hospital should educate them in how to deal with psychotic patients, in particular, on the job training when they visit and follow up the patients in the community.

"For mental health service, the officers followed up and visited psychiatric patients in our communities. I think they should teach us how to manage psychiatric patients as well. We are working in the communities, and then we should know how to deal with these patients and knowledge about active ageing" [PCP for 23 years]

As described earlier in barriers, primary care workers are working as a team, and a nurse could not care for psychiatric patients without support from other primary care workers. Mental health training should provide for all primary care providers.

Mental health training is not effective. Ahh, I remembered there was just only one time and one day but it was the training for all our province. I could not improve my skill for caring people with mental disorders and only myself had been trained. I think the psychiatric hospital should train all healthcare professionals in my primary care unit, not just nurses. I cannot work this task by myself, and I need support from our team. [PCP for 23 years]

One participant also mentioned that the mental health training courses should provide them with methods for promoting mental health and active ageing for older people with mental disorders living in the community.

"For me, I need to know methods for promoting mental health and active ageing among older people with mental disorders" [PCP for 17 years]

5.4 DISCUSSION

The first aim of this phase was to explore how primary care providers used the concept of active ageing in older people with mental disorders living in a Thai community. Primary care providers are recognised as influencing the health of older people living in communities worldwide, especially those who work in the primary care of developing countries (WHO, 2015b). In Thailand, primary care workers play active roles in preventative care and promotion of health for individuals and communities (Pagaiya & Noree, 2008). During the day of health promotion activities, all primary care staff work as a team to provide the activities for all older people living in their areas of primary care units as well (Thailand. Department of Health Service Support, 2010). Registered nurses play a vital role to plan, organise, and evaluate the health promotion activities in the community and also provide specialist care for older people in the day of health promotion activities (Thailand. Department of Health Service Support, 2010). Public health officers work as an assistant of nurses to help plan, manage, provide, and evaluate basic public health services in terms of health promotion and health education for older people (Bureau of Health Policy and Strategy, 2010). Dentist assistants provide basic dental care services in terms of prevention and treatment of diseases including disorders of the teeth and mouth, and health education regarding teeth (Bureau of Health Policy and Strategy, 2010). The workers prepare a place and environment to promote healthy activities and prepare older people for receiving care from other health professionals (Thailand. Department of Health Service Support, 2010).

The findings from phase one of this research show that primary care providers were unfamiliar with the notion of active ageing despite the fact that some participants have worked in primary care for 30 years. In Thailand, active ageing has a different definition given by Thai experts and thus has a different meaning (Saengprachaksakula, 2014). For example, active ageing was defined by Chansarn (2012, p. 2) “as the circumstance that elderly people have good physical and mental health, have work, family and community participants, and have income and living securities” (Chansarn, 2012). Overall, it is concerned with physical health, independence, volunteering, participation in social activities, and living safety which are based on the WHO active ageing model (WHO, 2002). After the research student explained the definition and determinants of the concept of active ageing by WHO some primary care providers did not understand what this meant, however, they could give examples of health activities that they promoted relevant to the concept. However, the health promotion activities from the findings of this phase were not inclusive of all of the components of the concept in accordance with the WHO model (WHO, 2002), in particular, in terms of “participation”. The concept of active ageing has been formulated into a Thai policy national agenda with strategies which promote the abilities of older people to remain actively engaged in society (as cited in TGRI, 2013; Jitapunkul & Wivatvanit, 2008). The Ministry of Public Health has also implemented this concept of healthy ageing into the public health care system at the primary care level (Thailand. Department of Health Service Support, 2010). However, the concept of healthy ageing is mainly focused on the Thai health services system (Thailand. Department of Health Service Support, 2010). This might make the Thai primary care providers familiar with the meaning of healthy ageing rather than the notion of active ageing.

According to the WHO model (WHO, 2002), promoting active ageing is how older people can achieve healthy, productive, safe and fulfilling lifestyles to optimise their quality of life. The concept of active ageing can be divided into three pillars, namely, participation, health, and security, as suggested by WHO (WHO, 2002). The promotion of active ageing in Taiwan showed that it was separated into five components, namely, participation, education, health, leisure, and security (Lin et al., 2013). The results of this phase from the perspectives of primary care staff indicated that active ageing promotional activities in rural Thai communities consist of four components, namely, health promotion, education or training, security, and participation. This is quite different from the findings of a previous study and the concept of active ageing (Lin et al., 2013; WHO, 2002). Health promotion activities in the Thai communities consist of health examinations are a basic requirement for primary care units in Thailand to investigate health status of all older people living in the community at least once a year, which is not counted health examinations in the service provided (Thailand. Department of Health Service Support, 2010). For example, these include monitoring body weight and blood pressure, dental checkups, screening for diabetes mellitus, depression symptoms, and suicidal ideation in the day of health promotion activities. Furthermore, the primary care providers managed assessments of mental health problems with screening for depression symptoms with 2-questions and 9-questions tools in older people living with chronic diseases, which were developed by Department of Mental Health, Ministry of Public Health (Department of Mental Health, 2015). The 2-questions tool is used by trained villages health volunteers or primary care workers to screen depression disorders in older people and then, the 9-questions tool is used by trained primary care staff to detect depression symptoms in those who respond positively to the 2-questions tool (Thailand. Department of Mental Health, 2015b). In addition to health promotion activities, primary care providers have educated

and trained older people and their caregivers in relation to self-care for basic health and hygiene care (Thailand. Department of Health Service Support, 2010). As reported in the results, the primary care staff in this phase of this research educated and trained older people and caregivers to care themselves and their relative in relation to wound cleaning and their diseases.

The determinant of security, the findings from the phase one of this research, found that all older people received a monthly living allowance from the central government and primary care workers in this study educated older people about their entitlement. In Thailand, the central government has provided a monthly living allowance for all older people age 60 years and over who do not have a pension to the amount of 600-1,000 Baht (AUD 23-38) per month based on their age since 2011 (Sripana, 2014). They also receive privileges from the government in terms of a reduction in the cost of transportation, and free entry into public services (Sripana, 2014). However, these are often not enough for financial security in Thai society, which has rising costs of living every year. Moreover, the primary care units built corridor hand railing to prevent older people from accidentally falling during their visits the health centres; this is part of promoting safety in order to enhance active ageing in older people and the link to age-friendly primary health care according to the WHO (WHO, 2004). The findings of this phase also revealed that six older people with a disability had been supported with equipment from the local government to increase their safety. These findings are related to the guidelines of health promoting hospitals in Thailand, whereby the primary care units cooperate with the local government or city council to enhance the safety of older people with disability in their home (Thailand. Department of Health Service Support, 2010).

Senior clubs or senior centres are an important part of activities for promoting active ageing in the Thai community, in particular, the component of participation. In Thailand, there are different cultural activities in each area or province that are organised by senior club members, which are part of the community (Thailand. Department of Health Service Support, 2010). The senior clubs provide different activities in each community. They commonly run activities for making “merit in the temple” (Rattanamongkolgul, Sritanyarat, & Manderson, 2012). This is consistent with the religious beliefs of Buddhists and is a crucial part of spirituality for enhancing well-being in Thai older people (Rattanamongkolgul et al., 2012). Older people can organise the activities of senior clubs by themselves without support from primary care staff such as making merit, which is important to Buddhist practice for determining the quality of the next life, and offering food to the monks on a daily basis in temples is one part of making merit. However, some activities of senior clubs are related to health promotion such as health education in terms of nutrition for older people, or common diseases in older people, which are provided by primary care providers (Thailand. Department of Health Service Support, 2010). Nevertheless, the senior clubs did not address all of the WHO model essential activities for older people.

The second aim of this phase in the PhD research was to identify the barriers and facilitators primary care providers experience when using/applying the concept of active ageing in older people with mental disorders living in a Thai community. The findings from this phase indicated that there was a variety factors impact on the promotion of active ageing in this group, namely, facilitators, barriers, resources and support, and knowledge and skills. In term of facilitators, the findings illustrated that the public psychiatric hospital in Ubonratchathani Province should support primary care providers in order to promote active ageing in older people with mental disorders. For example,

they can provide resources and support, and training courses for the promoting active ageing and caring people with mental illnesses. Moreover, funding and direct mental health policies from the central government are crucial facilitator factors to promote active ageing in this group. These results may link to WHO-Aims report on the mental health system in Thailand, that primary care providers face challenges in working to care for community-dwelling older people because they lack resources and skills in terms of mental illnesses (World Health Organization & Ministry of Public Health Thailand, 2006). Their main concern is how to enhance practice and support primary care providers to care for older people, particularly those who experience a mental health problem. In addition, supervision and training for primary care providers in Thailand are still inadequate with few resources (Ditton & Lehane, 2011). Consequently, they are less likely to be confident in caring for patients living in communities, particularly older people with mental disorders. In Thailand, the Department of Mental Health, Ministry of Public Health has ordered Prasrimahabhodi Psychiatric Hospital and the 10th Mental Health Centre, to support all healthcare staff caring for people with mental health problems in five provinces including the primary care units in this research (Thailand. Department of Mental Health, 2017). They must have trained or educated healthcare staff, prepare media or technology about mental health, supervise health workers, receive referrals for psychiatric patients to the psychiatric hospitals and follow up the patients after discharge from the psychiatric hospitals (Thailand. Department of Mental Health, 2017). However, the central Thai health policies currently focus on the physical health of Thai people such as health promotion, prevention of chronic diseases, infectious diseases, and epidemic diseases (Ministry of Public Health, 2017). The Department of Mental Health has pushed mental health policies into the central health policies of the Ministry of Public Health. Currently, the mental health policies can be the central Thai health

policies in some areas that are a high priority or urgent from the current Thai government such as screening depression disorders and suicide ideas in older people living with chronic diseases (Thailand. Department of Mental Health, 2017). The findings of this phase indicated that older people with chronic disease are examined to detect symptoms of depression and suicide ideas at least once a year because there are the key performance indicators and health policy from the central government. However, other mental disorders are still lack of concern from the central Thai health policies.

Barriers are important factors that affect how primary care providers can promote active ageing in older people with mental disorders. The findings of this phase pointed that a heavy workload, lack of knowledge and skills, lack of resources and support from specialists were crucial barriers of primary care providers to promote active ageing in this group. Health policies and adequate budget were also important barriers to promote active ageing in this phase. Barriers to the mental health policies were indirect budget, and the funding is not enough for working in the primary care units. These findings were similar to previous studies of western countries (Runciman et al., 2006; Wilhelmsson & Lindberg, 2009). Wilhelmsson and Lindberg (2009) explored community nurses' perspectives working in the community about the facilitators for health promotion in Sweden. The community nurses mentioned that the crucial facilitators were support and resources from health services, in particular, the mental health services and cooperation from other local organisations (Wilhelmsson & Lindberg, 2009). Barriers for health care providers caring and working with older people, including those with mental disorders in communities were also studied by Runciman et al. (2006). The participants in Runciman's study felt they lacked the skills to perform health promotion in older people living in the community (Runciman et al., 2006). Furthermore, WHO reported that integration of mental health in primary care needs to overcome several issues and challenges (World

Health Organization & Wonca Working Party on Mental Health, 2008) including the need for investment in the training of staff, reduction of heavy workloads, and adequate supervision from specialists' services. WHO recommended all governments should pay attention to key human resource management with adequate payment, resources, and support for dealing with people with mental disorders in primary care (World Health Organization & Wonca Working Party on Mental Health, 2008). In addition, coordination of a collaborative network between primary care and mental health service should be an urgent concern to integrate mental health services into primary care (World Health Organization & Wonca Working Party on Mental Health, 2008). Moreover, case studies from South Africa and Uganda indicated that the necessary supervisory and referral systems between mental health services and primary health care including the training of primary care staff are still needed to close the gap (Petersen et al., 2011). All of these concerns are similar to the findings from the perspectives of primary care staff in this PhD research.

Promotional activities from the findings of this phase were promoted for all older people living in the community. Older people with mental disorders were not directly offered and encouraged to join the health promotion activities. The primary care staff in Thailand from the phase one of this research need to be supported with training and resources to develop skills for promoting active ageing amongst older people with mental disorders. Furthermore, they need cooperation in the form of funds and sufficient human resources from local government organisations, and the family member of older people, in order to promote active ageing in this group. These results are similar to previous research in Thailand where the needs of staff in Health Promoting Hospitals or primary care units were identified by the heads of primary care units and nurses (Peachpansri, Thongcharoen, & Viripiromgool, 2013). Participants from the previous study also said

they needed support from specialists working in the district or province hospitals (Peachpansri et al., 2013). This can raise the issues that primary care workers are not able to do all the activities regarding caring older people living in the community by themselves and they need community support. Promoting active ageing in communities may be established with cooperation from community and partnership networks. Promoting active ageing in older people with mental disorders also needs to be supported by mental health services which are specialists in mental disorders or mental illnesses.

More importantly, the findings of this phase helped to develop a new instrument; the "Promoting Active Ageing in Older People with Mental Disorders Scale" (PAA-MD). The PAA-MD was divided into three main sections based on the results of this phase, namely, general information and familiarity with the concept of active ageing, promoting active ageing in older people with mental disorders living in the community, and factors that influence the promotion of active ageing in this group. The findings from this phase were used to help create the initial of PAA-MD as follow:

Table 5-2: The findings from focus group interviews in term of promotion activities in communities converted into items for section II of the PAA-MD

Categories	Converted into items
Health promotion	
Physical health	1.Health examination for all older people every year
	2.Home visit or follow-up for older people with a disability
Mental health	3.Assessment of depression symptoms in older people living with chronic disease
Education and training	
Older people	4.Trained older people to care for themselves
Caregivers	5.Trained caregivers to care for older people in general topics
	6.Trained caregivers to provide basic caring for older people such as wound cleaning
Security	
Financial safety	7.Pension from the government
Environment safety	8.Safety health services or friendly primary care
Living safety	9.Support equipment for living safety
Participation	
Senior club	10.Set up senior clubs for promoting activity of older People

Table 5-3: The findings from focus group interviews of factors that influence the promotion of active ageing converted into items for section III of the PAA-MD

Categories	Converted into items
Facilitators	1.Cooperation from local government, polititions, teachers, police, people in communities
	2.Cooperation from older people
	3.Cooperation from older people's family
	4.The leader of communities is key performant for promotional activities.
Barriers	5.Mental health is more difficult to understand than physical health.
	6.Mental health policy is not directly ordered by the government.
	7.There are less staff and high workload both physical and mental health.

Table 5-3: The findings from focus group interviews of factors that influence the promotion of active ageing converted into items for section III of the PAA-MD (Cont.)

Categories	Converted into items
Barriers	8.Budget is not enough to work both physical and mental health. 9.The role of mental task is not well documented or mental health tasks are not written in the job description 10.Mental health system is not supporting those working in primary care. 11.Primary care providers have a high workload and less quality of the works. 12.Staff lack knowledge in mental health.
Resources and support	13.They need to be supported by mental health services for consulting how to deal with severe psychotic symptoms. 14.They need to be supported by mental health service about media technology; poster and video. 15.They need to be trained knowledge of active ageing. 16.The budget should be adequate and directed toward mental health tasks and promoting active ageing in this group. 17.There needs to be supported media or technology for promoting active ageing.
Knowledge and skills	18.They need to understand psychotic symptoms and manage psychotic symptoms. 19.They would like to understand sign and symptoms of psychiatric disorders. 20.They need to understand how to care for people with mental disorders. 21.They need to understand basic counselling and communication with psychiatric patients. 22.They need to understand psychiatric disorders, medication, and side effects of medication. 23.They need to understand how to care for older people with mental disorders and methods for promoting active ageing.

5.5 STRENGTHS AND LIMITATIONS

The strengths of phase one in this PhD research were the findings of discussion from two focus groups, which were from two different types of primary care units in Thailand. The first one was a primary care unit associated with a Health Promoting Hospital in Thailand. The second primary care unit was associated with a district hospital in the Detudom district. The findings from the two focus groups provide insight and rich information on how primary care providers promote active ageing in older people with mental disorders and also indicate factors that influence the promotion of active ageing in this group. These findings helped to develop the PAA-MD.

However, there were some limitations from these focus groups interviews. Only six of eight primary care providers in the primary care unit were available in the first focus group because two staff members need to join a meeting at the Public Health Provincial in Ubonratchathani Province. However, the number of participants was counted as effective as participants numbered between five and eight persons meeting the ideal number of saturation of data as suggested by Krueger and Casey (2015). All eight primary care workers could participate in the second focus group discussion. Unfortunately, two FG participants had to leave 30 minutes into the FG. This research did not recruit village health volunteers of the primary care units to discussions in the FGs. The participants could not be representative of all public primary care units under the Ministry of Public Health, Thailand. However, the participants of this PhD research represented a variety of roles, which they expressed and gave examples from their experience about promoting active ageing for older people living in the community of their primary care units.

5.6 SUMMARY

The majority of primary care providers were unfamiliar with the term active ageing. While most used some aspects of active ageing such as health, education, participation, security, these did not cover all components of the WHO model, in particular, participation. The senior clubs, which were organised by older people in the community were not providing all essential activities for older people, and the activities were not running all year. Of concern, older people with mental disorders living in the community were not focused on to promote active ageing from the primary care providers. Only older people with chronic diseases were screened and examined to find symptoms of depression and suicide because they are health policies from the central government.

The next chapter presents the development, and pilot testing of a new survey instrument calls “Promoting Active Ageing in Older People with Mental Disorders Scale”. In this chapter, results, discussion, strengths and limitations, and summary of developing and pilot testing of the PAA-MD are also presented.

CHAPTER 6: PHASE 2 STEP 1: DEVELOPMENT AND PILOT TESTING OF A NEW INSTRUMENT "PROMOTING ACTIVE AGEING IN OLDER PEOPLE WITH MENTAL DISORDERS SCALE" (PAA-MD)

6.1 INTRODUCTION

Chapter five presented the findings of the qualitative approach with the Focus groups interviews from primary care providers, as well as the related discussion, strengths and limitations, and summary of FGs.

Chapter six, the objectives of phase 2 step 1: development and pilot testing of a new instrument "Promoting Active Ageing in Older People with Mental Disorder Scale" are reported. Then, the findings of item-generation, content validity, face validity, and the pilot study are described regarding scale development. The discussion, strengths and limitations, and a summary are also provided in this chapter.

6.2 OBJECTIVES AND RESEARCH QUESTIONS

The objectives of phase 2 step 1 were:

1. To develop the PAA-MD.
2. To test the content validity of the PAA-MD.
3. To test the face validity of the PAA-MD.
4. To test the internal and the external reliability of the PAA-MD from a pilot study.

The research questions of phase 2 step 1:

1. What are the main components of an instrument designed to measure promotion of active ageing in older people with mental disorders living in a Thai community, to identify factors that influence the promotion of active ageing in this group?

2. What are the psychometric properties of the new survey instrument from a pilot study?

2.1 What is the content validity?

2.2 What is the face validity?

2.3 What are the internal and external reliability?

The research methods of the phase two-step one were reported in previous chapter- Chapter four: Research design, plan, and methods.

6.3 RESULTS

6.3.1 Item generation

The initial PAA-MD can be divided into three sections as follows:

Section I: General information and familiarity with the concept of active ageing

The initial PAA-MD identifies the demographic information questionnaires that were developed by using close-ended and open-ended questions including questions about age, gender, marital status, educational background, occupation and duration of working. A history of training and experience of older people and older people with mental disorders was created to collect data. Furthermore, questions around familiarity with the concept of active ageing and its related concepts were sought. This section consists of 14 items.

Section II: Activities promoted or offered to older people with mental disorders living in the community

The initial PAA-MD designed to measure the promotion of active ageing in older people with mental disorders living in the community was categorised into the items. This section consisted of twenty-two items. The summative scale, the Likert scale with five scale points, was used based on the question “How often do you promote or offer the following activities of promoting active ageing in older people with mental disorders living in the

community?" The five responses of the Likert scale ranged from 0= Never; 1 = Sometime; 2 = Often; 3 = Usually; 4 = Always. This section comprises of 22 items.

Section III: Factors that influence the promotion of active ageing in older people with mental disorders living in the community

The initial PAA-MD designed to identify the factors that influence the promotion of active ageing in older people with mental disorders in the community was developed by using a summative scale, the five points of the Likert scale. It consists of twenty-three items. The summative scale was used to assess the following, "You will be invited to give opinion in each sentence for identifying factors that influence the promotion of active ageing in older people with mental disorders". The five responses of the Likert scale ranged from strongly disagree to strongly agree (1=strongly disagree, 2=disagree, 3=moderately agree, 4=agree, and 5=strongly agree). This section comprises of 23 items.

6.3.2 Content validity

The initial of PAA-MD was sent to a panel of nine experts specialising in multidisciplinary areas relevant to the study. Only seven experts replied the initial of PAA-MD to the research student. Thus, the expert panel consisted of two psychiatric nurses, two psychiatrists, a community nurse, a geriatrician, and an instrument developer to calculate agreement of items. Only section II and III of the PAA-MD could examine content validity.

The content validity index for the overall survey (S-CVI) of section II in the initial of PAA-MD used to measure the promotion of active ageing in older people with mental disorders living in the community was 0.82. There were five items, namely, 1, 2, 3, 5, 19 where the content validity index for individual items (I-CVI) fell below 0.78. They were therefore reviewed and revised.

The S-CVI of section III in the initial of PAA-MD for identifying factors that influence the promotion of active ageing in older people with mental disorders living in communities was 0.84. There were three items, namely, 2, 6, 11 in the I-CVI that were below 0.78. Therefore, they were reviewed and revised. The results of content validity are shown in table 6-1 and table 6-2.

Section II of the PAA-MD was revised into 28-items and divided into 52 sub-items to measure promotion activities of active ageing in older people with mental disorder living in the community. Section III of the PAA-MD was revised into 38-items to identify factors that influence the promotion of active ageing in older people with mental disorders living in the community. The PAA-MD was returned to the expert panel for final review prior to distribution for testing face validity.

Table 6-1: Results of content validity from an expert panel of section II in the initial of PAA-MD

Items	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Items - CVI
1	1	2	4	4	4	4	4	0.71
2	1	4	4	4	3	2	4	0.71
3	1	2	3	3	4	1	4	0.57
4	1	4	4	4	3	4	4	0.86
5	1	2	4	4	4	4	4	0.71
6	1	4	4	4	4	4	4	0.86
7	2	4	4	4	4	4	4	0.86
8	2	4	4	4	4	4	4	0.86
9	2	4	4	4	4	4	4	0.86
10	1	4	4	4	4	4	4	0.86
11	1	4	4	4	3	4	4	0.86
12	1	4	4	4	4	4	4	0.86
13	2	4	3	4	4	4	4	0.86
14	1	4	4	4	4	4	4	0.86
15	2	4	4	4	4	4	4	0.86
16	1	4	4	4	4	4	4	0.86
17	1	4	4	4	4	4	4	0.86
18	2	4	4	4	4	4	4	0.86
19	1	2	3	4	4	4	4	0.71
20	1	4	4	4	4	4	4	0.86
21	1	4	4	4	4	4	4	0.86
22	1	4	4	4	4	4	4	0.86
				S-CVI				**0.82**

Table 6-2: Results of content validity from an expert panel of section III in the initial of PAA-MD

Items	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Items-CVI
1	2	4	4	4	4	4	4	0.86
2	1	4	4	4	4	2	4	0.71
3	1	4	4	4	4	4	4	0.86
4	1	4	4	4	4	4	4	0.86
5	1	4	4	4	4	4	4	0.86
6	2	4	3	4	4	4	4	0.71
7	1	4	4	4	4	4	4	0.86
8	1	4	4	4	4	4	4	0.86
9	1	4	4	4	4	4	4	0.86
10	1	4	4	4	4	4	4	0.86
11	1	2	4	4	4	4	4	0.71
12	1	4	4	4	4	4	4	0.86
13	1	4	4	4	4	1	4	0.86
14	1	4	4	4	4	4	4	0.86
15	1	4	4	4	4	4	4	0.86
16	1	4	4	4	4	4	4	0.86
17	2	4	4	4	4	4	4	0.86
18	1	4	4	4	4	4	4	0.86
19	1	4	4	4	4	4	4	0.86
20	1	4	4	4	4	4	4	0.86
21	1	4	4	4	4	4	4	0.86
22	1	4	4	4	4	4	4	0.86
23	1	4	4	4	4	4	4	0.86
				S-CVI				**0.84**

6.3.3 Face validity

All participants who are primary care providers were female, with an age range of 31-58 years. The majority of participants were registered nurses, assistant health officers, and assistant dentists. Almost all primary care providers had graduated with a bachelor degree.

Older people with mental disorders comprised four females and one male. They aged between 62-73 years, with an average age of 66 years. They had been diagnosed with

anxiety and depression. However, at the time of interviewing for this study, their symptoms were stable.

The perspective of the participants indicated that most of the items of the PAA-MD were easy to understand, and only minor rewording was suggested. It was also noted that some words were redundant, and some questions were considered to be too long. They also recommended adding some examples of promotion of active ageing in their communities. The PAA-MD underwent minor revisions to some wording and more examples of promotion of active ageing were included before commencing on the pilot study. The details of the participants of this process are presented in table 6-3 and table 6-4.

Table 6-3: Characteristics of participants in face validity testing for primary care providers (n=10)

Characteristics	Number	Percent
Sex		
Male	0	
Female	10	100%
Age		
Age range	**31-58 years**	
Means	**42 years**	
Occupation		
Registered nurses	4	40%
Health officers	1	10%
Assistant health Officers	2	20%
Assistant Dentist	2	20%
Assistant Pharmacist	1	10%
Education		
Bachelor degree	9	90%
Master degree	1	10%

Table 6-4: Characteristics of participants in face validity testing for older people with mental disorders (n=5)

Characteristics	Number	Percent
Sex		
Male	1	20%
Female	4	80%
Age		
Age range	62-73 years	
Means	66 years	
Diagnosis		
Anxiety	3	60%
Depression	2	40%

6.3.4 The pilot study

The majority of participants in the pilot study were female, with age ranging from 22-60 years and a mean age of 34.88 years (S.D. = 9.32). They consisted of registered nurses, assistant pharmacists, and health officers. They had graduated with bachelor degrees in approximately 75% of the cases, and 67.5% worked in Health Promoting Hospitals. The details are reported in Table 6-5. Only section II and III of the PAA-MD could test internal consistency reliability and external reliability.

The results of the internal reliability testing of section II of the PAA-MD, assessing the promoting of active ageing in older people with mental disorders living in the community, showed a total Cronbach's Alpha of 0.975. Items 1.2, 1.3, and 21.2 had a corrected item-total correlation coefficient lower than 0.30 as presented in Table 6-6. Therefore, they were removed from the PAA-MD. Moreover, the internal reliability in section III of the PAA-MD, identifying factors that influence the promotion of active ageing in older people with mental disorders living in the community, found that the total Cronbach's Alpha was 0.964 for item 14 indicating the corrected item-total correlation coefficient lower than 0.30. It was then deleted from the PAA-MD as presented in Table 6-7.

The PAA-MD was recirculated to all forty participants after a two-week period for testing external reliability. Thirty-two participants completed the PAA-MD on both occasions. The response rate was 80 percent (n=32).

The results of test-retest reliability indicated that section II of the PAA-MD measuring the promotion of active ageing in older people with mental health disorders living in the community was significantly correlated to a total score. Each factor; participation, education, health, leisure, and security accounting for 0.970, 0.978, 0.983, 0.988, 0.951, and 0.939 respectively (P-value < 0.01) as presented in Table 6-8.

Furthermore, section III of the PAA-MD found that there was a significant correlation between the total score and between each factor; facilitators, barriers, knowledge, skills, and resources and support accounted for 0.988, 0.990, 0.966, 0.972, 0.961, and 0.983 respectively (P-value < 0.01) as presented in Table 6-9.

Briefly, the number of items in section II of the PAA-MD for measuring the promotion of active ageing in older people with mental disorders living in the community consisted of 56 items before pilot study testing. Three items were removed because of the corrected item-total correlation coefficient is lower than 0.30. Two new items were included from suggestions made by the pilot participants. Therefore, there were 55 items whose psychometric properties were tested in the next phase.

The number of items in section III of the PAA-MD for identifying factors that influence the promotion of active ageing in older people with mental disorders was initially 38 items and then one item was removed because the corrected item-total correlation coefficient was lower than 0.30. There were 37 items whose psychometric properties were evaluated in the next process.

Table 6-5: Characteristics of participants in the pilot study (n=40)

Characteristics	Number	Percent
Sex		
Male	7	17.5
Female	33	82.5
Age		
Age range (years)	22-60 years	
Means (SD)	34.88 (9.32)	
Occupation		
Registered nurses	23	57.5
Health officers	3	7.5
Assistant health Officers	3	7.5
Assistant dentists	2	5.0
Assistant pharmacist	1	2.5
Aids	5	12.5
Others	3	7.5
Education		
Lower than diploma	6	15.0
Diploma	4	10.0
Bachelor degree	30	75.0
Type of primary care		
Health Promoting Hospitals	27	67.5
Primary care units of district hospitals	13	32.5

Table 6-6: Internal consistency reliability of section II in the PAA-MD (n=40)

Promotion active ageing in older people with mental disorders in communities	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Participation		
1. Religious activities:		
1.1 Making merit	.597	.974
1.2 Church gatherings	-.007	.975
1.3 Pilgrimage group	.114	.975
2. Cultural activities:		
2.1 Respect older people in Songkran festival	.686	.974
3. Neighbourhood friendship activities:		
3.1 Birthday celebrations	.399	.975
3.2 Visit each other in villages	.608	.974
3.3 Follow and support postpartum care	.722	.974
3.4 Follow and support patients care	.705	.974
4. Political activities:		
4.1 National election	.386	.975
4.2 Local election	.418	.975
5. Senior clubs:		
5.1 Senior associations	.750	.974
5.2 Meeting of senior associations	.741	.974
6. Thai wisdom activities:		
6.1 Basketry	.732	.974
6.2 Weaving	.712	.974
6.3 Fortune telling	.577	.974
6.4 Thai herbal	.749	.974
7. Volunteer activities:		
7.1 Community cleaning	.745	.974
7.2 Meal delivery services	.477	.975
Education		
8. School of older people	.604	.974
9. Health education in primary care units	.660	.974
10. Life skills education:		
10.1 Agriculture	.620	.974
10.2 Mushroom cultivation	.559	.974
10.3 Sewing	.516	.974
10.4 Healthy cooking	.508	.975

Table 6-6: Internal consistency reliability of section II in the PAA-MD (n=40)

Promoting active ageing in older people with mental disorders in communities	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Health		
11. Promotion of physical health activities: Exercise	.674	.974
12. Assessment of physical health and screening health problems:	.795	.974
12.1 Annual health examination		
12.2 Assessment of attached to the bed	.776	.974
12.3 Assessment of Body Mass Index	.775	.974
13. Assessment of mental health problems: 13.1 Depression	.867	.974
13.2 Suicide risk	.768	.974
13.3 Dementia	.727	.974
14. Home visits: 14.1 Older people with mental disorders	.841	.974
14.2 Older people with disability	.871	.974
15. Health education for physical health	.799	.974
16. Health education for mental health:		
16.1 Observe mental health problems	.856	.974
16.2 Stress management	.869	.974
17. Health education for family of older people in physical health promotion:		
17.1 Nutrition	.814	.974
17.2 Medication administration	.839	.974
18. Health education for family of older people in mental health promotion: Respectful of older people	.716	.974
19. Promotion activities for improving family relationship:		
19.1 Family therapy	.762	.974
19.2 Family counselling	.834	.974
20. Teeth health activities:		
20.1 Teeth examination	.846	.974
20.2 Education on oral hygiene	.846	.974

Table 6-6: Internal consistency reliability of section II in the PAA-MD (n=40)

Promoting active ageing in older people with mental disorders in communities	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Leisure		
21. Recreation activities in the community:		
21.1 Local dancing	.813	.974
21.2 Local drama	.231	.979
22. Recreation activities outside the community:		
22.1 Religion outside in another city	.727	.974
22.2 Travel in another city	.437	.975
23. Promotion of suitable recreation activities:		
23.1 Reading book	.715	.974
23.2 Caring for animals	.702	.974
23.3 Planting trees	.676	.974
Security		
24. Welfare for older people:		
24.1 Monthly living cost	.748	.974
24.2 Welfare of community for supporting older People	.591	.974
25. Suggestion for saving money	.350	.975
26. Promotion activities for supporting income of older people: Selling products from older people (trees, vegetables, basketwork)	.747	.974
27. Health education for living safety: Healthy environments suitable for older people and older people living with disease	.468	.975
28. Activities for improving health environment for older people living safety: Destroy breeding mosquitoes	.627	.974
Cronbach's Alpha	**0.975**	

Table 6-7: Internal consistency reliability of section III in the PAA-MD (n=40)

Factors that influence promotion of active ageing in older people with mental disorders	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Facilitators		
1. Having a national policy for older people with mental disorders.	.641	.963
2. Having a health service policy for older people with mental disorders.	.682	.962
3. Having been taught or on the job training from mental health services.	.523	.963
4. Having supervision of mental health services.	.521	.963
5. Having a counselling system of care from mental health services.	.632	.963
6. Having collaboration with other government services, such as local government, police, and schools.	.459	.964
7. Having co-operation with older people with mental disorders.	.546	.963
8. Having cooperation from families of older people with mental disorders.	.515	.963
Barriers		
9. The policy for mental disorders in older people does not cover all diseases.	.401	.964
10. The job description of primary care providers for promoting active ageing in older people with mental disorders is not clear.	.578	.963
11. Health policy gives priority to care for physical health rather than mental health.	.464	.963
12. There is high workload in working in primary care units.	.382	.964
13. Mental health illnesses are stigmatised in Thai culture.	.417	.964
14. Some belief of health behaviour in older people in our communities is not appropriate	.287	.964
15. There is a lack of cooperation from older people with mental disorders.	.378	.964
16. There is a lack of cooperation from families of older people with mental disorders.	.458	.963
17. There is a lack of knowledge about how to promote active ageing in older people with mental disorders.	.558	.963
18. There is a lack of knowledge and insight into mental health problem of older people.	.516	.963
Knowledge		
19. Knowledge the principles for promoting active ageing in older people with mental disorders	.694	.962
20. Knowledge how to assess and screen older people with mental disorders	.748	.962

Table 6-7: Internal consistency reliability of section III in the PAA-MD (n=40)

Factors that influence promotion of active ageing in older people with mental disorders	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
21. Knowledge how to care for older people with mental disorders	.789	.962
22. Knowledge how to rehabilitate older people with mental disorders	.828	.962
23. Knowledge how to manage psychiatric medication and potential side effects	.664	.962
24. Knowledge common mental health problems in older people	.707	.962
25. Knowledge symptoms and severity of mental disorders in older people	.835	.962
26. Knowledge how to advise their family in supporting older people with mental disorder	.837	.962
Skills		
27. Having skills in promoting active ageing in older people with mental disorders.	.832	.962
28. Having skills in assessing and screening older people experiencing mental disorders.	.824	.962
29. Having skills in basic counselling for older people with mental disorders.	.798	.962
30. Having skills to care for older people with mental disorders.	.819	.962
31. Having skills to rehabilitate older people with mental disorders.	.815	.962
32. Having skills to communicate with older people with mental disorders.	.829	.962
33. Having skills to communicate with families of older people with mental disorders.	.810	.962
Resources and support		
34. Increasing human resources for promoting active ageing in primary care units.	.702	.962
35. Improving potential of primary care providers to address mental health in older people.	.697	.962
36. Increasing budget for supporting older people with mental disorders	.618	.963
37. Supporting media and technology to promote active ageing in older people with mental disorders.	.734	.962
38. Supporting media and technology for caring for older people with mental disorders.	.679	.962
Cronbach's Alpha	**0.964**	

Table 6-8: Internal reliability (n=40) and external reliability (n=32) of section II in the PAA-MD

Scale	Number of items	Cronbach's Alpha	*r*
Participation	18	0.923	0.978*
Education	6	0.842	0.983*
Health	19	0.982	0.988*
Leisure	7	0.761	0.951*
Security	6	0.827	0.939*
Total	**56**	**0.975**	**0.970***

*P < 0.01, two-tailed

Table 6-9: Internal reliability (n=40) and external reliability (n=32) of section III in the PAA-MD

Scale	Number of items	Cronbach's Alpha	*r*
Facilitators	8	0.948	0.990*
Barriers	10	0.885	0.966*
Knowledge	8	0.954	0.972*
Skills	7	0.978	0.961*
Resources and support	5	0.938	0.983*
Total	**38**	**0.964**	**0.988***

*P < 0.01, two-tailed

6.4 DISCUSSION

The purpose of this phase was to develop and test the preliminary results of the PAA-MD regarding item generation, content validity, face validity, and the pilot study. Previous instruments about the concept of active ageing in older people with mental disorders have still less evidence, and they are not examined to find out psychometric properties (Hutchison et al., 2006). Therefore, the PAA-MD was developed by using components in the notion of active ageing from WHO (WHO, 2002), namely, health, participation, and security. Moreover, it was created by using some components from the previous study in Taiwan, which was developed to examine activities of active ageing in general older people but it was not validated to test psychometric properties (Lin et al., 2013). The components of education and leisure of general older people were used to develop the PAA-MD following the previous study (Lin et al., 2013). In addition, section III of the PAA-MD used some components from a previous qualitative study that explored community nurses' perspectives of facilitators and barriers in working for health promotion, such as knowledge of health providers, guidelines, resources and support (Wilhelmsson & Lindberg, 2009).

The PAA-MD was also created by exploring the Thai culture and the health care system in Thailand by using the findings of phase I in this PhD research, a qualitative study from focus groups interviews in primary care providers. Furthermore, previous studies from Thailand were assisted in generating the item pool for the PAA-MD (Chansarn, 2012; Nantsupawat et al., 2010; Thailand. Department of Mental Health, 2015a; Thanakwang, Isaramalai, & Hattakit, 2014). As results, the PAA-MD is being able to assess and monitor the frequency, range of activities and factors associated with active ageing in older people with mental disorders.

Content validity testing of the PAA-MD by an expert panel indicated that there were five items in section II and three items in section III that had less than 0.78 of item relevance according to the expert's opinion. They were then revised because the content validity index should be at least 0.78 when six to ten experts are asked to rate the relevance of the item in a new instrument (Lynn, 1986).

The pilot testing determined that the overall internal consistency reliability in section II of the PAA-MD was excellent regarding acceptability ($\alpha > 0.90$) with the Cronbach's alpha coefficient more than the 0.70 recommended by George and Mallery (2000) (as mentioned in Chapter three). The internal consistency reliability in factor of participation and health were also excellent ($\alpha > 0.90$), factor of education and security showed a good level ($\alpha > 0.80$ to 0.90), and leisure was at an acceptable level ($\alpha > 0.70$). These fidnigs implies that section II of the PAA-MD has sufficient internal consistency reliability. Nevertheless, the findings from each item of section II in the PAA-MD found three items whose corrected item-total correlation was less than the acceptable level of less than 0.3, as recommended by Ferketich (1991); Nunnally and Bernstein (1994). Two of the three items were about the religious activities of Christians and Muslims, however, the majority of Thai older people are Buddhist and religious beliefs impact on their life, particularly for those who live in communities (Knodel et al., 2013). The third item was recreation activities in the community, and the local drama was seen as similar to local dancing which was mentioned in the main-item. These three questions were therefore removed from section II of the PAA-MD.

The external reliability, or stability over time, used Spearman's rank correlation to calculate the mean difference in scores between the first and second pilot testing. The results from the thirty-two participants of test-retest reliability of both the overall items

of section II and each component, namely, participation, education, health, leisure, and security, indicated a strong relationship with a coefficient value between 0.8 to 1. This implies that section II of the PAA-MD is stable over time, or in other words, the external reliability shows strong correlation.

Section III of the PAA-MD identifies factors that influence the promotion of active ageing in older people with mental disorders in the community. The internal consistency reliability indicated that the overall items and each component, namely, facilitators, knowledge, skills, and resources and support, showed an excellent level of acceptability ($\alpha > 0.90$). The items relating to barriers were also good ($\alpha > 0.80$) (George & Mallery, 2000). Therefore, this section of the PAA-MD is deemed to have acceptable internal reliability. Only one item, *'some belief of health behaviour in older people in our communities is not appropriate'*, showed that the corrected item-total correlation was at a less than acceptable level, using the criteria definition from Ferketich (1991) and Nunnally and Bernstein (1994). It was removed from section III of the PAA-MD. The external reliability, or stability over time, from thirty-two participants in section III of the PAA-MD, indicated strong correlation both of the overall section and each factor, namely facilitators, barriers, knowledge, skills, resources and support. These results indicate this section of the PAA-MD is stable over time.

6.5 STRENGTHS AND LIMITATIONS

The strengths of the phase two-step-one in this PhD research were the development of initial of PAA-MD used many sources both the findings from Focus groups interviews and the WHO's concept of active ageing including the previous studies. The content validity has tested a variety of experts relevant to the study and also sought agreement from them after revising the PAA-MD as their suggestions at the first time. The face

validity was examined from both primary care providers and older people with mental disorders. The pilot testing was evaluated to find both internal and external reliability. These strengths are quite a high standard and relevant as recommended by Creswell and Clark (2011) and DeVellis (2003).

However, the phase 2 step 1: development and pilot testing of a new survey instrument "Promoting Active Ageing in Older People with Mental Disorders Scale" showed some limitations and these are discussed below.

In the content validity testing, only seven experts from the nine experts identified replied to the initial PAA-MD. Nevertheless, the number of experts was higher than the minimum of three experts which was mentioned as the least number able to provide good responses in previous studies (Lynn, 1986; Waltz et al., 2005). The experts used in this phase of the research were also various specialities relevant to the study. They suggested useful feedback to help improve the initial survey instrument.

During the process of assessing face validity, only a registered nurse who was the key informant from that setting was available to meet with the researcher to hear the information. The other nine primary care staff provided written feedback in relation to the wording of the items. However, they provided excellent suggestions including that some words were redundant, and some questions were too long. They also recommended including some examples of promotion of active ageing in their communities.

The pilot study to assess test-retest reliability analysed the data from 32 participants of the 40 who had initially completed the PAA-MD in the first round. This is eight less than the initial number because eight participants were either in meetings or had left the unit during the time of the second pilot testing. However, the number of participants was still higher than the recommended sample size for a pilot study which is from ten to forty per

group as per Hertzog (Hertzog, 2008). Nonparametric Statistic of Spearman's rank correlation can also test stability over time or the external reliability of the PAA-MD.

6.6 SUMMARY

The PAA-MD was developed based on the Thai language by using the findings from the descriptive qualitative study, previous studies, and the concept of active ageing from WHO. The preliminary results of the PAA-MD; the promotion of active ageing in older people with mental disorders living in communities, and identification of factors that influence the promotion of active ageing in this group indicated that it has good content validity after some items were removed because the individual content validity index was lower than an acceptable level. The face validity was also acceptable for both primary care providers and older people with mental disorders who are respondent's audience of the new instrument. The PAA-MD also has high value in internal consistency reliability. The test-retest reliability showed the PAA-MD was good and had a quite significant strong relationship when compared with the response from the first and second times of the participants in pilot testing which can be interpreted as the PAA-MD being stable over time. The PAA-MD contains 105 items divided into three sections as reported in the previous section. However, the PAA-MD needs to be tested for its psychometric properties using a large sample size to analyse the new instrument with regards exploratory factor analysis and Cronbach's Alpha coefficient to confirm construct validity and internal consistency reliability again (DeVellis, 2003). This is because it was quite a new survey instrument in this subject area.

Summary of PAA-MD after the pilot testing:

Section I: General information and familiarity with the concept of active ageing

The following characteristics of participants were collected; sex, age, marital status, occupation, education, type of primary care unit, duration of working at primary care unit, history of caring for older people and older people with mental disorders, confidence in caring for older people with mental disorders, education or training in mental health care, care of older people, and care of older people with mental disorders. Participants were asked about their familiarity with the concept of active ageing and related concepts, namely, healthy ageing, successful ageing, ageing well, productive ageing, positive ageing, optimal ageing. This section consists of fourteen items.

Section II: Promoting active ageing in older people with mental disorders living in the community

The components of section II of the PAA-MD consists of participation, education, health, leisure, and security. While the total number of items is 28, some of the main items contain sub-items accounting for 54 sub-items in total. The factor 'participation' comprises 16 items from seven main-items. Education is seven items from 3 main items. Health consists of 19 items from 10 main-items. Leisure consists of 6 items from 3 main items. Security is composed of 6 items from 5 main-items. The summative five response Likert scale range from 'never' to 'always promoted or offered' active ageing in older people with mental disorders living in the community (0=Never, 1=Sometimes, 2=Often, 3=Usually, 4= Always).

Section III: Factors that influence the promotion of active ageing in older people with mental disorders in the community

This section consists of five main factors. These are; facilitators, barriers, resources and support, knowledge, and skills and combined have a total of 37 items. Facilitators comprise eight items, barriers or obstacles consists of 9 items, understanding is eight items, skills equals seven items, and resources and support comprise five items. The summative five response Likert scale ranges from strongly disagree to strongly agree (1=Strongly Disagree, 2=Disagree, 3=Moderately agree, 4=Agree, and 5=Strongly agree).

The following chapter, chapter seven, describes phase 2, step 2; testing the psychometric properties of the new instrument "Promoting Active Ageing in Older People with Mental Disorders Scale" (PAA-MD). In this chapter, results, discussion, strengths and limitations, and summary of testing psychometric properties of the PAA-MD from the cross-sectional study are presented.

CHAPTER 7: PHASE 2 STEP 2: TESTING THE PSYCHOMETRIC PROPERTIES OF THE NEW INSTRUMENT FROM A CROSS-SECTIONAL STUDY

7.1 INTRODUCTION

In the previous Chapters five and six, the results, discussion, strengths and limitations of the qualitative approach as well as the quantitative approach for developing and testing the preliminary results of the PAA-MD were reported.

Chapter seven describes the results from the cross-sectional study based on the quantitative approach for testing the psychometric properties of the PAA-MD. Firstly, the objectives of the study are described followed by the findings. The results section details the characteristics of the participants, their working and training experience, and familiarity with the concept of active ageing and its related concepts. The psychometric properties of section II and III of the PAA-MD are also presented. The perspectives of primary care staff in promoting active ageing in older people with mental disorders living in the community and the identifying factors that influence the promotion of active ageing in this group are then provided. Finally, discussion, strengths and limitations, and summary of testing psychometric properties are presented.

7.2 OBJECTIVES AND RESEARCH QUESTIONS

The objectives of phase 2 step 2 were:

1. To test psychometric properties of the PAA-MD from the cross-sectional study.
2. To examine the perspectives of primary care providers regarding promotion of active ageing in older people with mental disorders living in the Thai community.

3. To examine the perspectives of primary care providers regarding factors that influence the promotion of active ageing in older people with mental disorders living in the Thai community.

The research questions of phase 2 step 2:

1. What are the psychometric properties of the new survey instrument from the cross-sectional study?

    1.1 What is the construct validity?

    1.2 What is the internal consistency reliability?

2. What are the perspectives of primary care providers about promoting active ageing in older people with mental disorders living in a Thai community?

    2.1 What is the promotion of active ageing in this group?

    2.2 What are the factors that influence the promotion of active ageing in this group?

The research methods of the phase-two step-two were reported in the previous chapter, Chapter four - Research design, plan, and methods.

7.3 RESULTS

7.3.1 Response rate

The total response rate of the province was 94.3 percent. The Kho Wang District had the highest response rate that accounted for 100 percent whereas Lerngnoktha District was the lowest response rate of approximately 85.6 percent as shown in Table 7-1.

Table 7-1: The number of primary care providers in Yasothon Province

Districts	Sent	Received	Response rate (percent)
Muang	115	111	96.5
Lerngnoktha	121	104	85.6
Kham Khuean Kaeo	69	68	98.6
Pa Tio	51	46	90.2
Kho Wang	31	31	100
Thaicharoen	40	34	85.0
Maha Chana Chai	68	66	97.1
Kudchum	58	54	93.1
Sai Mun	36	32	88.9
Total	**579**	**546**	**94.3**

7.3.2 Characteristics of participants

The majority of participants were female accounting for 73.3% (n=400). They aged between 21-60 years with an average age of approximately 39.77 years (SD=9.81). Registered nurses, health officers, and assistant health officers provided the highest response rate to the survey, accounting for 35.2% (n=192), 29.3% (n=160), and 12.8% (n=70) respectively. Most participants held a bachelor (68.1%, n=372) and/or master degree (11.4%, n=62). Details of the participants are presented in Table 7-2.

Table 7-2: Characteristics of participants (n=546)

Characteristics	Number	Percent
Sex		
Male	146	26.7
Female	400	73.3
Age range (years)		
21-30	125	22.9
31-40	146	26.7
41-50	191	35.0
51-60	84	15.4
Means age (Standard Deviation)	39.77(9.81)	
Marital Status		
Single	135	24.7
Married	375	68.7
Divorced	29	5.3
Windowed	7	1.3
Occupation		
General practitioner	2	0.4
Pharmacist	1	0.2
Registered nurse	192	35.2
Health officer	160	29.3
Assistant health officer	70	12.8
Aids	26	4.8
Dental assistant	42	7.7
Assistant Pharmacist	29	5.3
Other	24	4.4
Education		
Lower than diploma	48	8.8
Diploma	59	10.8
Certificate	1	0.2
Bachelor degree	372	68.1
Master degree	62	11..4
Higher than master degree	3	0.5
Other	1	0.2

7.3.3 Work and training experience of participants

Most of the primary care providers, 87.9% (n=480), worked in the health promotion hospitals. The duration of their work experience in primary care was on average 8.45 years (SD=7.16). Those that worked between 1-5 years, over 20 years, and 6-10 years accounted for 33.9% (n=185), 24.0% (n=131) and 22.0% (n=120) respectively. The majority of participants, 52.0% (n=284), did not have experience in caring for older people with mental disorders and had only a moderate level of confidence in caring for this population. Forty-eight point seven percent (n=266) were not trained in caring for people with psychiatric illnesses while approximately 45.2% (n=247) had trained informally, such as having on the job training, and supervision. Moreover, 60.4 % (n=330) had received informal training in caring for older people, and 59.7 % (n=326) indicated they had received no training in caring for older people with mental disorders (as shown in Table 7-3).

Table 7-3: Working and training experience of participants (n=546)

Items	Frequency	Percent
Type of primary care		
Health promotion hospital	480	87.9
Primary care units of district hospital	62	114.4
Missing data	4	0.7
Duration of work experience in primary care (years)		
< 1	13	2.4
1 – 5	185	33.9
6-10	120	22.0
11-15	65	11.9
16-20	32	5.9
>20	131	24.0
Means (S.D.)	8.45 (7.16)	
Experience of caring for older people with mental disorders		
No	284	52.0
Yes	241	44.1
N/A	7	1.3
Missing data	14	2.6
Level of confidence in caring for older people with mental disorders		
A little	12	2.2
Moderately	140	25.6
Quite confident	84	15.4
Very confident	10	1.8
Type of education or training in psychiatric or mental health caring		
None	266	48.7
Informal: on the job training, supervision	247	45.2
Formal: certificate, degree diploma	32	5.9
Missing data	1	0.2
Type of education or training in caring for older people		
None	177	32.4
Informal: on the job training, supervision	330	60.4
Formal: certificate, degree diploma	39	7.2
Type of education or training in caring for older people with mental disorders		
None	326	59.7
Informal: on the job training, supervision	205	37.5
Formal: certificate, degree diploma	15	2.7

7.3.4 Familiarity with the concept of active ageing and other related concepts

The majority of participants, 91.6% (n=500), were unfamiliar with the concept of ageing and 92.9% (n=507) indicated that they did not understand how to promote active ageing in older people with mental disorders. However, healthy ageing was a concept that 56.2% (n=307) indicated they were familiar with, and successful ageing was a familiar concept for 34.4% (n=188) of participants. Details are presented in Table 7-4.

Table 7-4: Familiarity with the concept of active ageing and other related concepts (n=546)

Items	Frequency	Percent
Healthy ageing		
No	239	43.8
Yes	307	56.2
Successful ageing		
No	358	65.6
Yes	188	34.4
Ageing well		
No	384	70.3
Yes	162	29.7
Productive ageing		
No	365	66.8
Yes	181	33.2
Positive ageing		
No	382	70.0
Yes	164	30.0
Optimal ageing		
No	368	67.4
Yes	178	32.6
Active ageing		
No	500	91.6
Yes	46	8.4
Understand the concept of promoting active ageing in older people with mental disorders		
No	507	92.9
Yes	39	7.1

7.3.5 Psychometric properties of the PAA-MD

Prior to testing the psychometric properties of the PAA-MD, the data from this cross-sectional study was analysed using the Kolmogorov-Smirnov test. The results showed the data had normality of distribution and was suitable for further analysis. Therefore, the parametric statistics used to analyse the data are as follow (Hair et al., 2014; Suhr, 2017):

7.3.5.1 Promoting active ageing in older people with mental disorders living in the community

The construct validity of section II of the PAA-MD used exploratory factor analysis to examine the dimensions and group items. Table 7-5, shows the results of the exploratory factor analysis from all items. The sample size of this research was sufficient to use factor analysis with a KMO of 0.956. Bartlett's test of sphericity was also obtained to test that sufficient correlation exists between the variables that were $\chi^2(1431)= 26221.167$, $p<0.000$ statistically significant. The Eigenvalue greater than one score found eight components and cumulative variance accounted for 68.781%, as illustrated in Table 7-5. The Scree Plot also shows eight components where the Eigenvalue is greater than one, as can be seen in Figure 7-1.

When rotation method for Varimax with Kaiser Normalization was used, many items presented a high factor loading on more than one component, as shown in Table 7-6. Therefore, the items of section II in the PAA-MD were grouped into five factors based on the findings from a previous study (Lin et al., 2013), as well as theoretically justified based on the concept of active ageing which was developed by WHO (WHO, 2002), namely, participation, education, health, leisure, and security. Then, each factor of section II in the PAA-MD was re-analysed and will be presented in more detail the following pages. This section also found two items; neighbourhood friendship activities in term of

birthday celebrations, and health education in primary care units which indicated a community score less than 0.50 as presented in Table 7-6.

Table 7-5: Results of psychometric properties in section II of the PAA-MD from all items (n=546)

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	23.474	43.471	43.471	10.904	20.193	20.193
2	4.804	8.897	52.368	5.338	9.884	30.078
3	2.001	3.705	56.073	4.622	8.559	38.637
4	1.665	3.083	59.156	3.908	7.238	45.874
5	1.526	2.826	61.982	3.615	6.695	52.570
6	1.313	2.431	64.412	3.010	5.574	58.143
7	1.222	2.263	66.675	2.968	5.496	63.639
8	1.137	2.105	68.781	2.777	5.142	68.781
Kaiser-Meyer Olkin = 0.956						
Bartlett's Test of Sphericity as $\chi^2(1431) = 26221.167$, $p<0.000$						

Figure 7-1: Scree plot from exploratory factor analysis of section II in the PAA-MD

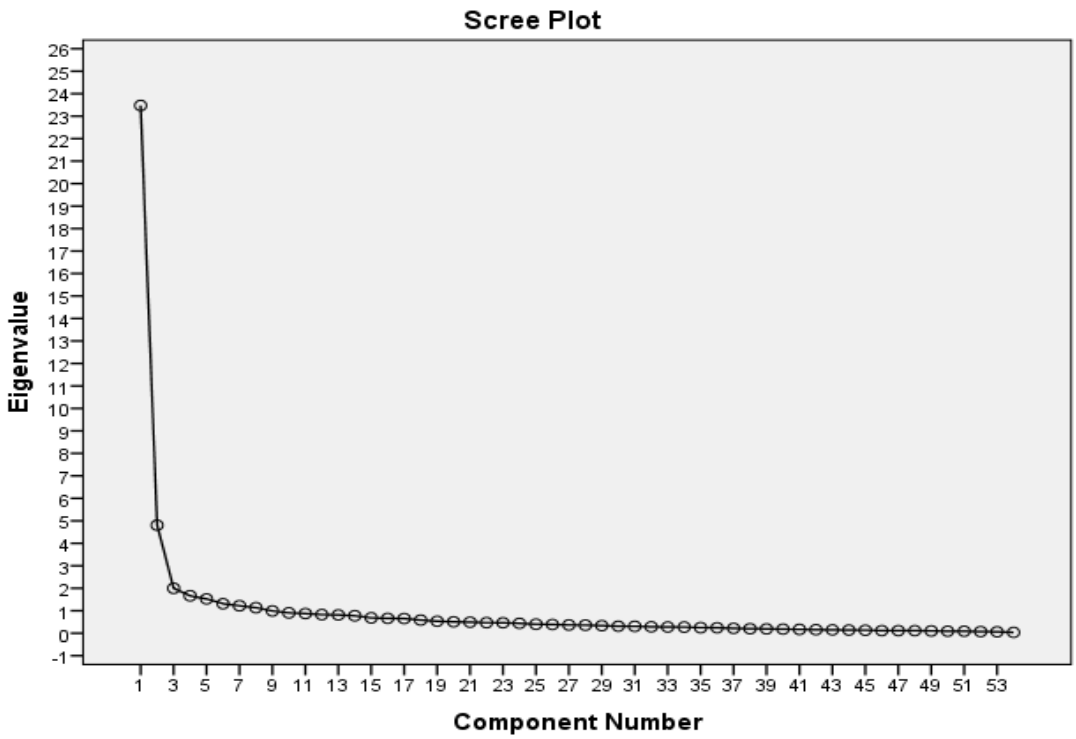

Table 7-6: Factor loading from rotated component matrix in section II of the PAA-MD and community score (n=546)

VARIMAX Rotated Factor-Loading Matrix[a]									
	Component								Community
Items	1	2	3	4	5	6	7	8	
1.Religious activities:									
Making merit	.212	.236	.253	.222	.317	.206	.410	.093	.534
2.Cultural activities:									
Respect older people in Songkran festival	.403	.090	.074	.087	.403	.015	.372	.307	.578
3.Neighbourhood friendship activities:									
3.1 Birthday celebrations	-.102	.176	.147	.129	.282	.530	.014	.068	.445
3.2 Visit each other in villages	.249	.138	.219	.213	.594	.295	.126	.093	.639
3.3 Follow and support postpartum care	.340	.154	.029	.089	.684	.078	.045	.048	.626
3.4 Follow and support patients care	.385	.121	.069	.118	.718	.083	.073	.109	.721
4.Political activities:									
4.1 National election	.153	.187	.223	.181	.090	.105	.764	.075	.749
4.2 Local election	.208	.206	.208	.212	.123	.101	.766	.087	.794
5.Senior clubs:									
5.1 Senior associations	.335	.185	.269	.411	.397	-.056	.319	.117	.664
5.2 Meetings of senior associations	.362	.192	.253	.437	.395	-.079	.306	.113	.691
6.Thai wisdom activities:									
6.1 Basketry	.265	.325	.193	.731	.114	.042	.178	.119	.809
6.2 Weaving	.274	.372	.189	.725	.099	.067	.166	.092	.825
6.3 Fortune telling	.138	.269	.163	.673	.021	.216	.135	.059	.639
6.4 Thai herbal	.284	.284	.241	.605	.263	.078	.106	.120	.686
7.Volunteer activities:									
7.1 Community cleaning	.204	.182	.178	.449	.418	.303	.160	.182	.634
7.2 Meal delivery services	.113	.255	.312	.478	.301	.245	.033	.171	.585
8.School of older people	.062	.563	.217	.030	.266	.232	.146	-.151	.538
9.Health education in primary care units	.151	.496	.198	.118	.260	.237	.198	-.047	.487
10.Life skills education:									
10.1 Agriculture	.141	.755	.239	.208	.140	.086	.111	.119	.745
10.2 Mushroom cultivation	.081	.820	.208	.127	.098	.083	.053	.094	.766
10.3 Sewing	.118	.803	.189	.252	.019	.104	.091	.163	.803
10.4 Healthy cooking	.168	.699	.234	.290	.127	.155	.050	.163	.726
10.5 Woven mats	.133	.707	.138	.330	.030	.123	.151	.221	.733
11.Promotion of physical health activities:									
Exercise	.321	.285	.221	.155	.429	.244	.199	.184	.575
12.Assessment of physical health and screening health problems:									
12.1 Annual health examination	.591	.123	-.035	-.003	.307	.068	.380	.265	.679
12.2 Assessment attached to the bed	.692	.117	-.018	.037	.362	.002	.254	.283	.770
12.3 Assessment of Body Mass Index	.678	.090	-.001	.010	.335	.045	.274	.309	.753
13.Assessment of mental health problems:									
13.1 Depression	.833	.089	.131	.110	.151	.010	.151	.152	.799
13.2 Suicide risk	.831	.095	.207	.044	.079	-.009	.052	-.004	.753
13.3 Dementia	.817	.146	.197	.124	.094	.019	.027	.029	.754
14.Home visits:									
14.1 Older people with mental disorders	.817	.075	.161	.204	.108	.026	.043	.110	.767
14.2 Older people with disability	.807	.051	.151	.148	.188	.019	.045	.121	.750

Table 7-6: Factor loading from rotated component matrix in section II of PAA-MD and community score (n=546)

VARIMAX Rotated Factor-Loading Matrix[a]	Component								Community
	1	2	3	4	5	6	7	8	
15.Health education for physical health	.764	.088	.176	.189	.207	.169	.002	.180	.762
16.Health education for mental health:									
16.1 Observe mental health problems	.808	.174	.167	.204	.075	.221	.022	.097	.818
16.2 Stress management	.789	.202	.193	.195	.081	.222	-.004	.082	.801
17.Health education for family of older people in physical health promotion:									
17.1 Nutrition	.651	.081	.167	.102	.201	.455	.212	.092	.769
17.2 Medication administration	.654	.132	.122	.152	.218	.433	.143	.149	.761
18.Health education for family of older people in mental health promotion:									
18.1 Respectful of older people	.521	.119	.236	.127	.176	.461	.171	.182	.663
19.Promotion activities for improving family relationship:									
19.1 Family therapy	.289	.315	.194	.072	.023	.680	.119	.071	.707
19.2 Family counselling	.363	.301	.220	.121	.039	.610	.121	.107	.685
20.Teeth health activities:									
20.1 Teeth examination	.611	.076	.108	.204	.098	.198	.381	.228	.679
20.2 Education on oral hygiene	.608	.091	.121	.189	.116	.224	.379	.251	.699
21.Recreation activities in the community: Local dancing	.319	.207	.476	.176	.208	.193	.251	.222	.595
22.Recreation activities outside the community:									
22.1 Religion tourism in another city	.165	.252	.674	.183	.133	.181	.262	.036	.698
22.2 Travel in another city	.124	.300	.699	.144	.110	.082	.155	-.063	.662
23.Promotion of suitable recreation activities:									
23.1 Reading book	.214	.262	.743	.142	.094	.150	.053	.178	.753
23.2 Caring for animals	.236	.266	.741	.191	.046	.107	.113	.204	.780
23.3 Planting trees	.279	.216	.730	.214	.056	.192	.071	.218	.796
24.Welfare for older people:									
24.1 Monthly living cost,	.413	.145	-.009	.101	.105	-.146	.154	.606	.625
24.2 Welfare of community for supporting older people	.366	.205	.219	.147	.165	.037	.123	.566	.610
25.Suggestion for saving money	.127	.146	.315	.106	.027	.323	-.034	.560	.568
26.Promotion activities for supporting income of older people: Selling products of older people (trees, vegetables, basketwork)	.212	.374	.395	.217	.129	.271	.116	.353	.616
27.Health education for living safety: Healthy environments suitable for older people and older people living with diseases	.282	.066	.208	.143	.080	.294	.071	.515	.510
28.Activities for improving health environment for older people living safety: Destroying breeding mosquitoes	.408	.073	.102	.102	.321	.111	.214	.462	.567

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization. a. Rotation converged in 8 iterations.

The results of exploratory factor analysis from a factor of participation were extracted into four components. Then, it was rotated by using Varimax with Kaiser Normalization. It indicated that some items could be more than one component. The factor of participation could be chosen as the first component because the eigenvalue and percent of variance were the highest, accounting for 7.678% and 47.985% respectively. Moreover, only 'birthday celebration' had an item-factor loading of less than 0.4. The details of this topic are shown in Table 7-7.

Table 7-7: Results of psychometric properties from factor of participation (n=546)

Factor 1 "Participation"	Component
	1
1.Religious activities: Making merit	0.698
2.Cultural activities: Respect older people in Songkran festival	0.625
3.Neighbourhood friendship activities:	
3.1 Birthday celebrations	0.384
3.2 Visit each other in villages	0.698
3.3 Follow and support postpartum care	0.582
3.4 Follow and support patients care	0.654
4.Political activities:	
4.1 National election	0.649
4.2 Local election	0.695
5.Senior clubs:	
5.1 Senior associations	0.778
5.2 Meetings of senior associations	0.786
6.Thai wisdom activities:	
6.1 Basketry	0.786
6.2 Weaving	0.787
6.3 Fortune telling	0.641
6.4 Thai herbal	0.770
7.Volunteer activities:	
7.1 Community cleaning	0.750
7.2 Meal delivery services	0.683
Eigenvalues	7.678
% of Variance accounted for	47.985
Kaiser-Meyer-Olkin	0.891
Bartlett's Test of Sphericity	$\chi^2(120)=5997.209$, $p<0.000$

In Table 7-8, the results of exploratory factor analysis from the factor of education found that it was extracted into only one component. The eigenvalue and percent of variance were 4.548% and 64.971% respectively. Furthermore, the item-factor loading of each item was greater than 0.40.

Table 7-8: Results of psychometric properties from factor of education (n=546)

Factor 2 "Education"	Component
	1
8.School of older people	0.667
9.Health education in primary care units	0.664
10.Life skills education:	
10.1 Agriculture	0.863
10.2 Mushroom cultivation	0.850
10.3 Sewing	0.876
10.4 Healthy cooking	0.853
10.5 Woven mats	0.836
Eigenvalues	4.548
% of Variance accounted for	64.971
Kaiser-Meyer-Olkin	0.899
Bartlett's Test of Sphericity	$\chi^2(21)=2446.395$, $p<0.000$

The results of exploratory factor analysis from a factor of health found that it was extracted into three components. It was then rotated by using Varimax with Kaiser Normalization. The findings also showed some items could be more than one component. Health could be selected as the first component because the eigenvalue and percent of variance were the highest, accounting for 11.735% and 61.762% respectively. The item-factor loading of each item was also greater than 0.40. The details of this factor analysis are shown in Table 7-9.

Table 7-9: Results of psychometric properties from factor of health (n=546)

Factor 3 "Health"	Component
	1
11.Promotion of physical health activities:	
Exercise	0.628
12.Assessment of physical health and screening health problems:	0.744
12.1 Annual health examination	
12.2 Assessment attached to the bed	0.805
12.3 Assessment of Body Mass Index	0.802
13.Assessment of mental health problems:	
13.1 Depression	0.858
13.2 Suicide risk	0.788
13.3 Dementia	0.810
14.Home visits:	
14.1 Older people with mental disorders	0.828
14.2 Older people with disability	0.826
15.Health education for physical health	0.853
16.Health education for mental health:	
16.1 Observe mental health problems	0.871
16.2 Stress management	0.855
17.Health education for family of older people in physical health promotion:	
17.1 Nutrition	0.829
17.2 Medication administration	0.837
18.Health education for family of older people in mental health promotion: Respectful of older people	0.750
19.Promotion activities for improving family relationship:	0.561
19.1 Family therapy	
19.2 Family counselling	0.627
20.Teeth health activities:	
20.1 Teeth examination	0.781
20.2 Education on oral hygiene	0.793
Eigenvalues	11.735
% of Variance accounted for	61.762
Kaiser-Meyer-Olkin	0.935
Bartlett's Test of Sphericity	$\chi^2(171)=11568.950$, $p<0.000$

As can be seen in Table 7-10, the results of component analysis from the factor of leisure found that it was extracted into only 1 component. The eigenvalue and percent of variance were 4.138% and 68.974% respectively. The item-factor loading of each item was also greater than 0.40.

Table 7-10 Results of psychometric properties from factor of leisure (n=546)

Factor 4 "Leisure"	Component
	1
21.Recreation activities in the community:	
Local dancing	0.746
22.Recreation activities outside the community:	
22.1 Religion tourism in another city	0.828
22.2 Travel in another city	0.768
23.Promotion of suitable recreation activities:	
23.1 Reading book	0.858
23.2 Caring for animals	0.889
23.3 Planting trees	0.885
Eigenvalues	4.138
% of Variance accounted for	68.974
Kaiser-Meyer-Olkin	0.841
Bartlett's Test of Sphericity	$\chi^2(15)=2511.089$, $p<0.000$

The results of exploratory factor analysis from a factor of security found that it was extracted into only one component. The eigenvalue and percent of variance were 3.182% and 53.035% respectively. The item-factor loading of each item was also greater than 0.40 (see in Table 7-11).

Table 7-11: Results of psychometric properties from factor of security (n=546)

Factor 5 "Security"	Component
	1
24.Welfare for older people:	
24.1 Monthly living cost,	0.700
24.2 Welfare of community for supporting older people	0.792
25.Suggestion for saving money	0.677
26.Promotion activities for supporting the income of older people: Selling produce from older people (trees, vegetables, basketwork)	0.744
27.Health education for living safety: Healthy environments suitable for older people and older people living with diseases	0.720
28.Activities for improving health environment for older people living safety: Destroying breeding mosquitoes	0.729
Eigenvalues	3.182
% of Variance accounted for	53.035
Kaiser-Meyer-Olkin	0.805
Bartlett's Test of Sphericity	$\chi^2(15)=1073.229$, $p<0.000$

The internal consistency reliability in section II of the PAA-MD from the large sample of primary care providers, show that the Cronbach's Alpha of all items was 0.974. The corrected item-total correlation coefficient of all items was greater than 0.30, ranging between 0.332 –0.754. Cronbach' Alpha in each factor of participation, education, health, leisure, and security reports 0.924, 0.905, 0.964, 0.908, and 0.820 respectively, and can be found in Table 7-12.

Table 7-12: Internal consistency reliability of section II in the PAA-MD (n=546)

Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Participation	**Cronbach's Alpha of Participation = 0.924**	
1.Religious activities:		
Making merit	0.639	0.974
2.Cultural activities:		
Respect older people in Songkran festival	0.605	0.974
3.Neighbourhood friendship activities:		
3.1 Birthday celebrations	0.332	0.974
3.2 Visit each other in villages	0.641	0.974
3.3 Follow and support postpartum care	0.526	0.974
3.4 Follow and support patients care	0.599	0.974
4.Political activities:		
4.1 National election	0.558	0.974
4.2 Local election	0.614	0.974
5.Senior clubs:		
5.1 Senior associations	0.697	0.974
5.2 Meetings of senior associations	0.706	0.974
6.Thai wisdom activities:		
6.1 Basketry	0.691	0.974
6.2 Weaving	0.703	0.974
6.3 Fortune telling	0.557	0.974
6.4 Thai herbal	0.696	0.974
7.Volunteer activities:		
7.1 Community cleaning	0.674	0.974
7.2 Meal delivery services	0.623	0.974
Education	**Cronbach's Alpha of Education = 0.905**	
8.School of older people	0.461	0.974
9.Health education in primary care units	0.549	0.974
10.Life skills education:		
10.1 Agriculture	0.630	0.974
10.2 Mushroom cultivation	0.548	0.974
10.3 Sewing	0.606	
10.4 Healthy cooking	0.659	
10.5 Woven mats	0.622	
Health	**Cronbach's Alpha of Health = 0.964**	
11.Promotion of physical health activities:		
Exercise	0.697	0.974
12.Assessment of physical health and screening health problems:		
12.1 Annual health examination	0.630	0.974
12.2 Assessment attached to the bed	0.678	0.974
12.3 Assessment of Body Mass Index	0.671	0.974
13.Assessment of mental health problems:		
13.1 Depression	0.703	0.974
13.2 Suicide risk	0.614	0.974
13.3 Dementia	0.664	0.974
14.Home visits:		
14.1 Older people with mental disorders	0.681	0.974
14.2 Older people with disability	0.669	0.974

Table 7-12: Internal consistency reliability of section II in the PAA-MD (n=546) (Cont.)

Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
15.Health education for physical health	0.730	0.973
16.Health education for mental health:		0.973
16.1 Observe mental health problems	0.749	
16.2 Stress management	0.746	0.973
17.Health education for family of older people in physical health promotion:		
17.1 Nutrition	0.736	0.973
17.2 Medication administration	0.754	0.973
18.Health education for family of older people in mental health promotion:		
Respectful of older people	0.714	0.974
19.Promotion activities for improving family relationship:		
19.1 Family therapy	0.594	0.974
19.2 Family counselling	0.651	0.974
20.Teeth health activities:		
20.1 Teeth examination	0.705	0.974
20.2 Education on oral hygiene	0.728	0.973
Leisure	**Cronbach's Alpha of Leisure = 0.908**	
21.Recreation activities in the community:		
Local dancing	0.708	0.973
22.Recreation activities outside the community:		
22.1 Religion tourism in another city	0.638	0.974
22.2 Travel in another city	0.544	0.974
23.Promotion of suitable recreation activities:		
23.1 Reading book	0.644	0.974
23.2 Caring for animals	0.671	0.974
23.3 Planting trees	0.697	
Security	**Cronbach's Alpha of Security = 0.820**	
24.Welfare for older people:		
24.1 Monthly living cost,	0.493	0.974
24.2 Welfare of community for supporting older people	0.635	0.974
25.Suggestion for saving money	0.485	0.974
26.Promotion activities for supporting income of older people:		
Selling produce from older people (trees, vegetables, basketwork)	0.692	0.974
27.Health education for living safety:		
Healthy environments suitable for older people and older people living with diseases	0.541	0.94
28.Activities for improving health environment for older people living safety:		
Destroying breeding mosquitoes	0.614	0.974
Total Cronbach's Alpha	**0.974**	

7.3.5.2 Factors that influence the promotion of active ageing in older people with mental disorders living in the community

The construct validity of section III of the PAA-MD used exploration factor analysis for examining the dimension and group items. All items from this section were tested with KMO before deciding to conduct exploratory factor analysis. The KMO was 0.954, and this confirmed the decision that the sample was large enough to analyse with exploratory factor analysis. Bartlett's Test was $\chi^2(666)=23524.074$, $p < 0.000$ and statistically significant. The findings from exploratory factor analysis indicated that it was grouped into five components where the Eigenvalue was greater than one. The details of this information are presented in Table 7-13. Figure 7-2, the Scree Plot, also shows five components in which the Eigenvalue was greater than one. There were five components or factors; facilitators, barriers, knowledge, skills, and resources and support, that emerged from the findings of phase one of the descriptive qualitative study and the literature review (Wilhelmsson & Lindberg, 2009). Next, each item in section III of the PAA-MD was analysed by rotation method using Varimax with Kaiser Normalization. It noted that some items could be grouped into more than one component. Therefore, the items were summarised into five factors as mentioned earlier. Then, each factor of section III in the PAA-MD was re-analysed. The results are illustrated in Table 7-15 to 7-19.

In addition, the community score of each item in section III of the PAA-MD was greater than 0.50. The details of this topic are shown in Table 7-14.

Table 7-13: Results of psychometric properties in section III of the PAA-MD from all items (n=546)

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	17.397	47.019	47.019	11.450	30.946	30.946
2	4.816	13.016	60.035	5.979	16.159	47.105
3	2.786	7.529	67.564	4.493	12.143	59.248
4	2.297	6.209	73.773	3.839	10.376	69.624
5	1.095	2.959	76.732	2.630	7.108	76.732
Kaiser-Meyer Olkin = 0.954						
Bartlett's Test of Sphericity as $\chi^2(666) = 23524.074$, $p<0.000$						

Figure 7-2: Scree plot from exploratory factor analysis of section III in the PAA-MD

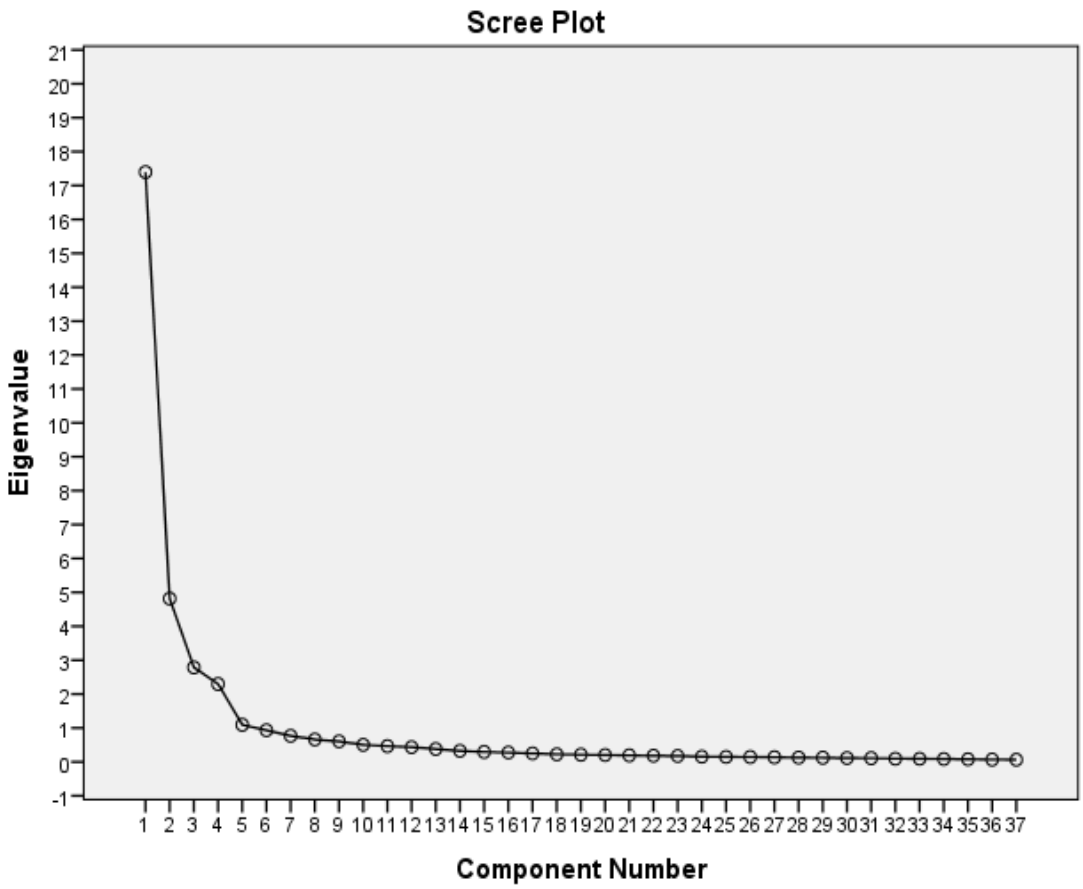

Table 7-14: Factor loading from rotated component matrix in section III of the PAA-MD and community score (n=546)

VARIMAX Rotated Factor-Loading Matrix[a]						
	Component					Community
Items	1	2	3	4	5	
1.Having a national policy for older people with mental disorders	.249	.739	.127	.189	.104	.671
2.Having a health service policy for older people with mental disorders	.282	.762	.126	.179	.116	.722
3.Having been taught or on the job training from mental health services	.301	.790	.052	.212	.049	.765
4.Having supervision from mental health services	.334	.801	.046	.122	.114	.783
5.Having a counselling system of care from mental health services	.315	.813	.113	.130	.072	.795
6.Having collaboration with other government services, such as local government, police, schools	.290	.792	.195	.077	.124	.770
7.Having co-operation with older people with mental Disorders	.325	.763	.181	.015	.185	.754
8.Having cooperation from families of older people with mental disorders	.323	.745	.216	.043	.230	.762
9.The policy for mental disorders in older people does not cover all diseases	.190	.198	.147	.247	.762	.739
10.The job description of primary care providers for promoting active ageing in older people with mental disorders is not clear	.147	.254	.110	.327	.745	.761
11.Health policy gives priority to care for physical health rather than mental health	.175	.150	.192	.358	.692	.697
12.There is high workload in working in primary care units	.105	.182	.358	.307	.521	.538
13.Mental health illnesses are stigmatised in Thai culture	.200	.079	.122	.585	.409	.570
14.There is a lack of cooperation from older people with mental disorders	.165	.192	.142	.813	.146	.767
15.There is a lack of cooperation from families of older people with mental disorders	.130	.151	.148	.846	.121	.793
16.There is a lack of knowledge about how to promote active ageing in older people with mental disorders	.037	.137	.246	.814	.256	.809
17.There is a lack of knowledge and insight into mental health problem of older people	.075	.131	.236	.796	.247	.773
18.Knowledge the principles for promoting active ageing in older people with mental disorders.	.736	.204	.135	.122	.040	.618
19.Knowledge how to assess and screen older people with mental disorders	.734	.291	.210	.015	.128	.684
20.Knowledge how to care for older people with mental disorders	.765	.250	.205	.049	.099	.701
21.Knowledge how to rehabilitate older people with mental disorders	.851	.189	.122	.070	.136	.798
22.Knowledge how to manage psychiatric medication and potential side effects	.833	.142	.127	.085	.197	.775

Table 7-14: Factor loading from rotated component matrix in section III of the PAA-MD and community score (n=456) (Cont.)

VARIMAX Rotated Factor-Loading Matrix[a]						
	Component					Community
	1	2	3	4	5	
23.Knowledge common mental health problems in older people	.838	.178	.167	.082	.209	.813
24.Knowledge symptoms and severity of mental disorders in older people	.846	.175	.139	.118	.178	.812
25.Knowledge how to advise their family in supporting older people with mental disorder	.868	.209	.139	.044	.120	.832
26.Having skills in promoting active ageing in older people with mental disorders	.820	.204	.032	.156	.012	.739
27.Having skills in assessing and screening older people experiencing mental disorders	.830	.265	.142	.088	.044	.789
28.Having skills in basic counselling for older people with mental disorders	.853	.272	.108	.086	.065	.825
29.Having skills to care for older people with mental disorders	.880	.237	.109	.091	.031	.852
30.Having skills to rehabilitate older people with mental disorders	.880	.221	.088	.113	.021	.844
31.Having skills to communicate with older people with mental disorders	.864	.251	.104	.080	.039	.829
32.Having skills to communicate with families of older people with mental disorders	.831	.279	.133	.098	.076	.801
33.Increasing human resources for promoting active ageing in primary care units	.196	.093	.829	.194	.136	.791
34.Improving potential of primary care providers to address mental health in older people	.188	.154	.875	.181	.103	.868
35.Increasing budget for supporting older people with mental disorders	.201	.149	.862	.194	.134	.862
36.Supporting media and technology to promote active ageing in older people with mental disorders	.208	.164	.867	.146	.120	.858
37.Supporting media and technology for caring for older people with mental disorders	.192	.186	.850	.149	.118	.830

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 7 iterations.

Table 7-15 shows the results of exploratory factor analysis from the factor of facilitators and found that only one component was extracted. The eigenvalue and percent of variance were 5.926% and 74.073% respectively. The item-factor loading of each item was also greater than 0.40.

Table 7-15: Results of psychometric properties from factor of facilitators (n=546)

Factor 1 "Facilitators"	Component
	1
1.Having a national policy for older people with mental disorders	0.815
2.Having a health service policy for older people with mental disorders	0.844
3.Having been taught or on the job training from mental health services	0.862
4.Having supervision from mental health services	0.881
5.Having a counselling system of care from mental health services	0.886
6.Having collaboration with other government services, such as local government, police, schools	0.873
7.Having co-operation with older people with mental Disorders	0.861
8.Having cooperation from families of older people with mental disorders	0.861
Eigenvalues	5.926
% of Variance accounted for	74.073
Kaiser-Meyer-Olkin	0.899
Bartlett's Test of Sphericity	$\chi^2(28)=4598.964, p<0.000$

The results of exploratory factor analysis from the factor of barriers found that it was extracted into two components. Then it was rotated by using Varimax with Kaiser Normalization. It showed some items could be more than one component. The factor of barriers was selected as the first component because the eigenvalue and percent of variance were the highest, accounting for 5.335 and 59.278% respectively. The item-factor loading of each item was also greater than 0.40. The details of this factor analysis are shown in Table 7-16.

Table 7-16: Results of psychometric properties from factor of barriers (n=546)

Factor 2 "Barriers"	Component
	1
9.The policy for mental disorders in older people does not cover all diseases	0.711
10.The job description of primary care providers for promoting active ageing in older people with mental disorders is not clear	0.760
11.Health policy gives priority to caring for physical health rather than mental health	0.757
12.There is high workload in working in primary care units	0.673
13.Mental health illnesses are stigmatised in Thai culture	0.740
14.There is a lack of cooperation from older people with mental disorders	0.798
15.There is a lack of cooperation from families of older people with mental disorders	0.793
16.There is a lack of knowledge about how to promote active ageing in older people with mental disorders	0.848
17.There is a lack of knowledge and insight into mental health problem of older people	0.834
Eigenvalues	5.335
% of Variance accounted for	59.278
Kaiser-Meyer-Olkin	0.896
Bartlett's Test of Sphericity	$\chi^2(36)3174.004=,p<0.000$

Table 7-17 presents the results of exploratory factor analysis from the factor of knowledge and found that it was extracted into only one component. The eigenvalue and percent of variance were 6.356 and 79.446% respectively. The item-factor loading of each item was also greater than 0.40.

The results of exploratory factor analysis from a factor of skills indicated that it was extracted into only one component. The eigenvalue and percent of variance were 6.042 and 86.308% respectively. The item-factor loading of each item was also greater than 0.40. The details of this factor are presented in Table 7-18.

Table 7-17: Results of psychometric properties from factor of knowledge (n=546)

Factor 3 "Knowledge"	Component
	1
18.Knowledge the principles for promoting active ageing in older people with mental disorders	0.828
19.Knowledge how to assess and screen older people with mental disorders	0.867
20.Knowledge how to care for older people with mental disorders	0.888
21.Knowledge how to rehabilitate older people with mental disorders	0.915
22.Knowledge how to manage psychiatric medication and potential side effects	0.902
23.Knowledge common mental health problems in older people	0.910
24.Knowledge symptoms and severity of mental disorders in older people	0.910
25.Knowledge how to advise their family in supporting older people with mental disorder	0.908
Eigenvalues	6.356
% of Variance accounted for	79.446
Kaiser-Meyer-Olkin	0.932
Bartlett's Test of Sphericity	$\chi^2(28)=5361.895, p<0.000$

Table 7-18: Results of psychometric properties from factor of skills (n=546)

Factor 4 "Skills"	Component
	1
26.Having skills in promoting active ageing in older people with mental disorders	0.873
27.Having skills in assessing and screening older people experiencing mental disorders	0.917
28.Having skills in basic counselling for older people with mental disorders	0.939
29.Having skills to care for older people with mental disorders	0.951
30.Having skills to rehabilitate older people with mental disorders	0.949
31.Having skills to communicate with older people with mental disorders	0.942
32.Having skills to communicate with families of older people with mental disorders	0.930
Eigenvalues	6.042
% of Variance accounted for	86.308
Kaiser-Meyer-Olkin	0.943
Bartlett's Test of Sphericity	$\chi^2(21)=5342.164, p<0.000$

Table 7-19, highlights the results of exploratory factor analysis for the factor of resources and support and found that it was extracted into only one component. The eigenvalue and percent of variance were 4.225 and 84.510% respectively. The item-factor loading of each item was also greater than 0.40.

Table 7-19: Results of psychometric properties from factor of resources and support (n=546)

Factor 5 "Resources and support"	Component
	1
33.Increasing human resources for promoting active ageing in primary care units	0.889
34.Improving potential of primary care providers to address mental health in older people	0.931
35.Increasing budget for supporting older people with mental disorders	0.929
36.Supporting media and technology to promote active ageing in older people with mental disorders	0.930
37.Supporting media and technology for caring for older people with mental disorders	0.917
Eigenvalues	4.225
% of Variance accounted for	84.510
Kaiser-Meyer-Olkin	0.88
Bartlett's Test of Sphericity	$\chi^2(10)=2986.316, p<0.000$

The internal consistency reliability in section III of the PAA-MD from the large sample of primary care providers show the Cronbach's Alpha of all items was 0.966. The corrected item-total correlation coefficient of all items was greater than 0.30, ranging between 0.492 – 0.774. Cronbach' Alpha in each of the factor of facilitators, barriers, knowledge, skills, resources and support indicated 0.950, 0.913, 0.962, 0.973, and 0.954 respectively, which is shown in Table 7-20.

Table 7-20: Internal consistency reliability of section III in the PAA-MD (n=546)

Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Facilitators	**Total Cronbach's Alpha of Facilitators = 0.950**	
1.Having a national policy for older people with mental disorders	0.636	0.965
2.Having a health service policy for older people with mental disorders	0.670	0.965
3.Having been taught or on the job training from mental health services	0.660	0.965
4.Having supervision from mental health services	0.674	0.965
5.Having a counselling system of care from mental health services	0.684	0.965
6.Having collaboration with other government services, such as local government, police, schools	0.683	0.965
7.Having co-operation with older people with mental disorders	0.683	0.965
8.Having cooperation from families of older people with mental disorders	0.710	0.965
Barriers	**Total Cronbach's Alpha of Barriers = 0.913**	
9.The policy for mental disorders in older people does not cover all diseases	0.542	0.966
10.The job role of primary care providers for promoting active ageing in older people with mental disorders is not clear	0.549	0.966
11.Health policy gives priority to caring for physical health rather than mental health	0.543	0.966
12.There is high workload in working in primary care units	0.508	0.966
13.Mental health illnesses are stigmatised in Thai culture	0.495	0.966
14.There is a lack of cooperation from older people with mental disorders	0.537	0.966
15.There is a lack of cooperation from families of older people with mental disorders	0.499	0.966
16.There is a lack of knowledge about how to promote active ageing in older people with mental disorders	0.492	0.966
17.There is a lack of knowledge and insight into mental health problem of older people	0.503	0.966
Knowledge	**Total Cronbach's Alpha of Understanding = 0.962**	
18.Knowledge the principles for promoting active ageing in older people with mental disorders	0.670	0.965
19.Knowledge how to assess and screen older people with mental disorders	0.730	0.965

Table 7-20: Internal consistency reliability of section III in the PAA-MD (n=546) (Cont.)

Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
20.Knowledge how to care for older people with mental disorders	0.732	0.965
21.Knowledge how to rehabilitate older people with mental disorders	0.747	0.965
22.Knowledge how to manage psychiatric medication and potential side effects	0.734	0.965
23.Knowledge common mental health problems in older people	0.774	0.965
24.Knowledge symptoms and severity of mental disorders in older people	0.771	0.965
25.Knowledge how to advise their family in supporting older people with mental disorder	0.761	0.965
Skills	**Total Cronbach's Alpha of Skills = 0.973**	
26.Having skills in promoting active ageing in older people with mental disorders	0.692	0.965
27.Having skills in assessing and screening older people experiencing mental disorders	0.758	0.965
28.Having skills in basic counselling for older people with mental disorders	0.769	0.965
29.Having skills to care for older people with mental disorders	0.763	0.965
30.Having skills to rehabilitate older people with mental disorders	0.752	0.965
31.Having skills to communicate with older people with mental disorders	0.755	0.965
32.Having skills to communicate with families of older people with mental disorders	0.774	0.965
Resources and support	**Total Cronbach's Alpha of Resources and support = 0.954**	
33.Increasing human resources for promoting active ageing in primary care units	0.558	0.966
34.Improving potential of primary care providers to address mental health in older people	0.587	0.966
35.Increasing budget for supporting older people with mental disorders	0.603	0.966
36.Supporting media and technology to promote active ageing in older people with mental disorders	0.595	0.966
37.Supporting media and technology for caring for older people with mental disorders	0.589	0.966
Total of Cronbach's Alpha	**0.966**	

7.3.6 The perspective of primary care providers regarding promoting active ageing in older people with mental disorders living in the community

Primary care providers indicated they always promoted active ageing in older people with mental disorder living in the community to participate in the cultural activities for *respecting older people in Songkran festival* accounted for 60.1% (n=328). They also promoted this group to join for *making merit* in Thai temples between 'usually' to 'always' and this accounted for 55.7% (n=304). With regards to items of education, school of older people showed the result of 'never promoted' at approximately 59.2% (n=323) whereas health education in primary care units was offered from 'sometimes' to 'always' at about 64.8% (n=354). According to the items regarding health, older people with mental disorders were promoted for exercise from 'often' to 'usually' resulting in around 61.0% (n=333). They were 'always' offered for assessment of physical health and screening health problems with annual health examination, assessment attached to the bed, and assessment of Body Mass Index accounted for 47.4% (n=259), 46.2% (n=252), and 45.2% (n=247) respectively. Moreover, the results from the item related to the assessment of mental health problems, namely depression, suicide risk, and dementia about showed they were always offered, accounting for 42.1% (n=230), 35.5% (n=195), and 35.0% (n=191) respectively. Older people with mental disorders and with a disability were 'always' promoted for home visits a result of approximately 35.3% (n=193) and 40.1% (n=219) respectively.

Results also showed health education for physical health, nutrition for older people with chronic diseases, observe mental health problems, and stress management from 'usually' to 'always' around 65.4% (n=357), 55.7% (n=307), and 56.6% (n=309) respectively. Older people with mental disorders were offered to join in leisure activities in the community with local dancing from 'often'' to usually', a result of 56.8% (n=310) and

outside the community with religion tourism and travel from 'sometimes' to 'usually' accounting for 74.5% (n=407) and 68.9% (n=376) respectively. Furthermore, they were always offered in relation to security with welfare for older people with the monthly living cost at approximately 69.0% (n=377) whereas welfare of community for supporting older people accounted for 39.9% (n=218). The details of this topic present in Table 7-21.

Table 7-21: Promoting active ageing in older people with mental disorders (n=546)

Items	How often do you promote the following activities?				
	Never n(%)	Sometime n(%)	Often n(%)	Usually n(%)	Always n(%)
Participation					
1.Religious activities: Making merit	34(6.2)	87(15.9)	121(22.2)	136(24.9)	168(30.8)
2.Cultural activities: Respect older people in Songkran festival	14(2.6)	36(6.6)	47(8.6)	121(22.2)	328(60.1)
3.Neighbourhood friendship activities:					
3.1 Birthday celebrations	219(40.1)	144(26.4)	92(16.8)	59(10.8)	30(5.5)
3.2 Visit each other in villages	27(4.9)	60(11.0)	152(27.8)	184(33.7)	123(22.5)
3.3 Follow and support postpartum care	57(10.4)	48(8.8)	118(21.6)	158(28.9)	164(30.0)
3.4 Follow and support patients care	23(4.2)	36(6.6)	112(20.5)	180(33.0)	195(35.7)
4.Political activities:					
4.1 National election	93(17.0)	85(15.6)	100(18.3)	116(21.2)	152(27.8)
4.2 Local election	60(11.0)	76(13.9)	113(20.7)	121(22.2)	175(32.1)
5.Senior clubs:					
5.1 Senior associations	35(6.4)	83(15.2)	181(33.2)	145(26.6)	101(18.5)
5.2 Meetings of senior associations	34(6.2)	85(15.6)	178(32.6)	143(26.2)	100(18.3)
6.Thai wisdom activities:					
6.1 Basketry	83(15.2)	131(24.0)	132(24.2)	118(21.6)	80(14.7)
6.2 Weaving	96(17.6)	129(23.6)	142(26.0)	110(20.1)	68(12.5)
6.3 Fortune telling	194(35.5)	151(27.7)	109(20.0)	56(10.3)	34(6.2)
6.4 Thai herbal	80(14.7)	110(20.1)	156(28.6)	123(22.5)	75(13.7)
7.Volunteer activities:					
7.1 Community cleaning	44(8.1)	99(18.1)	171(31.3)	135(24.7)	97(17.8)
7.2 Meal delivery services	89(16.3)	158(28.9)	168(30.8)	95(17.4)	36(6.6)

Table 7-21: Promoting active ageing in older people with mental disorders (n=546)

Items	How often do you promote the following activities?				
	Never n(%)	Sometime n(%)	Often n(%)	Usually n(%)	Always n(%)
Education					
8.School of older people	323(59.2)	80(14.7)	64(11.7)	53(9.7)	26(4.8)
9.Health education in primary care units	192(35.2)	109(20.2)	116(21.2)	86(15.8)	43(7.9)
10.Life skills education:					
10.1 Agriculture	181(33.2)	130(23.8)	135(24.7)	63(11.5)	35(6.4)
10.2 Mushroom cultivation	239(43.8)	128(23.4)	126(23.1)	32(5.9)	17(3.1)
10.3 Sewing	219(40.1)	138(25.3)	112(20.5)	47(8.6)	26(4.8)
10.4 Healthy cooking	180(33.0)	129(23.6)	147(26.9)	68(12.5)	19(3.5)
10.5 Woven mats	187(34.2)	117(21.4)	120(22.0)	71(13.0)	46(8.4)
Health					
11.Promotion of physical health activities:					
Exercise	22(4.0)	99(18.1)	173(31.7)	160(29.3)	92(16.8)
12.Assessment of physical health and screening health problems:	18(3.3)	37(6.8)	87(15.9)	145(26.6)	259(47.4)
12.1 Annual health examination					
12.2 Assessment attached to the Bed	23(4.2)	26(4.8)	87(15.9)	158(28.9)	252(46.2)
12.3 Assessment of Body Mass Index	18(3.3)	32(5.9)	89(16.3)	160(29.3)	247(45.2)
13.Assessment of mental health problems:					
13.1 Depression	22(4.0)	30(5.5)	100(18.3)	164(30.0)	230(42.1)
13.2 Suicide risk	47(8.6)	37(6.8)	103(18.9)	165(30.2)	194(35.5)
13.3 Dementia	42(7.7)	52(9.5)	105(19.2)	156(28.6)	191(35.0)
14.Home visits:					
14.1 Older people with mental disorders	25(4.6)	47(8.6)	102(18.7)	179(32.8)	193(35.3)
14.2 Older people with disability	23(4.2)	41(7.5)	100(18.3)	163(29.9)	219(40.1)
15.Health education for physical health:					
Nutrition for older people with chronic diseases	21(3.8)	49(9.0)	119(21.8)	190(34.8)	167(30.6)
16.Health education for mental health:					
16.1 Observe mental health Problems	30(5.5)	65(11.9)	147(26.9)	167(30.6)	137(25.1)
16.2 Stress management	28(5.1)	65(11.9)	144(26.4)	180(33.0)	129(23.6)

Table 7-21: Promoting active ageing in older people with mental disorders (n=546)

Items	How often do you promote the following activities?				
	Never n(%)	Sometime n(%)	Often n(%)	Usually n(%)	Always n(%)
17.Health education for family of older people in physical health promotion:					
17.1 Nutrition	20(3.7)	59(10.8)	139(25.5)	197(36.1)	130(23.8)
17.2 Medication administration	18(3.3)	50(9.2)	121(22.2)	203(37.2)	154(28.2)
18.Health education for family of older people in mental health promotion:					
18.1 Respectful of older people	23(4.2)	57(10.4)	115(21.1)	203(37.2)	148(27.1)
19.Promotion activities for improving family relationship:					
19.1 Family therapy	90(16.5)	130(23.8)	151(27.7)	122(22.3)	53(9.7)
19.2 Family counselling	59(10.8)	104(19.0)	151(27.7)	149(27.3)	83(15.2)
20.Teeth health activities:					
20.1 Teeth examination	22(4.0)	48(8.8)	117(21.4)	178(32.6)	181(33.2)
20.2 Education on oral hygiene	21(3.8)	45(8.2)	121(22.2)	175(32.1)	184(33.7)
Leisure					
21.Recreation activities in the community:					
Local dancing	60(11.0)	83(15.2)	160(29.3)	150(27.5)	93(17.0)
22.Recreation activities outside the community:					
22.1 Religion tourism in another City	94(17.2)	130(23.8)	161(29.5)	116(21.2)	45(8.2)
22.2 Travel in another city	142(26.0)	167(30.6)	133(24.4)	76(13.9)	28(5.1)
23.Promotion of suitable recreation activities:					
23.1 Reading books	81(14.8)	151(27.7)	168(30.8)	104(19.0)	42(7.7)
23.2 Caring for animals	85(15.6)	131(24.0)	175(32.1)	112(20.5)	43(7.9)
23.3 Planting trees	66(12.1)	130(23.8)	167(30.6)	130(23.8)	53(9.7)
Security					
24.Welfare for older people:					
24.1 Monthly living cost,	31(5.7)	26(4.8)	36(6.6)	76(13.9)	377(69.0)
24.2 Welfare of community for supporting older people	55(10.1)	54(9.9)	98(17.9)	121(22.2)	218(39.9)
25.Suggestion for saving money	164(30.0)	109(20.0)	118(21.6)	87(15.9)	62(11.4)

Table 7-21: Promoting active ageing in older people with mental disorders (n=546)

Items	How often do you promote the following activities?				
	Never n(%)	Sometime n(%)	Often n(%)	Usually n(%)	Always n(%)
26.Promotion activities for supporting income of older people: Selling produce from older people (trees, vegetables, basketwork)	88(16.1)	113(20.7)	168(30.8)	108(19.8)	68(12.5)
27.Health education for living safety: Healthy environments suitable for older people and older people living with diseases	94(17.2)	66(12.1)	132(24.2)	145(26.6)	102(18.7)
28.Activities for improving health environment for older people living safety: Destroying breeding mosquitoes	22(4.0)	31(5.7)	87(15.9)	166(30.4)	239(43.8)

7.3.7 The perspectives of primary care providers regarding factors that influence the promotion of active ageing in older people with mental disorders living in the community

Primary care providers indicated that '*having co-operation from families', 'older people with mental disorders', 'having a national' and 'a health service policies for older people with mental disorders'* were facilitator factors that influence the promotion of active ageing in this group accounted for 84.6% (n=462), 83.1% (n=454), 81.1% (n=443), and 80.9% (n=442) respectively. They also reported that a high workload in the job, the job description being unclear, and lack knowledge in the mental health problems of older people, are the three most important barriers preventing the promotion of active ageing in this group resulting in approximately 86.6% (n=473), 78.6% (n=429) and 78.5% (n=428) respectively. Factors of knowledge in terms of mental health illnesses found that ''*how to care for older people with mental disorders*', '*how to assess and screen older*

people with mental disorders', and '*common mental health problems in older people*' affected the promotion of active ageing in older people with mental disorder with results of about 79.3% (n=433), 77.8%(n=425), and 77.3% (n=422).

Primary care providers also rated that communicate with families, basic counselling, and assessing and screening older people with mental disorders, were the most important skills for promoting active ageing in this group with the result of about 75.8% (n=414), 73.8% (n=403), and 73.7% (n=403) respectively. They also believed that improving the potential of primary care providers to address mental health in older people, increasing the budget for supporting older people with mental disorders, and supporting media and technology to promote active ageing in older people with mental disorders were the most important resources and support for promoting active ageing in this group with the responses of around 84.3% (n=460), 84.0% (n=459), and 83.3% (n=455). The table 7-22 shown information of this frequency.

Table 7-22: Factors that influence the promotion of active ageing in older people with mental disorders living in the community (n=546)

Items	Score				
	Strongly disagree n(%)	Disagree n(%)	Moderately agree n(%)	Agree n(%)	Strongly agree n(%)
Facilitators					
1.Having a national policy for older people with mental disorders	41(7.5)	62(11.4)	165(30.2)	161(29.5)	117(21.4)
2.Having a health service policy for older people with mental disorders	39(7.1)	65(11.9)	177(32.4)	149(27.3)	116(21.2)
3.Having been taught or on the job training from mental health services	53(9.7)	96(17.6)	188(34.4)	129(23.6)	80(14.7)
4.Having supervision from mental health services	47(8.6)	72(13.2)	187(34.2)	163(29.9)	77(14.1)
5.Having a counselling system of care from mental health services	39(7.1)	78(14.3)	170(31.1)	162(29.7)	97(17.8)
6.Having collaboration with other government services, such as local government, police, schools	30(5.5)	81(14.8)	188(34.4)	155(28.4)	92(16.8)
7.Having co-operation with older people with mental disorders	27(4.9)	65(11.9)	199(36.4)	158(28.9)	97(17.8)
8.Having cooperation from families of older people with mental disorders	23(4.2)	61(11.2)	182(33.3)	175(32.1)	105(19.2)
Barriers					
9.The policy for mental disorders in older people does not cover all diseases	42(7.7)	90(16.5)	233(42.7)	131(24.0)	50(9.2)
10.The job description of primary care providers for promoting active ageing in older people with mental disorders is not clear.	32(5.9)	85(15.6)	213(39.0)	166(30.4)	50(9.2)

Table 7-22: Factors that influence the promotion of active ageing in older people with mental disorders living in the community (n=546)

Items	Score Strongly disagree n(%)	Disagree n(%)	Moderately agree n(%)	Agree n(%)	Strongly agree n(%)
11.Health policy gives priority to physical health care rather than mental health	39(7.1)	80(14.7)	199(36.4)	156(28.6)	72(13.2)
12.There is a high workload in primary care units	20(3.7)	53(9.7)	146(26.7)	142(26.0)	185(33.9)
13.Mental health illnesses are stigmatised in Thai culture	41(7.5)	98(17.9)	215(39.4)	126(23.1)	64(11.7)
14.There is a lack of cooperation from older people with mental disorders	30(5.5)	113(20.7)	215(39.4)	129(23.6)	59(10.8)
15.There is a lack of cooperation from families of older people with mental disorders	36(6.6)	104(19.0)	208(38.1)	137(25.1)	61(11.2)
16.There is a lack of knowledge about how to promote active ageing in older people with mental disorders	30(5.5)	97(17.8)	191(35.0)	151(27.7)	77(14.1)
17.There is a lack of knowledge and insight into mental health problem of older people	36(6.6)	82(15.0)	209(38.3)	151(27.7)	68(12.5)
Knowledge					
18. Knowledge the principles for promoting active ageing in older people with mental disorders	54(9.9)	99(18.1)	205(37.5)	149(27.3)	39(7.1)

Table 7-22: Factors that influence the promotion of active ageing in older people with mental disorders living in the community (n=546)

Items	Score				
	Strongly disagree n(%)	Disagree n(%)	Moderately agree n(%)	Agree n(%)	Strongly agree n(%)
19. Knowledge how to assess and screen older people with mental disorders	27(4.9)	94(17.2)	222(40.7)	152(27.8)	51(9.3)
20. Knowledge how to care for older people with mental disorders	30(5.5)	83(15.2)	219(40.1)	170(31.1)	44(8.1)
21. Knowledge how to rehabilitate older people with mental disorders	32(5.9)	112(20.5)	219(40.1)	147(26.9)	36(6.6)
22. Knowledge how to manage psychiatric medication and potential side effects	35(6.4)	116(21.2)	213(39.0)	150(27.5)	32(5.9)
23. Knowledge common mental health problems in older people	32(5.9)	92(16.8)	233(42.7)	156(28.6)	33(6.0)
24. Knowledge symptoms and severity of mental disorders in older people	38(7.0)	89(16.3)	242(44.3)	144(26.4)	33(6.0)
25. Knowledge how to advise their family in supporting older people with mental disorder	32(5.9)	101(18.5)	232(42.5)	142(26.0)	39(7.1)
Skills					
26. Having skills in promoting active ageing in older people with mental disorders	50(9.2)	135(24.7)	199(36.4)	127(23.3)	35(6.4)
27. Having skills in assessing and screening older people experiencing mental disorders	35(6.4)	108(19.8)	205(37.5)	158(28.9)	40(7.3)

Table 7-22: Factors that influence the promotion of active ageing in older people with mental disorders living in the community (n=546)

Items	Score				
	Strongly disagree n(%)	Disagree n(%)	Moderately agree n(%)	Agree n(%)	Strongly agree n(%)
28. Having skills in basic counselling for older people with mental disorders	35(6.4)	108(19.8)	213(39.0)	144(26.4)	46(8.4)
29. Having skills to care for older people with mental disorders	33(6.0)	113(20.7)	213(39.0)	140(25.6)	47(8.6)
30. Having skills to rehabilitate older people with mental disorders	42(7.7)	118(21.6)	212(38.8)	133(24.4)	41(7.5)
31. Having skills to communicate with older people with mental disorders	41(7.5)	110(20.1)	210(38.5)	138(25.3)	47(8.6)
32. Having skills to communicate with families of older people with mental disorders	38(7.0)	94(17.2)	218(39.9)	144(26.4)	52(9.5)
Resources and support					
33. Increasing human resources for promoting active ageing in primary care units	36(6.6)	61(11.2)	128(23.4)	161(29.5)	160(29.3)
34. Improving potential of primary care providers to address mental health in older people	22(4.0)	64(11.7)	112(20.5)	174(31.9)	174(31.9)
35. Increasing the budget for supporting older people with mental disorders	20(3.7)	67(12.3)	111(20.3)	160(29.3)	188(34.4)
36. Supporting media and technology to promote active ageing in older people with mental disorders	23(4.2)	68(12.5)	133(24.4)	146(26.7)	176(32.2)
37. Supporting media and technology for caring for older people with mental disorders	30(5.5)	67(12.3)	130(23.8)	152(27.8)	167(30.6)

7.4 DISCUSSION

The purpose of phase-two step-two of this PhD research was to test the psychometric properties of the new survey instrument; the PAA-MD, by seeking feedback from the large sample of 546 participants.

Section I of the PAA-MD was used to evaluate familiarity with the concept of active ageing and related concepts, including characteristics, work, and training experience of participants. The findings showed that the majority of primary care providers, greater than 90%, indicated being unfamiliar with the concept of active ageing. More than half indicated a greater understanding of the concept of healthy ageing. This may be because the concept of healthy ageing has had a focus at the community level from the Ministry of Public Health in Thailand (Thailand. Department of Health Service Support, 2010) and has been implemented into the health system of Thailand, in particular at the primary care level (Thailand. Department of Health Service Support, 2010). The results from this PhD research also indicated that primary care providers were less likely to be trained in relation to caring for older people, particularly those older people with mental disorders. The Department of Mental Health (DMH), which is one of the organisation in Ministry of Public Health, has trained primary care staff in terms of mental health care for many years and refresher training is undertaken every year (World Health Organization & Ministry of Public Health Thailand, 2006). However, it does not focus on how to support primary care providers who care for older people with mental disorders. The findings from this current research raises important issues for the DMH with regard to training for primary care staff. They should focus on how to enhance the skills of staff in primary care to care for older people with mental disorders and make these available to all primary care workers based on their education and roles.

Section II of the PAA-MD was created to measure the level of promoting active ageing in older people living in the Thai community and consists 54 items. It was tested for psychometric properties to evaluate construct validity and internal consistency reliability. The construct validity indicated eight components, and these were analysed by means of exploratory factor analysis. However, some items found a high factor loading on more than one component after using a rotation method, Varimax with Kaiser Normalization. According to Hair et al. (2014), variables, where the cross-loading presents relatively high loadings on more than one factor, are usually removed unless theoretically justified or, the objective is strictly data reduction. Therefore, this section of the PAA-MD used theoretical justification from the literature as well as the concept of active ageing from the WHO to merge or group items into five factors or components, namely; participation, education, health, leisure, and security (Lin et al., 2013; WHO, 2002). Then, each factor was re-analysed to examine an item-factor loading. Section II of the PAA-MD illustrated that two items; *neighbourhood friendship activities in terms of birthday celebrations*, and *health education in primary care units*, achieved a community score of less than 0.50, and only *birthday celebrations* were found to have an item-factor loading of less than 0.40. Only the item of *birthday celebrations* in section II of the PAA-MD was removed because it had a factor loading less than 0.4 and did not meet the criteria for retaining nor was it highlighted by experts in the field as appropriate (Hair et al., 2014). This is reported in Chapter three. This item was selected from a previous study from Taiwan (Lin et al., 2013). It may be representative of the difference in culture between Taiwan and Thailand and in particular of Thai older people living in rural communities. Moreover, section II of PAA-MD indicated internal consistency reliability by using Cronbach's Alpha which was found to be greater than 0.7. The overall items and each factor were at an acceptable value for a new instrument (DeVillis, 2012; Hair et al., 2014). In addition, the corrected

item-total correlation coefficient of all items was greater than 0.30 showing an acceptable value for a new instrument (DeVillis, 2012; Hair et al., 2014). To summarise, the total items of section II in the PAA-MD comprised 53 items after testing of psychometric properties from the large sample.

Section III of the PAA-MD was designed to identify factors that influence the promotion of active ageing in older people with mental disorders living in the Thai community. This section consisted of 37 items that could be divided into five factors; facilitators, barriers, knowledge, skills, and resource and support which emerged from the findings of focus group discussion in the phase one and a previous study (Wilhelmsson & Lindberg, 2009). The construct validity of this section illustrated five factors as reported in results of this Chapter. Therefore, the items of this section were merged or grouped into five factors as mentioned earlier. As mentioned in the results section, the items in the factors of 'knowledge' and 'skills', 18 to 32, could be summarised together because of the results of the rotated factor loading, ranging from 0.734-0.880, and because the meaning of the items was quite similar. Furthermore, the community score of all items was greater than 0.50 which indicated an acceptable level for a new instrument (Hair et al., 2014). Additionally, the internal consistency reliability of overall items and each factor interpreted using Cronbach's Alpha were greater than 0.70, again, an acceptable level for a new instrument (DeVillis, 2012; Nunnally & Bernstein, 1994). The corrected item-total correlation coefficient of all items was also greater than 0.30 indicating an acceptable value for a new instrument (DeVillis, 2012; Hair et al., 2014). Briefly, section III of the PAA-MD could be a total of 37 or 32 items if items from 18 to 32 were grouped together and condensed into ten (10) items after testing psychometric properties from the large sample.

The results from analysis of the participant's responses presented the perspective of primary care providers in relation to the promotion of active ageing in older people with mental disorders living in the community. The participants pointed out that the most frequent activity for promoting active ageing in this group were cultural activities by *respect older people in Songkran festival* and religious activities by *making merit* in the Thai temples. These findings showed a similar perspective to Thai older persons in relation to understanding active ageing (Thanakwang, Isaramalai, & Hattakit, 2014). Thai older people pointed out that participation in the society, making spirituality, and maintaining a healthy lifestyle, including managing later life security, were identified as active ageing in their opinion (Thanakwang, Isaramalai, & Hattakit, 2014).

Generally, primary care workers promoted active ageing in this group and focused on a component of health rather than the other factors of participation, leisure, and security. For example, they promoted *physical health with exercise activities*, *assessment of physical health and screening health problems*, and *assessment of mental health problems* including *home visits of older people with mental health.* These may imply that they provided health promotion activities based on their main responsibility from the government such as health promotion, disease prevention, cure and care (Thailand. Ministry of Public Health, 2011).

Analysis of participants' responses also demonstrated the perspective of primary care providers regarding factors that influence the promotion of active ageing in this group. The participants mentioned that *high heavy workloads in primary care settings, the lack of clarity regarding their job role and promotion of active ageing, and a lack of knowledge and insight into mental health problems of older people* were important barriers for them. These results were similar to the findings of other studies (Grundberg

et al., 2016; Haddad et al., 2005; Lester et al., 2005). The primary care staff felt they lacked sufficient skills and knowledge to care people with severe mental illnesses or older people with co-morbidities and mental health problems (Grundberg et al., 2016; Haddad et al., 2005). Health policy should support the education of primary care providers to enhance skills regarding mental health (Haddad et al., 2005; Lester et al., 2005). The results also reported that *having cooperation from older people with mental disorders and their family* could help the primary care workers to ensure successful promotion of active ageing in this group. Therefore, older people with mental disorders and their family are key informants to increase the level of promoting active ageing in the Thai community. These findings were quite similar to a previous study from Taiwan, which found the perspectives of older people were important factors in terms of promoting active ageing activities in the community (Lin et al., 2013). For instance, inconvenient transportation and lack of a partner with whom to attend the activities with were preventing them from participating in active ageing activities in the Taiwan community study (Lin et al., 2013).

7.5 STRENGTHS AND LIMITATIONS

The phase-two step-two of this PhD research showed several strengths including that the sample size was higher than a recommendation for testing psychometric properties of a new instrument as suggestions by DeVellis (2003); Nunnally and Bernstein (1994), who suggest a minimum of five to ten samples per item or greater than 300 subjects. The sample size of this phase was 546 participants, which is considerably greater than the 300 subjects recommended to make a good estimation of the final sample needed for testing psychometric properties of a new instrument (DeVillis, 2012). Furthermore, the Kaiser-Meyer-Olkin (KMO) value both section II and III of PAA-MD indicated that the sample was adequate to analysis with exploratory factor analysis (Hair et al., 2014).

Only 5.7% of participants did not respond to the survey which means the response rate was 94.3%. The response rate of this study is quite similar to a previous study, which evaluated the psychometric properties of a competency scale for primary care managers in Thailand, which had a 96.95% return rate (Kitreerawutiwong, Sriruecha, & Laohasiriwong, 2015). However, the response rate of this research was higher than the large mail based national cohort study in Thailand which reported only a 71.3 percent of 87,134 participants (Seubsman et al., 2011).

It should be noted that this current cross-sectional survey recruited 579 primary care staff and was provided with administrative support for the distribution, follow-up, and pick-up of the PAA-MD from staff of the health province. This may have helped the study to achieve a high response rate. This phase also found that 9.89 % of completed surveys included a missing score on at least one item. According to the criteria proposed by Hair et al. (2014), missing data of less than 10 % for an individual case or observation can usually be ignored. Therefore, the cases containing missing data were not deleted during the data analysis process of this study.

7.6 SUMMARY

This study provides the results from testing of the psychometric properties of a new survey instrument used to measure the promotion of active ageing in older people with mental disorders living in the Thai community and identify factors that influence the promotion of active ageing in this group. The PAA-MD may be used in primary care to assess health promotion activities directed at active ageing in older people with mental disorders living in rural communities and to examine the factors that influence the promotion of active ageing in this group. The findings from participant responses of the

PAA-MD should also inform the development of strategies to prepare and support primary care providers for promoting active ageing in this group.

The next chapter provides an overall summary of the study, discussion, implications, recommendations for future research, strengths and limitations, and conclusion of this PhD research.

CHAPTER 8: DISCUSSION AND CONCLUSION

8.1 INTRODUCTION

In the previous Chapters five, six, and seven the findings, discussion, strengths and limitations from the FG interviews, the developing and pilot testing of the PAA-MD and testing psychometric properties of the PAA-MD from the large sample were reported.

This chapter, Chapter eight, provides a summary of the study, discussion of the overall research, implications, and recommendations for future research. Strengths and limitations of the study and a conclusion are also reported.

8.2. SUMMARY OF THE STUDY

As reported in Chapter one and two, promoting active ageing in older people with mental disorders is still not evident in practice, particularly for those who live in the community. Most importantly, there have been no attempts to develop an instrument for measuring the promotion of active ageing among older people with mental disorders living in the community, or the influencing factors in this group.

As described in the introduction to this PhD research, the main aims of this thesis were to develop and test a new survey instrument designed to: a) measure the promotion of active ageing in older people with mental disorders living in the community of Thailand, and b) identify factors that influence the promotion of active ageing in this group.

8.2.1 The objectives were:

1. To explore how primary care providers understand the concept of active ageing.
2. To explore how primary care providers use/apply the concept of active ageing.

3. To examine the perspectives of primary care providers regarding the promotion of active ageing.

4. To identify the perspectives of primary care providers regarding factors that influence the promotion of active ageing.

5. To develop an instrument for measuring the promotion of active ageing and identifying factors that influence the promotion of active ageing.

6. To psychometrically test an instrument for measuring the promotion of active ageing and identifying factors that influence promotion active ageing in this group.

8.2.2 The research questions were:

1. What are the perspectives of primary care providers about promoting active ageing in older people with mental disorders living in a Thai community?

1.1 What do they understand the concept 'active ageing'?

1.2 How do they use/apply the concept of active ageing?

1.3 What is the promotion of active ageing in this group?

1.4 What are the factors that influence the promotion of active ageing in this group?

2. What are the main components of an instrument designed to measure the promotion of active ageing in older people with mental disorders living in a Thai community and that identifies factors that influence the promotion of active ageing in this group?

3. What are the psychometric properties of the new survey instrument?

3.1 What is the content validity?

3.2 What is the face validity?

3.3 What are the internal and external reliability?

3.4 What is the construct validity?

8.2.3 Mixed methodology design approach

This study reported here was divided into two main phases.

8.2.3.1 Phase one: FG interviews with primary care providers

A qualitative descriptive study used focus group methods to explore the perspective of primary care providers about promoting active ageing in older people living in the Thai community and identifying factors that influence the promotion of active ageing in this group. Fourteen participants are working at two primary care units in Detudom District, Ubonratchathani Province, were recruited into focus groups that lasted approximately an hour per group. A directed content analysis of the interview data revealed three main categories: unfamiliarity with the concept of active ageing, promotion activities in communities, and factors that influence the promotion of active ageing. Briefly, the results showed the majority of primary care staff were unfamiliar with the term of active ageing. While most used some aspects of active ageing such as participation, health, education or security, these did not cover all components of the WHO model of active ageing. The findings of this phase helped to develop an initial draft of a new instrument, calls “Promoting Active Ageing in Older People with Mental Disorders Scale” (PAA-MD) reported in detail in Chapter four: research design, plan, and methods including Chapter five: focus group interviews and findings.

8.2.3.2 Phase two: a quantitative design approach as described in Chapters four, six and seven was divided into two steps as follows:

1. The phase-two step-one

This phase involved the development and pilot testing of the instrument, “Promoting Active Ageing in Older People with Mental Disorders Scale” (PAA-MD) which was described in depth in Chapters four and six. This step comprised of four processes,

namely, item generation, content validity testing, assessing face validity, and pilot testing the instrument.

1. Item-generation

The PAA-MD was developed based on the Thai language. The resources used to help create the PAA-MD were the findings of the focus group interviews in phase one, previous studies found during the literature review, and the WHO model of active ageing. The PAA-MD was separated into three sections. Section one comprising of demographic data, working experience, and familiarity with the concept of active ageing. Section two comprising of measuring promoting active ageing in older people with mental disorders living in the community. Finally, section three identifies factors that influence the promotion of active ageing in older people with mental disorders living in the community. Section two and three of the PAA-MD used the five-point Likert scale to rate responses from opinions of primary care providers.

2. Testing content validity

The content validity of the PAA-MD was tested with nine experts who are specialists relevant to the study, namely, two psychiatric nurses, two psychiatrists, a community nurse, a gerontological nurse, a geriatric physician, an expert in linguistics and culture, and one expert in instrument development with a focus on ageing. However, only seven experts replied to an initial draft of the PAA-MD. They were asked to rate the relevance of each item in section two and three of the PAA-MD and to assess the clarity and conciseness of the close-ended items in section one of the PAA-MD. They were also invited to make recommendations in the wording for any items that were thought likely to be ambiguous, unclear, or inappropriate. The PAA-MD was revised after this process based on the content validity index and suggestions from the experts.

3. Assessing face validity

The face validity of the PAA-MD was evaluated with ten primary care providers who work in a primary care unit of Muang District, Ubonratchathani Province. They were asked to assess the PAA-MD regarding wording for any item that was ambiguous, unclear, or inappropriate. They were also asked to give feedback about the response sets of the PAA-MD. Furthermore, five older people with mental disorders, such as anxiety disorder or depressive disorder that were otherwise stable health wise and with good cognition, were invited to comment on any item that was difficult to understand and/or suggests additional activities that promote active ageing in their community. Following this feedback, the PAA-MD wording was changed, and more examples of activities that promote active ageing in older people with mental disorders living in the community were added.

4. Pilot testing

The internal consistency reliability of the PAA-MD was tested with forty primary care staff working in primary care units in Muang, Warinchamraph, and Khemarath districts in Ubonratchathani Province. The participants were different persons from those who were recruited in phase one of the qualitative descriptive study and those used in assessing face validity. The PAA-MD was also evaluated for external reliability, or stability over time, two weeks later using the same participants. However, only 32 participants responded to the pilot testing request for the second time to test external reliability or stability over time.

Section one of the PAA-MD was used to collect demographic data of the participants and examine familiarity with the concept of active ageing and related concepts, was not changed following the pilot testing of this section.

Section two of the PAA-MD was considered sufficient regarding overall internal consistency reliability as reported in Chapter six. Nevertheless, three items had corrected item-total correlation of less than the acceptable level of less than 0.3 (Ferketich, 1991; Nunnally & Bernstein, 1994). They were therefore removed from this part of the PAA-MD. The external reliability or stability over time of the PAA-MD in both the overall items of section two and each component, namely, participation, education, health, leisure, and security, indicated a strong relationship with a coefficient value between 0.8 to 1 as described in Chapter three and four. These results imply that section two of the PAA-MD is stable over time.

Testing of section three in the PAA-MD indicated that internal consistency reliability of the overall items and each component, namely, facilitators, knowledge, skills, and resources and support were at an excellent level of acceptance ($\alpha > 0.90$). The component of barriers was at a good level ($\alpha > 0.80$) (George & Mallery, 2000). Therefore, this section of the PAA-MD demonstrated an acceptable level of internal reliability. Only one item: 'some belief of health behaviour in older people in our communities is not appropriate', showed that corrected item-total correlation was at a less than an acceptable level by using criteria definition from Ferketich (1991) and Nunnally and Bernstein (1994). It was removed from section three of the PAA-MD. The external reliability or stability over time from 32 participants in section three of the PAA-MD indicated strong correlation both of the overall section and each factor: facilitators, barriers, knowledge, skills, resources and support. These findings indicate that the results from this section of the PAA-MD are stable over time.

2. Phase-two step-two

This phase used the cross-sectional survey design to test the psychometric properties of the PAA-MD by all primary care staff in Yasothon Province, Thailand which was a

different setting from the previous phase and this was reported in Chapter four, and seven. The cross-sectional survey also assisted in generating large amounts of information to examine the perspective of primary care providers regarding the promotion of active ageing in older people with mental disorders living in the community and factors that influence the promotion of active ageing in this group. The PAA-MD was distributed to 579 participants and 546 respondents, or approximately 94.3 percent, replied. The psychometric properties were evaluated using exploratory factor analysis for testing construct validity, and Cronbach's Alpha coefficient to examine internal consistency reliability. Only section two and three could be tested for the psychometric properties because they are continuous variables. Section one was analysed with frequency and percentages.

The entire 54 items in section two of the PAA-MD were created to measure the promotion of active ageing in older people with mental disorders living in the community. This section was divided into five factors, namely, participation, education, health, leisure, and security as described in Chapters six and seven. Testing showed that two items; '*neighbourhood friendship activities'* in terms of birthday celebrations, and *'health education' in primary care units*, achieved a community score of less than 0.50, and only 'birthday celebrations' was found to have an item-factor loading of less than 0.40. After re-analysis in the factor of participation, only the item of 'birthday celebration' in section two of the PAA-MD was removed because it had a factor loading of less than 0.4. The internal consistency reliability by using Cronbach's Alpha in this section was found to be greater than 0.7 both for the overall items and for each factor, which is an acceptable value for a new instrument (DeVillis, 2012; Hair et al., 2014). In addition, the corrected item-total correlation coefficient of all items was greater than 0.30 - again an acceptable

value for a new instrument (DeVillis, 2012; Hair et al., 2014). To summarise, the total items of section two in the PAA-MD comprised 53 items.

The 37 items in section three of the PAA-MD were designed to identify factors that influence the promotion of active ageing in older people with mental disorders living in the community. This section was divided into five factors, namely, facilitators, barriers, knowledge, skills, and resource and support, as reported in Chapters six and seven. The items in the factor of 'knowledge and skills', (18 to 32 items) could be summarised together because of the rotated factor loading, ranging from 0.734-0.880, and the meaning of the items was quite similar. Furthermore, the community score of all items in this section was greater than 0.50 which indicated an acceptable level for a new instrument (Hair et al., 2014). Additionally, the internal consistency reliability of overall items and each factor interpreted using Cronbach's Alpha were greater than 0.70, an acceptable level for a new instrument (DeVillis, 2012; Nunnally & Bernstein, 1994). The corrected item-total correlation coefficient of all items was also greater than 0.30 indicating an acceptable value for a new instrument (DeVillis, 2012; Hair et al., 2014). To conclude, section three of the PAA-MD could be a total of 37 items, or 32 items if the items from 18 to 32 were grouped and condensed into ten items.

The findings of the cross-sectional study indicated that the majority of primary care staff were unfamiliar with the concept of active ageing. In addition, the perspectives of primary care providers regarding the promotion of active ageing in older people with mental disorders living in the community showed that the item; - *the respect older people in Songkran festival,* - was the most frequent activity in this group. The second most frequent activity was; *followed by visit each other in villages* and *follow and support patients care*. '*Making merit'* in the Thai temples, a Buddhist religious activity, was also an important

component to promoting active ageing in this group. They promoted *physical health with exercise activities*, *assessment of physical health and screening health problems*, and *assessment of mental health problems* including *home visits for older people with mental health*. Generally, primary care workers promoted active ageing in older people with mental disorders living in the community. However, they focused mainly on components of health, rather than other factors such as participation, leisure, and security.

In relation to the perspectives of primary care providers regarding factors that influence the promotion of active ageing in this group; they complained that heavy workloads in primary care settings and the job description regarding the promotion of active ageing, were the important barriers. They also pointed out that lack of knowledge and insight into the mental health problems of older people was a barrier to working in primary care. The most crucial facilitators for promoting active ageing in this group were cooperation from older people with mental disorders and their family. Moreover, the results showed that resources and support are vital factors that influence the promotion of active ageing in this group and that Thai health policy should recognise this and provide media and technology support for mental health, increase human resources, and increase the budget for primary care settings.

8.3 DISCUSSION

This PhD research examined the factor structure and psychometric properties from a large sample of 546 participants and the pilot testing by 40 primary care providers of a new instrument. The results strongly suggest that the new instrument, the PAA-MD, is a validated self-reporting scale for measuring the level of promoting active ageing in older people living in a Thai community and for identifying factors that influence the promotion of active ageing in this group. The description of the factors and definition of promoting

active ageing was systematically developed for the specific context of the study and translated in measurable terms to create the new instrument. The factors measured by this instrument are similar to those found in a previous study by (Lin et al., 2013), namely, participation, education, health, leisure, and security as well as the components based on WHO's active ageing model, namely, participation, health, security (WHO, 2002). In addition, the components/factors that influence the promotion of active ageing in older people living in the community are similar to a previous study that examines district nurses' perspectives regarding facilitators and barriers in working for health promotion such as knowledge of health providers, guideline, resources and support (Wilhelmsson & Lindberg, 2009). However, the items of each factor were developed based on the finding of focus groups interview from phase one of this PhD research and literature review of previous studies (Chansarn, 2012; Nantsupawat et al., 2010; Thailand. Department of Mental Health, 2015a; Thanakwang, Isaramalai, & Hattakit, 2014)

Content validity illustrated congruence between factor structure and the data collection tool (Polit & Beck, 2006). The findings of item validation in both section two and section three of the PAA-MD from seven experts relevant to the study showed that the value of content validity index for individual items (I-CVI) is greater than 0.78. Therefore they were retained in the new instrument. The content validity index for the overall survey (S-CVI) of the new instrument was higher than 0.80 showing acceptable standards of S-CVI (Polit & Beck, 2006). Furthermore, the PAA-MD was refined following the expert's recommendations and then it was sent to the experts again for their input and agreement before assessment of face validity. They agreed with the revisions of PAA-MD and there was no need for further revision following feedback from the five experts at this stage.

Face validity of the new instrument showed suitable words and phrases according to the evaluation from the primary care providers who responded to the tool testing. The measuring also tested face validity of the instrument in older people with mental disorders, who are one of the stakeholders of primary care staff. These processes help improve how the items of a new instrument appear to respondents and others, as suggested by Cohen et al. (2013) and Thomas et al. (1992).

Internal consistency reliability from both pilot testing of 40 staff and the large sample of 546 staff, showed Cronbach's alpha and item-total correlation of the PAA-MD for both section two and three was a good homogeneity. The ranking of each factor of Cronbach's alpha in the PAA-MD was 0.820 to 0.973 showed that the items in each factor are adequate samples of content in each component (Nunnally & Bernstein, 1994). Item-total correlation coefficient ranged from 0.332 to 0.774, which was considered acceptable because items in each factor were associated with each other (Tavakol & Dennick, 2011) and did not present redundancy (Streiner, Norman, & Cairney, 2008).

External reliability, or stability over time, of the PAA-MD from 32 respondents in both section two and three indicated a strong relationship both for the overall section and in each factor individually with Spearman's Correlation Coefficient between 0.8 to 1, as suggested by Smarandache (2008). These findings implied that section two and three of the PAA-MD are stable over time or that external reliability is strong.

Construct validity in section two of the PAA-MD using exploratory factor analysis, indicated eight factors, which extracted with 68.781% of the total percentage of variance. Whereas section three of the PAA-MD shown five factors extracting 76.732%, which showed the percentage of variance was adequate in capturing the main feature of the phenomenon (Pett, Lackey, & Sullivan, 2003). However, the items of section two were

grouped into five factors by using the findings from a previous study (Lin et al., 2013), as well as theoretically justified based on the concept of active ageing from the WHO's model (WHO, 2002). The number in each factor for both section two and three of the PAA-MD ranged from five to 19 items, which demonstrated that each factor should be at least three items (Hair et al., 2014).

The findings of this PhD research identified important barriers that influence the promotion of active ageing in older people with mental disorders living in the community of Thailand. Primary care workers lacked knowledge and skills in relation to mental illnesses. The current health policy from the Ministry of Public Health mainly focused on physical health rather than mental health problems. In Thailand, the top three common mental health problems of older Thai persons were: anxiety disorder, depression, and insomnia (Thailand. Department of Mental Health, 2015c). Older people with anxiety, depression disorders, or similar issues are usually treated by general practitioners who are trained by psychiatrists from Department of Mental Health, Ministry of Public Health (Thailand. Department of Mental Health, 2015c). They are also cared by nurses who are trained by psychiatric nurses from Department of Mental Health, Ministry of Public Health(Thailand. Department of Mental Health, 2015c). However, many primary health providers lack the understanding and skills necessary to support older people with mental health problems (Thailand. Department of Mental Health, 2015c). These findings were also similar to a previous study, which found district nurses could not detect mental health problem early and were not promoting care for mental health in older people with multiple health conditions living in the community (Grundberg et al., 2016). A previous study also reported that most of the primary care staff felt that the care of people with severe mental illnesses was too specialised for routine primary care (Lester et al., 2005). Lack of

sufficient skills and knowledge in terms of severe mental disorders were also barriers in managing older people with mental health problems (Lester et al., 2005).

The literature also stated that patients with mental disorders preferred to consult primary care staff rather than health professionals who are specialists in mental health (Lester et al., 2005). Department of Mental Health, Ministry of Public Health, Thailand should urgently consider how to address the barriers of promoting active ageing in older people with mental disorders living in a Thai community. Primary care providers need to develop an understanding of the mental health issues of older people. Health policy needs to promote education and training for the development of specialist skills and knowledge in promoting mental health and wellbeing for older people.

The findings from this PhD research also shown that the facilitators of promoting active ageing in this group. These included supervision from the mental health services, such as on the job training, and supervision from specialists of mental health in primary care settings. Furthermore, appropriate training courses on mental health problems for all primary care staff was a vital facilitator to promote active ageing in this group. These results are similar to those found from a previous non-Thai study that showed primary care staff lacked training for caring for people with mental health problems (Haddad et al., 2005; Murray et al., 2006). Staff needed education programs to improve their knowledge and skills in assessing mental health problems, managing depression and anxiety, and intervention in severe mental symptoms.

Although the Department of Mental Health, Ministry of Public Health, Thailand has currently supervised and trained primary care staff every year (World Health Organization & Ministry of Public Health Thailand, 2006), a study shows that supervision and training for primary care providers in Thailand is still inadequate and has few

resources (Ditton & Lehane, 2011). Current training courses focus on nurses or health officers because of the limited budget provide by the Government (World Health Organization & Ministry of Public Health Thailand, 2006). Many primary care staff members do not have the opportunity to attend these courses. Primary care staff cannot provide holistic care for their patients because of lack skills in assessment and diagnoses of diseases and lack of supervision from specialists (Ditton & Lehane, 2011). There is a need to develop mental health training specifically for primary care providers to enhance their knowledge and skills in assessing and treating patients experiencing mental health illnesses living in the community. It should also be noted that the training courses should be developed based on the participant's background education and role in primary care units and that all primary care staff should be educated regarding mental health conditions and the concept of active ageing. Moreover, the supervision and on the job training for primary care providers should be organised more often during the year.

Moreover, the findings of this PhD research found that the majority of primary care providers were unfamiliar with the concept of active ageing but more than half of the participants were quite familiar with the concept of healthy ageing. This may be because the Ministry of Public Health, Thailand has implemented and focused on the concept of healthy ageing at the community level since 2010 (Thailand. Department of Health Service Support, 2010). Although primary care staff implemented some activities related to active ageing and health promotion in the community, the health promotion activities did not cover all aspects of the WHO's concept of active ageing, in particular, components of participation and security. In the light of this, the Ministry of Public Health in Thailand needs to refocus policy to active ageing in order to be consistent with the WHO model.

Based on the findings of this PhD research, Ministry of Public Health, Department of Mental Health, Thailand should urgently consider how to support primary care providers

to promote active ageing in older people with mental disorders living in the community. Nurses, in particular, should be able to develop and apply key skills to care for older people with mental disorders, namely, interviewing, and counselling. Nurses should have appropriate interpersonal skills as recommended by the World Health Organization and Wonca Working Party on Mental Health (2008). Other primary care staff should be educated based on their education and roles in the primary care units as reported in implication for education.

8.4 IMPLICATIONS

8.4.1 Implications for practice

As reported in Chapter two of the integrative review, older people with mental disorders were less likely to achieve active ageing compared with older people without mental disorders. Older people with mental disorders were also unrecognised from both the researchers and policymakers. The findings of this PhD research also indicated that older people with mental disorders living in the Thai community were less likely to be involved in the promotion of active ageing for enhancing well-being or quality of their life as reported in Chapter five and seven. Moreover, the promotion of active ageing in Thai primary care units did not cover all components of the WHO model.

The findings of this PhD research indicated the need to increase the promotion of active ageing in older people living in the community or rural areas of Thailand. Such findings may be applied to rural areas in developing countries with similarities to the Thai community. The promotion of active ageing in this group should be recognized in terms of participation, education, health, leisure, and security. Activities related to participation and leisure in the community for older people with mental disorders may be needed to enhance the quality of life and their functions.

Furthermore, the PAA-MD developed from the PhD research could be used in primary care to assess health promotion activities directed at active ageing in older people with mental disorders living in the community and to examine the factors that influence the promotion of active ageing in this group. The outcomes from the PAA-MD testing process can show the level of promoting active ageing in this group and will be useful to find strategies for developing programs in relation to addressing these circumstances.

8.4.2 Implications for health policy

Promotion of active ageing in older people with mental disorders living in rural communities of Thailand is an important issue that requires urgent attention to enhance active ageing in this group. The health policy developers, in particular, those in the Department of Mental Health, should pay attention to how they can support primary care providers to promote active ageing in this group.

The Royal Thai Government or the central government should promote policy to:

1. Prioritise the promotion of active ageing in older people with mental disorders,
2. Provide more funding to primary care units directed toward the promotion of active ageing in older people with mental disorders,
3. Review staffing structures and human resources in order to ensure the promotion of active ageing with a focus on mental health and wellbeing of older people,
4. Support the Ministry of Public Health to promote active ageing in older people with mental disorders.

Ministry of Public Health, Department of Mental Health, Thailand should promote policy to:

1. Prepare mental health professionals to support primary care providers,

2. Empower the mental health system to support primary care providers for promoting active ageing in older people with mental disorders,

3. Provide adequate supervision regarding mental health problems for primary care providers,

4. Educate all primary care providers based on their current education and roles to promote active ageing in older people with mental disorders,

5. Develop new technology and media to support primary care providers to promote active ageing in older people with mental disorders,

6. Develop and implement clinical practice guidelines that promote active ageing in older people with mental disorders, particularly for the primary care units,

7. Implement the promotion of active ageing in older people with mental disorders living in the community.

The local government, such as city councils should promote policy to:

1. Support primary care providers to promote active ageing in older people with mental disorders,

2. Provide funding support to promote active ageing in older people with mental disorders,

3. Provide public transportation for older people to participate in activities of active ageing,

4. Provide equipment to increase the safe living of older people with mental disorders and disability,

5. Increase safety by improving the environment in the community to enhance active ageing in older people,

6. Encourage older people with mental disorders and their caregivers to participate in the promotional activities in the community,

7. Encourage people living in the community to support older people to enhance active ageing,

8. Advocate for the public about the promotion of active ageing in the community.

8.4.3 Implications for education

The present study recommends education preparation to improve knowledge, attitude and skills for all primary care staff in primary care units based on their education and roles:

Registered nurses who graduated with a four-year programme from an accredited institution education in the field of nursing and midwifery are equipped with knowledge and skills to plan, manage, evaluate health promotion activities in the community, and provide mental health care for older people (Bureau of Health Policy and Strategy, 2010). To prepare nurses as primary care providers, content for their post-registration education should be mandated to include:

1. Training knowledge about the promotion of active ageing in older people with mental disorders,

2. Improving attitudes about care and help older people with mental disorders and their caregivers,

3. Training knowledge regarding detecting the signs and symptoms and severity of psychiatric disorders, communicate with patients with mental health problems including essential counselling and communication skills, manage medication and side effects of antipsychotic medications, refer psychiatric patients to specialists in mental health services,

4. Preparing them for supervision other primary care providers.

Health officers who graduated with a four year health bachelor's degree from university education and whose main role in primary care units is to work as an assistant of nursing

to help plan, manage, provide, and evaluate basic public health services in terms of health promotion and health education for older people (Bureau of Health Policy and Strategy, 2010). Their post-basic education could be educated by mental health professionals of mental health services as follows:

1. Training knowledge about the promotion of active ageing in older people with mental disorders,

2. Improving attitudes about care and help older people with mental disorders and their caregivers,

3. Training knowledge regarding how to educate older people with mental disorders and their caregivers in terms of mental health promotion, help nurses to detect signs and symptoms including assessing severity level of psychiatric diseases, help nurses to plan, organise, and evaluate the promotion of active ageing in older people with mental disorders,

5. Helping them to prepare for enhancing safe living in older people with mental disorders, increasing aged-friendly health services for older people with mental disorders related to services for safety when they visit the primary care units.

Assistant health officers who are health professionals or non-medical professionals graduated after two years in public health or related fields from public schools of MoPH and whose main role is to help support health officers working in the primary care units (Bureau of Health Policy and Strategy, 2010) should be educated by mental health services as follows:

1. Training them for supporting nurses and health officers about the promotion of active ageing in older people with mental disorders, encourage older people with mental disorders to participate in the promotion of active ageing,

2. Improving attitude about care and help older people with mental disorders and their caregivers,

3. Training knowledge regarding health education older people with mental disorders and their caregivers,

4. Education them for support nurses to early detect signs and symptoms including assessing severity level of psychiatric diseases,

5. Education them for assisting health offices to enhance living safety in older people with mental disorders, assist health officers for increasing aged-friendly primary health care for older people with mental disorders about health services safety when they visit the primary care units.

Pharmacy technicians or assistant pharmacists who are health professionals or assistants pharmacists graduated after two years education from public health schools of MoPH in the field of basic pharmacy and whose role in primary care units is to prepare medication and health education under the supervision of a pharmacist or other health professionals (Bureau of Health Policy and Strategy, 2010) should be educated by mental health services as follows:

1. Training them for supporting nurses and health officers about the promotion of active ageing in older people with mental disorders, encourage older people with mental disorders to participate in the promotion of active ageing,

2. Improving attitude about care and help older people with mental disorders and their caregivers,

3. Training knowledge regarding support nurses to promote active ageing in older people with mental disorders, prepare and dispense psychiatric medications under the supervision of nurses or health officers for older people with mental disorders,

4. Education them for assisting nurses to early detect side effects of psychiatric medications, assist nurses to educate regarding psychiatric medications for older people with mental disorders.

Assistant dentists who are health professionals or assistants dentists graduated from public health schools of MoPH in the field of basic dental skills and whose main role in primary care units is to support others healthcare professionals and provide basic dental care (Bureau of Health Policy and Strategy, 2010) should be educated by mental health services as follows:

1. Training them for supporting nurses and health officers about the promotion of active ageing in older people with mental disorders, encourage older people with mental disorders to participate in the promotion of active ageing,

2. Improving attitude about care and help older people with mental disorders and their caregivers,

3. Training knowledge regarding support nurses and health officers to provide basic dental care about prevention and treatment of diseases including disorders of the teeth and mouth for older people with mental disorders, provide health education about teeth for older people with mental disorders.

Aids or workers who graduated at least from high school and are trained in basic health skills to support other health care professionals in primary care units and whose main role is to prepare older people and health service environments for receiving care from health care professionals should be educated by mental health services as follows:

1. Training them for supporting nurses and health officers about the promotion of active ageing in older people with mental disorders, encourage older people with mental disorders to participate in the promotion of active ageing,

2. Improving attitude about care and help older people with mental disorders and their caregivers,

3. Training them how to help others health care professionals to promote active ageing in older people with mental disorders, help assistant health officers to encourage older people with mental disorders to participate in the promotion of active ageing,

4. Training them how to help health officers or assistant health officers to enhance living safety for older people with mental disorders, enhance aged-friendly primary health care for older people with mental disorders.

8.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The PAA-MD may not be generalised beyond this research population, but it could be:

1. Tested in a new sample of Thailand population using confirmatory factor analysis or structural equation modelling which would provide more evidence and confirm value of the psychometric properties of the instrument,

2. Translated to others languages or modified for similar areas or others related concepts such as healthy ageing, optimal ageing, and successful ageing,

3. Modified to examine the perspective of other participants in both government and non-government organisations such as police, teachers, and politicians who would benefit from learning more about promoting active ageing in older people in general, or more specifically older people with mental disorders living in the community,

4. Shortened by reducing items for use in a short instrument, which could help the users to evaluate the promotion of active ageing in older people with mental disorders in a shorter time,

5. Used to explore differences in groups and diseases in the community for promoting active ageing in others diseases,

6. Used to show progression and change over time,

7. Used to evaluate the effectiveness of the education/training for primary care providers.

8.6 STRENGTHS AND LIMITATIONS OF THE STUDY

The strengths of this PhD research were the development of the new instrument, the PAA-MD from several sources from several sources including the extant literature on active ageing, the WHO model of active ageing and FG interviews with professionals involved in primary care. The new instrument, the PAA-MD was psychometrically tested for validity and reliability, namely, content validity, face validity, and construct validity, internal consistency reliability, and external reliability. Findings revealed high level of validity and reliability. In addition, the tool is likely to have great utility in the primary care setting as it takes a short time to complete.

There were some limitations. The PAA-MD was developed based on the Thai language. The participants of this PhD research were recruited by a convenience sample from only two provinces of a total of 76 provinces in Thailand. Therefore, the responses cannot be representative of all primary care staff in Thailand, and the PAA-MD must be re-examined and adjusted before being used as a measurement in other contexts. However, all of the public primary care settings in Thailand are organised by the Ministry of Public Health, the Royal Thai Government, and are guided by similar health policies for implementing the health care system.

8.7 CONCLUSION

The Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD) has high levels of reliability and validity and takes approximately 10-15 minutes to complete. Internal consistency reliability shows good homogeneity, and external reliability shows a strong relationship or is stable over time. Furthermore, content validity

is at an acceptable level, face validity is suitable for the specific respondents, and construct validity is deemed adequate to capture the required phenomena. After testing psychometric properties from the cross-sectional study, the components of a new instrument or the PAA-MD are refined and divided into three sections as reported in Appendix 20-21. The PAA-MD is intended to be used for older people, aged 60 years and older, who are experiencing anxiety, depression disorders or similar issues in Thailand.

The next section of this PhD research will provide the appendices relevant to the study, namely, the ethics approval from the University of Newcastle, permission to collect data from Ubonratchathani and Yasothon Provinces, the information statement and consent forms for all participants, the verified cross-language validity, the integrative review of this research proposal, and the PAA-MD in both English and Thai languages.

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APPENDIX 1: Approved human research ethics of this study

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Professor Isabel Higgins**
Cc Co-investigators / Research Students:	**Doctor Amanda Wilson** **Professor Sally Chan** **Miss Kedsaraporn Kenbubpha**
Re Protocol:	**Promoting active ageing in older people with mental disorders in Primary Care Units in Thailand: The development and psychometric testing of an assessment tool**
Date:	**16-Dec-2015**
Reference No:	**H-2015-0379**
Date of Initial Approval:	**15-Dec-2015**

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Professor Isabel Higgins**
Cc Co-investigators / Research Students:	**Doctor Amanda Wilson** **Professor Sally Chan** **Miss Kedsaraporn Kenbubpha**
Re Protocol:	**Promoting active ageing in older people with mental disorders in Primary Care Units in Thailand: The development and psychometric testing of an assessment tool**
Date:	**16-Mar-2017**
Reference No:	**H-2015-0379**

Thank you for your **Variation** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to a variation to the above protocol.

Variation to formally record the following amendments to the previously-approved protocol:

1.The number of participants recruited increased from 550 to 657.

2. Because of unreliable postal services, information packages, with surveys, were distributed by Heads of the Health Districts.

Your submission was considered under **Expedited** review by the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is **Approved** effective **09-Mar-2017**.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request.

Dr Kerry Dally
Acting Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
NIER, Block C
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

APPENDIX 2: Permission for data collection from Ubonratchathani Province

บันทึกข้อความ

ส่วนราชการ สำนักงานสาธารณสุขจังหวัดอุบลราชธานี กลุ่มงานการแพทย์ฯ โทร ๐๔๕-๒๖๒๖๙๒ต่อ๓๒๐๐

ที่ อบ ๐๐๓๒.๐๑๓/ ๓๓๙ **วันที่** ๒๑ กันยายน ๒๕๕๘

เรื่อง พิจารณาลงนามอนุญาตเก็บข้อมูลวิจัยในพื้นที่

เรียน นายแพทย์สาธารณสุขจังหวัดอุบลราชธานี

ด้วย นางสาวเกษราภรณ์ เคนบุปผา นักศึกษาระดับปริญญาเอก สาขาการพยาบาล จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The university of Newcastle, Australia) ได้ทำการวิจัยเรื่อง การส่งเสริมภาวะพฤตพลัง ในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย

ในการนี้ เพื่อให้กระบวนการวิจัยในครั้งนี้ บรรลุตามวัตถุประสงค์ของโครงการ นางสาวเกษราภรณ์ เคนบุปผา จึงใคร่ขออนุญาตเก็บข้อมูลโครงการสัมภาษณ์เชิงกลุ่ม ในกลุ่มเจ้าหน้าที่สาธารณสุขระดับตำบล ในการส่งเสริมและสนับสนุนผู้สูงอายุที่ป่วยเป็นโรคจิตเวช ในจังหวัดอุบลราชธานี ซึ่งจะลงเก็บข้อมูลในห้วงเดือนตุลาคม ๒๕๕๘ ถึง กุมภาพันธ์ ๒๕๕๙ ในพื้นที่อำเภอเดชอุดม รายละเอียดตามเอกสารที่แนบเรียนมาพร้อมนี้

จึงเรียนมาเพื่อโปรดพิจารณาลงนามอนุญาต ให้เก็บข้อมูล ดังกล่าวในพื้นที่ต่อไป

(นางนภาพร จันทนบ)
หัวหน้ากลุ่มงานการแพทย์และสุขภาพจิต

ลงนามแล้ว

(นายสุรพล ลอยหา)
นายแพทย์สาธารณสุขจังหวัดอุบลราชธานี

Suggested Reply to Miss KedsarapornKenbubpha

Provincial letter head

The Ubonratchathani Provincial Health Office, Thailand would like to give permission for your research project "Promoting activeageing in older people with mental disorders in Thai Primary Care Units: the development andpsychometric testing of an assessment tool" to conduct data in our primary care units.

Your Sincerely,

(Dr Suraporn Loiha)

Provincial Chief Medical Officer Ubonratchathani,

APPENDIX 3: Permission for data collection from Yasothon Province

Ref.No 0032.003/ 2647

Yasothon Provincial Health Office

Sarakang1 Rd, Meuang district,35000

September 17, 2015

Dear Miss Kedsaraporn Kenbubpha (PhD candidate)

The Yasothon Provincial Health Office, Thailand would like to give permission for your research project "Promoting active ageing in older people with mental disorders in Thai Primary Care Units: the development and psychometric testing of an assessment tool" to conduct data in our primary care units.

Sincerely Yours

(Mr. Peerasak Pholpruksar)

Yasothon Provincial Chief executive medical officer

APPENDIX 4: Information Statement of an expert panel (English version)

THE UNIVERSITY OF
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AUSTRALIA

Kedsaraporn Kenbubpha (PhD candidate)
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Tel: 091-837-3515(Thai)
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Professor Isabel Higgins (Supervisor)
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E-mail: isabel.higgins@newcastle.edu.au
Professor Sally Wai-chi Chan (Supervisor)
Tel: +61 2 4921 6770 Fax: +61 2 4921 6770
Email: sally.chan@newcastle.edu.au
Dr Amanda Wilson (Supervisor)
Tel: +61 2 49216635
Email: amanda.wilson@newcastle.edu.au

School of Nursing and Midwifery
University of Newcastle
University Drive
Callaghan, 2308

Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Expert panel

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Who is doing this research?
This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders. According to the literature review, promoting active ageing in older people with mental disorders is an area that is under-researched. Most important, there have been no attempts to develop the instrument for measuring the level of promotion active ageing among older people with mental disorders in primary care. The evidence in relation to how primary care providers promote active ageing in older people with mental disorders and how to support primary care for promoting active ageing in this group are also need to study.

Who can take part?

Specialists in multidisciplinary areas relevant to the study are invited to take part in this research. The expert panel will consist of one expert on gerontological nursing, one psychiatric nurse, one psychiatrist, one community nursing expert, one geriatric medicine expert, one linguistic and culture expert, and one instrument development expert. Inclusion criteria of experts will be based on their qualifications and experience in the areas. They will be selected from academic institutes of Thailand such as universities or colleges.

What will you be asked to do?

You will be asked to give a score of the draft survey instrument by rating each item on a 4-point scale based on relevance and appropriateness, ranging from 1 (not relevant), 2 (somewhat relevant), 3 (quite relevant), to 4 (very relevant). You are being asked to assess the clarity and conciseness of the closed questions within the draft survey instrument with a "yes" or "no" response on each item. In addition, you will be invited to review the wording of the draft survey instrument so that it is clear and appropriate. Completing this process should take up to 10-15 minutes.

What choice do you have?

Taking part in this research is up to you. Only those people who give their informed consent will be included in the project. Whether or not you take part will not affect your work or position in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

If you participate, we will give you a coded identification number on all the forms we use. During data collection in Thailand, the collected data will be securely stored in the research student's office that can only be accessed by the research student in Thailand. All the study information will be kept in a password protected computer or in locked cabinets that can only be accessed by the research student in Thailand. On the completion of data collection, all data will be transferred and stored again securely in a locked filing cabinet in the School of Nursing and Midwifery; the University of Newcastle (UoN), Australia for five years after

completion of the research, then the data will be destroyed in accordance with the UoN Research Data and Materials Management policy and procedure. Due care will be taken to ensure that all data are completely destroyed. Electronic data will be securely stored on the University of Newcastle's own Cloud secure storage system. All copies of the collected data will only be accessed by the research student and the research supervisors named above.

How will the information collected be used?
The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?
You will not be identifiable in the summary of findings. If you would like to see the results of the study, you should contact the research student by email at the above address. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?
There are no known risks. This study will provide a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. Furthermore, the findings may provide information strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is the purpose of the enclosed thank you gift?

A thank you gift for your time has been provided in the form of a pen.

What do you need to do to participate?
Please read this information statement and be sure you understand its contents before you agree to participate. You are being asked to trial/test the draft survey instrument enclosed and provide your comments and or recommendation about the draft survey instrument by reviewing appropriate wording and suitable response sets. If you would like to take part this research, Please return the signed Inform Consent Form and the draft survey instrument to the research student, Ms Kedsaraporn Kenbubpha in the envelope provided.

For more information
If you have any questions or want more information please contact the research student on the phone number given above:

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au
Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

APPENDIX 5: Information Statement of primary care providers for Focus groups (English version)

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Dr Amanda Wilson (Supervisor)
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Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Primary care providers in Ubonratchathani Province
Focus Group

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Who is doing this research?

This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders. According to the literature review, promoting active ageing in older people with mental disorders is an area that is under-researched. Most important, there have been no attempts to develop the instrument for measuring the level of promotion active ageing among older people with mental disorders in primary care. The evidence in relation to how primary care providers promote active ageing in older people with mental disorders and how to support primary care for promoting active ageing in this group are also need to study.

Who can take part?

Primary care providers working in primary care units of Ubonratchathani Province can take part in this research.

What will you be asked to do?

You will be asked to take part in a group discussion, called a focus group, where you will be asked a range of questions, outlined below, about your experiences of promoting and engaging active ageing in older people with anxiety, depression or similar issues in your primary care units. You will also be asked to suggest the methods you use or that you are aware of for promoting active ageing in this group, and the things that assist with this, and the things that hinder this process. The focus group will take place in a private room in one of the primary care units in Ubonratchathani Province during January to February 2016. The duration of the focus group will be approximately 1-1.5 hours. During the focus group you will be invited to discuss your ideas about active ageing. Questions asked will include:

1. Can you tell me what you understand by the term active ageing? Can you give some examples of this in your community?
2. What are your perceptions or experience about promoting active ageing with older people with mental disorders?
3. Do you use any methods for promoting/engaging older people with mental disorders using the WHO active ageing model or any other model? What programs/activities do you currently use and how are these applied?
4. What helps you to promote or engage with active ageing?
5. What gets in the way of this or prevents you from engaging in active ageing?
6. What resources/support do you need to promote and implement WHO active ageing?
7. Please give some examples of the knowledge and skills you think need to promote active ageing amongst older people with mental disorders in rural Thailand?

We are also asking your permission to audio record the focus group discussion for transcription, by the research student in order to assist with the analysis of data later. During the focus group discussion the research student may also need to take notes for the proceedings of the focus group meeting.

What choice do you have?

Taking part in this research is up to you. Only those people who give their informed consent will be included in the project. Whether or not you take part will not affect your work or position in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

We won't ask you about personal or identifying information during the focus group. If you want to use a false name during the discussion you can. The focus group discussion will be recorded and parts will be transcribed (typed out), by the research student, for analysis later. You are asked to maintain confidentiality of the focus group discussion. This means that you are asked not to reveal any names of people, places, services etc in this study. You can also ask for anything that you say in the group to be edited or deleted. During data collection in Thailand, the data will be securely stored in the research student's office that can only be accessed by the research student. All the information will be kept in password protected computer or in locked cabinets that can only be accessed by the researchers. At the end of the study, all paper documents (consent forms, surveys) will be kept in locked storage. Electronic information relating to the study will be stored securely on the University of Newcastle's own Cloud secure storage system.

How will the information collected be used?

The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?

You will not be identifiable in the summary of findings. If you would like to see the results of the study, you should contact the research student by email at the above address. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?

There are no known risks. This study will provide a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. Furthermore, the findings may provide information strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is purposed to give a token payment?

You will be given a token payment of 100 Baht following the focus group. This is provided to support your transportation costs.

What do you need to do to participate?

Please read this information statement and be sure you understand its contents before you agree to participate in the Focus Group meeting. If you would like to take part, you need to complete the Informed Consent Form which requests your contact details. Send the signed Informed Consent form to the research student, Ms Kedsaraporn Kenbubpha in the envelope provided and she will then contact you to schedule a meeting at a mutually agreed time.

For more information

If you have any questions or want more information please contact the research student on the phone number above.

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au
Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

Research project "Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of a survey instrument 2015-2016"

APPENDIX 6: Information Statement of primary care providers for testing face validity (English version)

THE UNIVERSITY OF
NEWCASTLE
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Professor Sally Wai-chi Chan (Supervisor)
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Dr Amanda Wilson (Supervisor)
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Email: amanda.wilson@newcastle.edu.au

School of Nursing and Midwifery
University of Newcastle
University Drive
Callaghan, 2308

Information Statement for the Research Project
"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Primary care providers in Ubonratchathani Province
Face validity

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Who is doing this research?
This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders. According to the literature review, promoting active ageing in older people with mental disorders is an area that is under-researched. Most important, there have been no attempts to develop the instrument for measuring the level of promotion active ageing among older people with mental disorders in primary care. The evidence in relation to how primary care providers promote active ageing in older people with mental disorders and how to support primary care for promoting active ageing in this group are also need to study.

Who can take part?

Primary care providers working in primary care units in Ubonratchathani Province can take part in this research.

What will you be asked to do?

You will be asked to provide feedback on a survey instrument looking at assessing and promoting active ageing in older people with anxiety, depression or similar issues in primary care units. We would like your opinion on the wording, response sets, which are the best and worst questions, how easy the questions are to understand and answer and any other issues or problems you may notice. The research student will interview you and ask your feedback of the draft survey instrument. Completing this should take up to 10-15 minutes.

What choice do you have?

Taking part in this research is up to you. Only those people who give their informed consent will be included in the project. Whether or not you take part will not affect your work or position in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

We won't ask you about personal or identifying information during the meeting. We will give you a coded identification number on all the forms we use. During data collection in Thailand, the collected data will be securely stored in the research student's office that can only be accessed by the research student in Thailand. All the study information will be kept in a password protected computer or in locked cabinets that can only be accessed by the research student in Thailand. On the completion of data collection, all data will be transferred and stored again securely in a locked filing cabinet in the School of Nursing and Midwifery; the University of Newcastle (UoN), Australia for five years after completion of the research, then the data will be destroyed in accordance with the UoN Research Data and Materials Management policy and procedure. Due care will be taken to ensure that all data are completely destroyed. Electronic data will be securely stored on the University of Newcastle's own Cloud secure storage system. All copies of the collected data will only be accessed by the research student and the research supervisors named above.

How will the information collected be used?
The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?
You will not be identifiable in the summary of findings. If you would like to see the results of the study, you should contact the research student by email at the above address. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?
There are no known risks. This study will provide a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. Furthermore, the findings may provide information strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is the purpose of the enclosed thank you gift?
A thank you gift for your time has been provided in the form of a pen.

What do you need to do to participate?
Please read this information statement and be sure you understand its contents before you agree to participate. If you would like to take part, you need to complete the Informed Consent Form which requests your contact details and return this in the reply paid envelope to the research student. Upon receipt of your consent the research student will make contact with you in order to provide you with the draft survey instrument. You are being asked to give your feedback on the draft survey instrument about appropriate wording and suitable response sets. The research student will interview you and ask your feedback of the draft survey instrument. On completion of the draft survey instrument you are invited to give the draft survey instrument to the research student, Ms Kedsaraporn Kenbubpha.

For more information
If you have any questions or want more information please contact the research student on the phone number above.

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Research project "Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of a survey instrument 2015-2016"

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

APPENDIX 7: Information Statement of older people with mental disorders for testing face validity (English version)

1

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Professor Sally Wai-chi Chan (Supervisor)
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Email: sally.chan@newcastle.edu.au
Dr Amanda Wilson (Supervisor)
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Email: amanda.wilson@newcastle.edu.au

School of Nursing and Midwifery
University of Newcastle
University Drive
Callaghan, 2308

Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Older people in Ubonratchathani Province
Face validity

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Research project "Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of a survey instrument 2015-2016"

Who is doing this research?

This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders.

Who can take part?

Older people, aged 60 years and older, who live in Ubonratchathani province and who visit a primary care unit for anxiety, depression or similar issues are invited to take part in this study.

What will you be asked to do?

If you agree to participate, the research student will make contact with you in order to arrange a meeting with you to be held in a private room at your primary care units. At this meeting the research student will give you a copy of the draft survey instrument. Completing this should take up to 10-15 minutes. We want to know if there are ways we could improve the survey instrument. The research student will interview you and ask your feedback on the draft survey instrument. The research student will talk to you about the instrument and seek your feedback on wording or any ways that could improve the instrument. The research student will collect the draft survey instrument from you when completed.

What choice do you have?

Taking part in this research is up to you. Only those people who give their informed consent will be included in the project. Whether or not you take part will not affect you or the care you receive in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

We won't ask you about personal or identifying information during the meeting. We will give you a coded identification number on all the forms we use. During data collection in Thailand, the collected data will be securely stored in the research student's office that can only be accessed by the research student in Thailand. All the study information will be kept in a password protected computer or in locked cabinets that can only be accessed by the research student in Thailand. On the completion of data collection, all data will be transferred and stored again securely in a locked filing cabinet in the School of Nursing and Midwifery; the University of Newcastle (UoN), Australia for five years after completion of the research, then the data will be destroyed in accordance with the UoN Research Data and Materials Management policy and procedure. Due care will be taken to ensure that all data are completely destroyed. Electronic data will be securely stored on the University of Newcastle's own Cloud secure storage system. All copies of the collected data will only be accessed by the research student and the research supervisors named above.

How will the information collected be used?

The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?

You will not be identifiable in the summary of findings. If you would like to see the results of the study, we can send them to you or you can pick up a copy from this primary care centre. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?

There are no known risks to participating however, should you become distressed during this process the research student will stop the review process and check to see whether or not you wish to proceed or not. The research student is an experienced psychiatric nurse with skills in providing supportive psychotherapy for basic support and counselling. Should you indicate a need for support you will be offered information for access to local counselling and support services and invited to consider ceasing the review without fear of retribution. Any data relating to you will be removed from the interview.

The benefits are that this study will provide a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. Furthermore, the findings may provide information strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is the purpose of the enclosed thank you gift?
A thank you gift for your time has been provided in the form of a pen.

What do you need to do to participate?
Please read this information statement and be sure you understand its contents before you agree to participate. If you would like to take part, you need to complete the Informed Consent Form which requests your contact details and return this in the reply paid envelope to the research student. Upon receipt of your consent the research student will make contact with you in order to provide you with the draft survey instrument. You are being asked to give your feedback on the draft survey instrument about appropriate wording. The research student will interview you and ask your feedback about the wording of the draft survey instrument. On completion of the draft survey instrument you are invited to give the draft survey instrument to the research student, Ms Kedsaraporn Kenbubpha.

For more information
If you have any questions or want more information please contact the research student on the phone number above.

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Research project "Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of a survey instrument 2015-2016"

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel:045-262692 Ext 3200(THAI), email: mentalhealthubon@gmail.com

APPENDIX 8: Information Statement of primary care providers of pilot testing (English version)

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Professor Isabel Higgins (Supervisor)
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Professor Sally Wai-chi Chan (Supervisor)
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Email: sally.chan@newcastle.edu.au
Dr Amanda Wilson (Supervisor)
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Email: amanda.wilson@newcastle.edu.au

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Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Primary care providers in Ubonratchathani Province
Pilot Study

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Who is doing this research?
This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders. According to the literature review, promoting active ageing in older people with mental disorders is an area that is under-researched. Most important, there have been no attempts to develop the instrument for measuring the level of promotion active ageing among older people with mental disorders in primary care. The evidence in relation to how primary care providers promote active ageing in older people with mental disorders and how to support primary care for promoting active ageing in this group are also need to study.

Who can take part?

Primary care providers working in primary care units in Ubonratchathani Province can take part in this research.

What will you be asked to do?

You will be asked to provide feedback on a survey instrument looking at assessing and promoting active ageing in older people with anxiety, depression or similar issues in primary care units. We would like your opinion on which are the best and worst questions, how easy the questions are to understand and answer and any other issues or problems you may notice. We also need you to answer the instrument in order to test the reliability of the draft survey instrument. Completing this should take up to 10-15 minutes. The research student will remain in the primary care unit vicinity in order to answer any questions about the draft survey instrument.

What choice do you have?

Taking part in this research is up to you. Only those people who give their informed consent will be included in the project. Whether or not you take part will not affect your work or position in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

We won't ask you about personal or identifying information during the meeting. We will give you a coded identification number on all the forms we use. During data collection in Thailand, the collected data will be securely stored in the research student's office that can only be accessed by the research student in Thailand. All the study information will be kept in a password protected computer or in locked cabinets that can only be accessed by the research student in Thailand. On the completion of data collection, all data will be transferred and stored again securely in a locked filing cabinet in the School of Nursing and Midwifery; the University of Newcastle (UoN), Australia for five years after completion of the research, then the data will be destroyed in accordance with the UoN Research Data

and Materials Management policy and procedure. Due care will be taken to ensure that all data are completely destroyed. Electronic data will be securely stored on the University of Newcastle's own Cloud secure storage system. All copies of the collected data will only be accessed by the research student and the research supervisors named above.

How will the information collected be used?
The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?
You will not be identifiable in the summary of findings. If you would like to see the results of the study, you should contact the research student by email at the above address. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?
There are no known risks. This study will provide a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. Furthermore, the findings may provide information strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is the purpose of the enclosed thank you gift?
A thank you gift for your time has been provided in the form of a pen.

What do you need to do to participate?
Please read this information statement and be sure you understand its contents before you agree to participate. If you would like to take part, you need to complete the Informed Consent Form which requests your contact details and return this in the reply paid envelope to the research student. Upon receipt of your consent the research student will make contact with you in order to provide you with the draft survey instrument. You are being asked to give your feedback about appropriate wording of the instrument and we would like you to note your responses on the draft survey instrument. The research student remains at the primary care unit to answer any questions about the draft survey instrument if needed. When completed we request that you give the draft survey instrument to the research student, Ms Kedsaraporn Kenbubpha.

For more information
If you have any questions or want more information please contact the research student on the phone number above.

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au
Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

APPENDIX 9: Information Statement of primary care providers of the cross-sectional study (English version)

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Email: kedsaraporn.kenbubpha@uon.edu.au

Professor Isabel Higgins (Supervisor)
Tel: +61 2 49216144 Fax: +61 2 49216301
E-mail: isabel.higgins@newcastle.edu.au
Professor Sally Wai-chi Chan (Supervisor)
Tel: +61 2 4921 6770 Fax: +61 2 4921 6770
Email: sally.chan@newcastle.edu.au
Dr Amanda Wilson (Supervisor)
Tel: +61 2 49216635
Email: amanda.wilson@newcastle.edu.au

School of Nursing and Midwifery
University of Newcastle
University Drive
Callaghan, 2308

Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 3; Dated 16/12/15
Primary care providers in Yasothon province
Survey

You are invited to take part in a study about promoting active ageing in older people with anxiety, depression or similar issues in rural Thailand.

Who is doing this research?
This research project is being conducted by Kedsaraporn Kenbubpha as part of her Doctoral studies under the supervision of Professor Isabel Higgins, Professor Sally Wai-chi Chan, and Dr Amanda Wilson from the School of Nursing and Midwifery, Faculty of Health and Medicine, the University of Newcastle, Australia.

Why is this research being done?

This research aims are: 1) to develop and test a survey instrument to measure promoting active ageing for older people with mental disorders in primary care units and 2) to explore how primary care providers are using the World Health Organisation's active ageing model for older people with mental disorders. According to the literature review, promoting active ageing in older people with mental disorders is an area that is under-researched. Most important, there have been no attempts to develop the instrument for measuring the level of promotion active ageing among older people with mental disorders in primary care. The evidence in relation to how primary care providers promote active ageing in older people with mental disorders and how to support primary care for promoting active ageing in this group are also need to study.

Who can take part?

Primary care providers working in primary care units in Yashothon Province can take part in this research.

What will you be asked to do?

You will be asked to complete the enclosed survey instrument that is designed to assess the promotion of active ageing in older people with anxiety, depression or similar issues in primary care units in Thailand. Completing this should take up to 10-15 minutes.

What choice do you have?

Taking part in this research is up to you. Whether or not you take part will not affect your work or position in any way. If you decide to take part, you can stop or withdraw your information at any time before publication without giving a reason.

How will your privacy be protected?

Your name and any personal information are not needed to participate in the survey. The survey instrument will be allocated a coded identification number which will not be linked to your name. During data collection in Thailand, the collected data will be securely stored in the research student's office that can only be accessed by the research student in Thailand. All the study information will be kept in a password protected computer or in locked cabinets that can only be accessed by the research student in Thailand. On the completion of data collection, all data will be transferred and stored again securely in a locked filing cabinet in the School of Nursing and Midwifery; the University of Newcastle (UoN), Australia for five years after completion of the research, then the data will be destroyed in accordance with the UoN Research Data and Materials Management policy and procedure. Due care will be taken to ensure that all data are completely destroyed. Electronic data will be securely stored on the University of Newcastle's own Cloud secure storage system. All copies of the collected data will only be accessed by the research student and the research supervisors named above.

How will the information collected be used?
The results may be published in scientific journals and used in presentations. Any reports and publications from this study will be summarised.

Can I see the results of the study?
You will not be identifiable in the summary of findings. If you would like to see the results of the study, you should contact the research student by email at the above address. The findings will be summarized and published following completion of the study during the following year.

What are the risks and benefits of participating?
There are no known risks. This study will provide findings from a standard survey instrument to assess level of promoting active ageing among older people with mental disorders in primary care. The findings may provide information about strategies/processes/resources to enable the Government to promote and engage older people with mental disorders in rural Thailand.

What is the purpose of the enclosed thank you gift?
A thank you gift for your time has been provided in the form of a pen.

What do you need to do to participate?
Please read this information statement and be sure you understand its contents before you agree to participate. If you have any questions about the study please contact the research student, Kedsaraporn Kenbubpha according to the details above. If you would like to take part in this research, please complete the survey instrument which will take 10-15 minutes of your time. By completing and returning the survey instrument to the research student in the reply paid envelope enclosed you are giving your consent for this research.

For more information
If you have any questions or want more information please contact the research student on the phone number above.

Yours sincerely,

Miss Kedsaraporn Kenbubpha &

Dr Isabel Higgins, Chief Investigator

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au
Local contact to Medical and Mental Health Service, the Yasothon Provincial Health Office, Muang District, Yasothon, 35000 Tel: 045-712233 Ext 135 or 136 (THAI), email: ubon_sri@hotmail.com

APPENDIX 10: Informed Consent Form for the Research Project (English version)

THE UNIVERSITY OF
NEWCASTLE
AUSTRALIA

Ms Kedsaraporn Kenbubpha/ Professor Isabel Higgins
Professor Sally Wai-chi Chan/ Dr Amanda Wilson
School of Nursing and Midwifery
The University of Newcastle
University Drive Callaghan, NSW 2308
AUSTRALIA
Tel: +61 2 49215585 (Australia)
Tel: 091 837 3515 (Thai)
Email: kedsaraporn.kenbubpha@uon.edu.au
isabel.higgins@newcastle.edu.au
sally.chan@newcastle.edu.au
amanda.wilson@newcastle.edu.au

Informed Consent Form for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"
Document Version 2; Dated 5/12/15

Primary care providers in Ubonratchathani Province
Focus Group

- I agree to participate in the above research project and give my consent freely.
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- I understand I can withdraw from the project at any time without giving a reason.
- I consent to participate in a focus group between 1-1.5 hours which will be recorded.
- I understand that my personal information will remain confidential to the researchers.
- I have had the opportunity to have questions answered to my satisfaction.
- I agree to maintain the confidentiality of the group discussion.

Print Name:_____**Signature:**_____

Date: _____**Phone:**_____

Address: _____

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au. Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

THE UNIVERSITY OF
NEWCASTLE
AUSTRALIA

Ms Kedsaraporn Kenbubpha/ Professor Isabel Higgins
Professor Sally Wai-chi Chan/ Dr Amanda Wilson
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sally.chan@newcastle.edu.au
amanda.wilson@newcastle.edu.au

Information Statement for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 2; Dated 5/12/15
Expert panel

- I agree to participate in the above research project and give my consent freely.
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- I understand I can withdraw from the project at any time without giving a reason.
- I consent to test and review the draft survey instrument.
- I understand that my personal information will remain confidential to the researchers.
- I have had the opportunity to have questions answered to my satisfaction.

Print Name:_____**Signature:**_____

Date: _____**Phone:**_____

Address: _____

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au. Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

THE UNIVERSITY OF
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amanda.wilson@newcastle.edu.au

Informed Consent Form for the Research Project:

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 2; Dated 5/12/15
Primary care providers in Ubonratchathani Province
Face validity

- I agree to participate in the above research project and give my consent freely.
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- I understand I can withdraw from the project at any time without giving a reason.
- I consent to provide feedback on the draft survey instrument.
- I understand that my personal information will remain confidential to the researchers.
- I have had the opportunity to have questions answered to my satisfaction.

Print Name:_____**Signature:**_____

Date: _____**Phone:**_____

Address: _____

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au. Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

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Informed Consent Form for the Research Project

"Promoting active ageing in older people with mental disorders in Thai Primary Care Units: The development and psychometric testing of an assessment tool"

Document Version 2; Dated 5/12/15
Older people in Ubonratchathani Province

- I agree to participate in the above research project and give my consent freely.
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- I understand I can withdraw from the project at any time without giving a reason.
- I consent to provide comments and suggestions amendment on the draft survey instrument.
- I understand that my personal information will remain confidential to the researchers.
- I have had the opportunity to have questions answered to my satisfaction.
- If you would like to see the results, we can send them to you or you can pick up a copy from this centre.

Print Name: _____

Signature/Thumb print:_____**Date:** _____

Phone:_____

Address: _____

Witness Name:_____Signature:_____

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2015-0379 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au. Local contact to Medical and Mental Health Service, the Ubonratchathani Provincial Health Office, Muang District, Ubonratchathani, 34000 Tel: 045-262692 Ext 3200 (THAI), email: mentalhealthubon@gmail.com

APPENDIX 11: Information Statement of an expert panel (Thai version)

1

THE UNIVERSITY OF
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นางสาวเกษราภรณ์ เคนบุปผา (นักศึกษาปริญญาเอก)
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ศ.ดร. Isabel Higgins (อาจารย์ที่ปรึกษา)
โทรศัพท์ : +61 2 49216144 (ออสเตรเลีย) โทรสาร : +61 2 49216301
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ศ.ดร. Sally Wai-chi Chan (อาจารย์ที่ปรึกษา)
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ดร.Amanda Wilson (อาจารย์ที่ปรึกษา)
โทรศัพท์ : +61 2 49216635 (ออสเตรเลีย)
Email:amanda.wilson@newcastle.edu.au

โรงเรียนการพยาบาลและผดุงครรภ์
มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย
University Drive
Callaghan, 2308

ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ
"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:
การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"
เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558
ผู้เชี่ยวชาญ

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการ โดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally

Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช เนื่องจากการทบทวนวรรณกรรมที่ผ่านมาพบว่ายังไม่มีการศึกษาวิจัยเกี่ยวกับส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ที่สำคัญอย่างยิ่งคือยังไม่มีการพัฒนาเครื่องมือเพื่อวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตในสถานบริการระดับปฐมภูมิ รวมทั้งยังไม่มีหลักฐานที่เกี่ยวกับผู้ให้บริการในสถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชอย่างไร และมีวิธีการจะสนับสนุนให้สถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุกลุ่มนี้อย่างไร

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เชี่ยวชาญที่มีประสบการณ์ในหลายๆสาขาที่เกี่ยวข้องกับการศึกษา เพื่อให้ข้อเสนอแนะในการพัฒนาและปรับปรุงเครื่องมือประเมินผล ได้แก่ จิตแพทย์ อายุรแพทย์ พยาบาลจิตเวช พยาบาลผู้สูงอายุ พยาบาลชุมชน รวมทั้งผู้เชี่ยวชาญด้านการพัฒนาเครื่องมือ และผู้เชี่ยวชาญด้านภาษาและวัฒนธรรม โดยมีคุณสมบัติตามวุฒิการศึกษาและประสบการณ์ที่เกี่ยวข้องในด้านนั้น ซึ่งคัดเลือกมาจากสถาบันการศึกษา ได้แก่ มหาวิทยาลัยและวิทยาลัยต่างๆของประเทศไทย

อะไรคือลักษณะกิจกรรมในกระบวนการวิจัย?

ท่านจะถูกเชิญชวนให้ค่าคะแนนของร่างเครื่องมือสำรวจ โดยการให้ค่าคะแนนตามระดับความสอดคล้องและเหมาะสมของแต่ละข้อคำถามกับการประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ได้แก่ ค่าคะแนน *1* หมายถึง ไม่สอดคล้อง *2* หมายถึง สอดคล้องบางส่วน *3* หมายถึง ค่อนข้างสอดคล้อง*4* หมายถึง มีความสอดคล้องมาก นอกจากนี้ท่านจะถูกร้องขอให้ประเมินความตรงของเนื้อหาของแต่ละข้อคำถาม และให้ข้อเสนอแนะเพิ่มเติมในการใช้คำในแต่ละข้อคำถามว่าเหมาะสมหรือไม่ ซึ่งจะใช้เวลาโดยประมาณ 10-15 นาที

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณี

ที่ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ถ้าท่านเข้าร่วมโครงการวิจัย เราจะใช้ตัวเลขเป็นรหัสในเอกสารทั้งหมดให้ท่าน ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเฉพาะนักศึกษาวิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บโดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม) จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ในตู้เก็บเอกสารในโรงเรียนพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นเวลา 5 ปี หลังการดำเนินการวิจัยสิ้นสุดลง แล้วเอกสารจะถูกทำลายภายใต้ระเบียบและวิธีการของมหาวิทยาลัยนิวคาสเซิลส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล สำเนาเอกสารของการเก็บข้อมูลทั้งหมดเฉพาะนักศึกษาวิจัยและคณะอาจารย์ที่ปรึกษาเท่านั้นที่จะสามารถเข้าถึงข้อมูลได้

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปเสนอในเวทีวิชาการและตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์ตามความเหมาะสม ทุกรายงานของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในเป็นการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการให้ของขวัญแทนคำขอบคุณในการวิจัยครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับปากกาเป็นของสมนาคุณ

อะไรคือสิ่งที่ท่านควรปฏิบัติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากมีข้อสงสัยหรือข้อคำถามเกี่ยวกับการวิจัยโปรดติดต่อผู้วิจัยตามที่อยู่ข้างล่างนี้ หากท่านตกลงเข้าร่วมการวิจัยขอความกรุณาท่านเซ็นใบยินยอมสมัครใจเข้าร่วมโครงการวิจัยและตอบทุกข้อคำถามในแบบสอบถามและส่งเอกสารทั้งหมดกลับคืนนักวิจัย, นางสาวเกษราภรณ์ เคนบุปผา ด้วยซองจดหมายที่ติดแสตมป์ตามที่อยู่ที่แนบมาพร้อมนี้

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ตามที่อยู่ข้างบน

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่ กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

APPENDIX 12: Information Statement of primary care providers for Focus groups (Thai version)

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THE UNIVERSITY OF NEWCASTLE AUSTRALIA

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โรงเรียนการพยาบาลและผดุงครรภ์

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ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ

"การส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:

การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"

เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558

การสนทนากลุ่ม

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการโดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally

Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช เนื่องจากการทบทวนวรรณกรรมที่ผ่านมาพบว่ายังไม่มีการศึกษาวิจัยเกี่ยวกับส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ที่สำคัญอย่างยิ่งคือยังไม่มีการพัฒนาเครื่องมือเพื่อวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตในสถานบริการระดับปฐมภูมิ รวมทั้งยังไม่มีหลักฐานที่เกี่ยวกับผู้ให้บริการในสถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชอย่างไร และมีวิธีการจะสนับสนุนให้สถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุกลุ่มนี้อย่างไร

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เข้าร่วมการวิจัยที่เหมาะสมกับวัตถุประสงค์ของการศึกษาวิจัย คือ เจ้าหน้าที่ผู้ปฏิบัติงานในสถานบริการปฐมภูมิของจังหวัดอุบลราชธานีของประเทศไทย

อะไรคือลักษณะกิจกรรมในกระบวนการวิจัย?

ท่านจะถูกเชิญชวนให้ตอบคำถามและมีส่วนร่วมในการสัมภาษณ์เชิงกลุ่มด้วยคำถามตามรายละเอียดข้างล่างเกี่ยวกับประสบการณ์และการส่งเสริมสนับสนุนผู้สูงอายุที่มีอาการโรควิตกกังวล โรคซึมเศร้าหรืออาการป่วยทางจิตเวชอื่นๆในสถานบริการปฐมภูมิของท่าน รวมทั้งท่านจะถูกขอร้องช่วยให้คำแนะนำเกี่ยวกับวิธีการทำให้ตระหนัก ส่งเสริม และวิธีการที่จะเป็นอุปสรรคในการดำเนินงานภาวะพฤฒพลังในสถานบริการของท่าน กลุ่มสนทนานี้จะดำเนินการในห้องเฉพาะในสถานบริการปฐมภูมิจังหวัดอุบลราชธานีโดยจะใช้เวลาประมาณ 1-1.5 ชั่วโมง ระว่างการสนทนากลุ่มท่านจะถูกขอความร่วมมือในการแสดงความคิดเห็นเกี่ยวกับภาวะพฤฒพลัง ดังคำถามต่อไปนี้

1. *ขอให้ท่านช่วยเล่าให้ฟังเกี่ยวกับความเข้าใจในนิยามของคำว่า ภาวะพฤฒพลัง โดยช่วยยกตัวอย่างประกอบในชุมชนของท่าน*
2. *อะไรคือการรับรู้หรือประสบการณ์ของท่านเกี่ยวกับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคจิตเวช*
3. *ท่านเคยใช้วิธีการในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคจิตเวช หรือ วิธีการอื่นๆหรือไม่*

4. อะไรคือโปรแกรมหรือกิจกรรมที่ท่านใช้กับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในปัจจุบันและท่านใช้อย่างไรบ้าง

5. อะไรบ้างที่จะช่วยสนับสนุนให้ท่านมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช ปัจจัยอะไรบ้างที่เป็นอุปสรรคหรือปัจจัยที่ช่วยสนับสนุนให้ส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีป่วยเป็นโรคจิตเวช ช่วยยกตัวอย่างประกอบ

6.ขอให้ท่านยกตัวอย่างทรัพยากรหรือการสนับสนุนต่างๆที่ท่านต้องการใช้ในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคจิตเวช

7. ขอให้ท่านยกตัวอย่างความรู้และทักษะที่ท่านต้องการเพื่อใช้การส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคจิตเวช

การสนทนากลุ่มจะมีการขออนุญาตบันทึกการสนทนาด้วยเทปเพื่อช่วยให้นักศึกษาวิจัยในการถอดรหัสบทสนทนา รวมทั้งจะมีการบันทึกบทสนทนาในกระดาษโดยนักวิจัย

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณีที่ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ท่านจะไม่ถูกถามเกี่ยวกับข้อมูลส่วนบุคคลหรือการบ่งชี้ความเป็นเอกลักษณ์ต่างๆระหว่างการสนทนากลุ่ม รวมทั้งท่านสามารถใช้ชื่อปลอมในระหว่างการสนทนากลุ่มได้ด้วย การสนทนากลุ่มจะมีการบันทึกและถอดเทปโดยนักศึกษาวิจัยเพื่อใช้การวิเคราะห์ข้อมูล ท่านถูกร้องขอให้เก็บบทสนทนากลุ่มเป็นความลับ นั่นหมายถึงว่า ท่านต้องปกปิดชื่อบุคคลสถานที่และหน่วยบริการในการศึกษาวิจัยในครั้งนี้ นอกจากนี้ท่านยังสามารถร้องขอให้มีการแก้ไขหรือลบข้อความทุกอย่างในระหว่างการสนทนาได้ ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเฉพาะนักศึกษาวิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บโดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม)จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์และนำเสนอในเวทีวิชาการตามความเหมาะสม ทุกรายงานและการตีพิมพ์เผยแพร่ของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในเป็นการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการจ่ายค่าตอบแทนในการวิจัยในครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับค่าตอบแทน 100 บาทในการเข้าร่วมสนทนากลุ่ม เพื่อเป็นอำนวยความสะดวกในการเดินทางเข้าร่วมการสนทนากลุ่มในครั้งนี้

อะไรคือสิ่งที่ท่านควรปฏิบัติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากมีข้อสงสัยหรือข้อคำถามเกี่ยวกับการวิจัยโปรดติดต่อนักศึกษาวิจัย หากท่านตกลงเข้าร่วมการวิจัยโปรดกรอกรายละเอียดในเอกสารใบพิทักษ์สิทธิพร้อมลงนามเข้าร่วมการวิจัยและส่งเอกสารดังกล่าวมายังนักศึกษาวิจัยตามที่อยู่ในเอกสารนี้ ทั้งนี้นักศึกษาวิจัยจะติดต่อท่านเพื่อนัดหมายเวลาต่อไป

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ข้างบนนี้

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่ กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

APPENDIX 13: Information Statement of primary care providers for testing face validity (Thai version)

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โรงเรียนการพยาบาลและผดุงครรภ์

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ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ

"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:

การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"

เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558

ผู้ให้บริการในสถานบริการปฐมภูมิในจังหวัดอุบลราชธานี

ความเที่ยงตรงกับกลุ่มเป้าหมาย

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการโดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช เนื่องจากการทบทวนวรรณกรรมที่ผ่านมาพบว่ายังไม่มีการศึกษาวิจัยเกี่ยวกับส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ที่สำคัญอย่างยิ่งคือยังไม่มีการพัฒนาเครื่องมือเพื่อวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตในสถานบริการระดับปฐมภูมิ รวมทั้งยังไม่มีหลักฐานที่เกี่ยวกับผู้ให้บริการในสถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชอย่างไร และมีวิธีการจะสนับสนุนให้สถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุกลุ่มนี้อย่างไร

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เข้าร่วมการวิจัยที่เหมาะสมกับวัตถุประสงค์ของการศึกษาวิจัย คือ เจ้าหน้าที่ผู้ปฏิบัติงานในสถานบริการปฐมภูมิจังหวัดอุบลราชธานีของประเทศไทย

อะไรคือลักษณะกิจกรรมในกระบวนการวิจัย?

ท่านจะถูกเชิญชวนให้ข้อเสนอแนะและตอบคำถามในร่างเครื่องมือเพื่อประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาโรคทางจิตเวช ได้แก่ ภาวะวิตกกังวล โรคซึมเศร้า หรือปัญหาสุขภาพจิตอื่นๆที่มารับบริการในสถานบริการปฐมภูมิ ข้อเสนอแนะของท่านเกี่ยวกับข้อคำถามใดที่มีประโยชน์หรือควรปรับปรุงรวมทั้งความยากง่ายในการตอบคำถามหรือเสนอปัญหาอื่นๆที่จะเป็นประโยชน์ต่อการปรับปรุงร่างเครื่องมือประเมินผลดังกล่าว

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณีที่

ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ถ้าท่านเข้าร่วมโครงการวิจัย เราจะใช้ตัวเลขเป็นรหัสในเอกสารทั้งหมดให้ท่าน ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเพียงเฉพาะนักศึกษาวิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บโดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม)จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ในตู้เก็บเอกสารในโรงเรียนพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นเวลา 5 ปี หลังการดำเนินการวิจัยสิ้นสุดลง แล้วเอกสารจะถูกทำลายภายใต้ระเบียบและวิธีการของมหาวิทยาลัยนิวคาสเซิลส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล สำเนาเอกสารของการเก็บข้อมูลทั้งหมดเฉพาะนักศึกษาวิจัยและคณะอาจารย์ที่ปรึกษาเท่านั้นที่จะสามารถเข้าถึงข้อมูลได้

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์และนำเสนอในเวทีวิชาการตามความเหมาะสม ทุกรายงานและการตีพิมพ์เผยแพร่ของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในเป็นการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการให้ของขวัญแทนคำขอบคุณในการวิจัยครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับปากกาเป็นของสมนาคุณ

อะไรคือสิ่งที่ท่านควรปฏิบัติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากท่านตกลงเข้าร่วมการวิจัยขอความกรุณาท่านเซ็นใบยินยอมสมัครใจเข้าร่วมโครงการวิจัยและส่งกลับนักศึกษาวิจัยตามจดหมายที่จ่าหน้าซองติดแสตมป์มาพร้อมนี้ เมื่อได้รับใบยินยอมเข้าร่วมการวิจัย นักศึกษาวิจัยจะติดต่อท่านเพื่อให้ร่างเครื่องมือประเมินผล ท่านจะถูกร้องขอให้ข้อเสนอแนะในร่างแบบสอบถามเกี่ยวกับคำเหมาะสมและข้อความต่างๆ โดยนักศึกษาวิจัยจะสัมภาษณ์ท่านและถามเกี่ยวกับร่างเครื่องมือประเมินผล เมื่อท่านให้ข้อเสนอแนะเรียบร้อยแล้วขอความกรุณาท่านส่งคืนร่างเครื่องมือประเมินผลแก่นักศึกษาวิจัย,นางสาวเกษราภรณ์ เคนบุปผา

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ตามที่อยู่ข้างบน

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

APPENDIX 14: Information Statement of older people with mental disorders for testing face validity (Thai version)

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THE UNIVERSITY OF NEWCASTLE AUSTRALIA

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โรงเรียนการพยาบาลและผดุงครรภ์

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ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ

"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:

การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"

เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558

ผู้สูงอายุในจังหวัดอุบลราชธานี

ความเที่ยงตรงกับกลุ่มเป้าหมาย

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการโดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เข้าร่วมการวิจัยที่เหมาะสมกับวัตถุประสงค์ของการศึกษาวิจัย คือ ผู้สูงอายุที่มารับบริการในสถานบริการปฐมภูมิในจังหวัดอุบลราชธานีที่มีปัญหาทางสุขภาพจิตและจิตเวช ได้แก่ ความเครียด ภาวะซึมเศร้า หรือ อาการอื่นๆที่เกี่ยวข้องกับปัญหาทางสุขภาพจิตและจิตเวช

อะไรคือสิ่งที่ท่านถูกเชิญชวนในการดำเนินการวิจัยในครั้งนี้?

ท่านจะถูกเชิญชวนให้ข้อเสนอแนะและตอบคำถามในร่างเครื่องมือเพื่อประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาโรคทางจิตเวช ได้แก่ ภาวะวิตกกังวล โรคซึมเศร้า หรือปัญหาสุขภาพจิตอื่นๆที่มารับบริการในสถานบริการปฐมภูมิ ข้อเสนอแนะของท่านเกี่ยวกับข้อคำถามใดที่มีประโยชน์หรือควรปรับปรุงรวมทั้งความยากง่ายในการตอบคำถามหรือเสนอปัญหาอื่นๆที่จะเป็นประโยชน์ต่อการปรับปรุงร่างเครื่องมือประเมินผลดังกล่าว

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณีที่ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ถ้าท่านเข้าร่วมโครงการวิจัย เราจะใช้ตัวเลขเป็นรหัสในเอกสารทั้งหมดให้ท่าน ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเพียงนักศึกษา

วิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บโดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม)จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ในตู้เก็บเอกสารในโรงเรียนพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นเวลา 5 ปี หลังการดำเนินการวิจัยสิ้นสุดลง แล้วเอกสารจะถูกทำลายภายใต้ระเบียบและวิธีการของมหาวิทยาลัยนิวคาสเซิล ส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล สำเนาเอกสารของการเก็บข้อมูลทั้งหมดเฉพาะนักศึกษาวิจัยและคณะอาจารย์ที่ปรึกษาเท่านั้นที่จะสามารถเข้าถึงข้อมูลได้

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์และนำเสนอในเวทีวิชาการตามความเหมาะสม ทุกรายงานและการตีพิมพ์เผยแพร่ของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในเป็นการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการให้ของขวัญแทนคำขอบคุณในการวิจัยครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับปากกาเป็นของสมนาคุณ

อะไรคือสิ่งที่ท่านควรปฏิบัติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากท่านตกลงเข้าร่วมการวิจัยขอความกรุณาท่านเซ็นใบยินยอมสมัครใจเข้าร่วมโครงการวิจัยและส่งกลับนักศึกษาวิจัยตามจดหมายที่จ่าหน้าซองติดแสตมป์มาพร้อมนี้ เมื่อได้รับใบยินยอมเข้าร่วมการวิจัย นักศึกษาวิจัยจะติดต่อท่านเพื่อให้ร่างเครื่องมือประเมินผลท่านจะถูกร้องขอให้ข้อเสนอแนะในร่างแบบสอบถามเกี่ยวกับคำเหมาะสมและข้อความต่างๆ โดย

นักศึกษาวิจัยจะสมัภาษณ์ท่านและถามเกี่ยวกับร่างเครื่องมือประเมินผล เมื่อท่านให้ข้อเสนอแนะเรียบร้อยแล้ว ขอความกรุณาท่านส่งคืนร่างเครื่องมือประเมินผลแก่นักศึกษาวิจัย,นางสาวเกษราภรณ์ เคนบุปผา

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ตามที่อยู่ข้างบน

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่ กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

APPENDIX 15: Information Statement of primary care providers for pilot testing (Thai version)

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ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ

"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:

การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"

เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558

ผู้ให้บริการในสถานบริการปฐมภูมิในจังหวัดอุบลราชธานี

การศึกษานำร่อง

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการโดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช เนื่องจากการทบทวนวรรณกรรมที่ผ่านมาพบว่ายังไม่มีการศึกษาวิจัยเกี่ยวกับส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ที่สำคัญอย่างยิ่งคือยังไม่มีการพัฒนาเครื่องมือเพื่อวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตในสถานบริการระดับปฐมภูมิ รวมทั้งยังไม่มีหลักฐานที่เกี่ยวกับผู้ให้บริการในสถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชอย่างไร และมีวิธีการจะสนับสนุนให้สถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุกลุ่มนี้อย่างไร

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เข้าร่วมการวิจัยที่เหมาะสมกับวัตถุประสงค์ของการศึกษาวิจัย คือ เจ้าหน้าที่ผู้ปฏิบัติงานในสถานบริการปฐมภูมิจังหวัดอุบลราชธานีของประเทศไทย

อะไรคือลักษณะกิจกรรมในกระบวนการวิจัย?

ท่านจะถูกเชิญชวนให้ข้อเสนอแนะและตอบคำถามในร่างเครื่องมือเพื่อประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตในสถานบริการปฐมภูมิ ข้อเสนอแนะของท่านเกี่ยวกับข้อคำถามใดที่มีประโยชน์หรือควรปรับปรุง รวมทั้งความยากง่ายในการตอบคำถามหรือเสนอปัญหาอื่นๆที่จะเป็นประโยชน์ นอกจากนี้การตอบคำถามของท่านจะถูกนำไปวิเคราะห์ความเที่ยงของเครื่องมือ

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณีที่ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ถ้าท่านเข้าร่วมโครงการวิจัย เราจะใช้ตัวเลขเป็นรหัสในเอกสารทั้งหมดให้ท่าน ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเพียงเฉพาะนักศึกษาวิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บ โดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม)จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ในตู้เก็บเอกสารในโรงเรียนพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นเวลา 5 ปี หลังการดำเนินการวิจัยสิ้นสุดลง แล้วเอกสารจะถูกทำลายภายใต้ระเบียบและวิธีการของมหาวิทยาลัยนิวคาสเซิลส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล สำเนาเอกสารของการเก็บข้อมูลทั้งหมดเฉพาะนักศึกษาวิจัยและคณะอาจารย์ที่ปรึกษาเท่านั้นที่จะสามารถเข้าถึงข้อมูลได้

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์และนำเสนอในเวทีวิชาการตามความเหมาะสม ทุกรายงานและการตีพิมพ์เผยแพร่ของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็น โรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการให้ของขวัญแทนคำขอบคุณในการวิจัยครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับปากกาเป็นของสมนาคุณ

อะไรคือสิ่งที่ท่านควรปฏิบัติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากท่านตกลงเข้าร่วมการวิจัยขอความกรุณาท่านเซ็นใบยินยอมสมัครใจเข้าร่วมโครงการวิจัยและส่งกลับนักศึกษาวิจัยตามจดหมายที่จ่าหน้าซองติดแสตมป์

มาพร้อมนี้ เมื่อได้รับใบยินยอมเข้าร่วมการวิจัย นักศึกษาวิจัยจะติดต่อท่านเพื่อให้ร่างเครื่องมือประเมินผล ท่านจะถูกร้องขอให้ตอบคำถามและเสนอแนะร่างแบบสอบถามเกี่ยวกับคำเหมาะสมและข้อความต่างๆ โดยนักศึกษาวิจัยจะรอตอบคำถามในกรณีที่ท่านสงสัยเกี่ยวกับร่างเครื่องมือประเมินผล เมื่อท่านได้ตอบคำถามเรียบร้อยแล้ว ขอความกรุณาท่านส่งคืนร่างเครื่องมือประเมินผลแก่นักศึกษาวิจัย,นางสาวเกษราภรณ์ เคนบุปผา

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ตามที่อยู่ข้างบน

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่ กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

APPENDIX 16: Information Statement of primary care providers for the cross-sectional study (Thai version)

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ใบพิทักษ์สิทธิผู้เข้าร่วมการวิจัยของโครงการ

"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:

การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"

เอกสารผ่านการปรับปรุงครั้งที่ 3 วันที่ 16/12/2558

ผู้ให้บริการในสถานบริการปฐมภูมิในจังหวัดยโสธร

การสำรวจ

ท่านได้รับเชิญเข้าร่วมการวิจัย เรื่อง การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล

ใครคือผู้ที่ศึกษาวิจัยในครั้งนี้?

งานวิจัยชิ้นนี้เป็นดำเนินการโดยนางสาวเกษราภรณ์ เคนบุปผา ซึ่งเป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกสาขาการพยาบาล ภายใต้การให้คำปรึกษาของโปรเฟสเซอร์ Isabel Higgins โปรเฟสเซอร์ Sally Wai-chi Chan และดอกเตอร์ Amanda Wilson จากโรงเรียนการพยาบาลและการผดุงครรภ์ คณะแพทย์ศาสตร์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย (The University of Newcastle, Australia)

ทำไมโครงการวิจัยนี้จึงถูกจัดทำขึ้น?

วัตถุประสงค์ของการวิจัยเพื่อ 1) พัฒนาและทดสอบเครื่องมือสำหรับใช้วัดการส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานบริการปฐมภูมิ 2) ศึกษาวิเคราะห์ผู้ให้บริการในหน่วยปฐมภูมิมีการใช้แนวทางขององค์การอนามัยโลกเกี่ยวกับภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช เนื่องจากการทบทวนวรรณกรรมที่ผ่านมาพบว่ายังไม่มีการศึกษาวิจัยเกี่ยวกับส่งเสริมภาวะพฤฒพลังสำหรับผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช ที่สำคัญอย่างยิ่งคือยังไม่มีการพัฒนาเครื่องมือเพื่อวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตในสถานบริการระดับปฐมภูมิ รวมทั้งยังไม่มีหลักฐานที่เกี่ยวกับผู้ให้บริการในสถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชอย่างไร และมีวิธีการจะสนับสนุนให้สถานบริการปฐมภูมิมีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุกลุ่มนี้อย่างไร

ใครคือกลุ่มเป้าหมายในการวิจัยครั้งนี้?

ในการวิจัยครั้งนี้ได้คัดสรรผู้เข้าร่วมการวิจัยที่เหมาะสมกับวัตถุประสงค์ของการศึกษาวิจัย คือ เจ้าหน้าที่ผู้ปฏิบัติงานในสถานบริการปฐมภูมิจังหวัดยโสธรของประเทศไทย

อะไรคือลักษณะกิจกรรมในกระบวนการวิจัย?

ท่านจะถูกเชิญชวนให้ตอบคำถามในเครื่องมือเพื่อประเมินการส่งเสริมภาวะพฤฒพลังของผู้สูงอายุที่ป่วยเป็นโรคจิตเวช ภาวะวิตกกังวล โรคซึมเศร้า หรือผู้มีปัญหาสุขภาพจิตอื่นๆที่มารับบริการในสถานบริการปฐมภูมิ ซึ่งจะถูกจัดส่งในซองติดแสตมป์ทางไปรษณีย์ โดยจะใช้เวลาประมาณ 10-15 นาที

อะไรคือทางเลือกต่อการพิจารณาเข้าร่วมการวิจัยในครั้งนี้?

การเข้าร่วมการวิจัยเป็นสิทธิของท่าน เฉพาะท่านที่เซ็นยินยอมเข้าร่วมการวิจัยเป็นลายลักษณ์อักษรจึงจะถูกรวมเข้าในโครงการ การตัดสินใจเข้าร่วมการวิจัยหรือไม่เข้าร่วมการวิจัยของท่านนั้น จะไม่มีผลใดๆต่อการทำงานและไม่มีผลเสียต่อท่านหรือผลกระทบต่อความสัมพันธ์ของท่านและนักวิจัยแต่อย่างใด ในกรณีที่ท่านเข้าร่วมการวิจัยท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาก่อนที่การวิจัยจะถูกเผยแพร่โดยไม่มีผลกระทบต่อท่านแต่อย่างใด

ท่านจะถูกพิทักษ์สิทธิความเป็นส่วนบุคคลอย่างไร?

ถ้าท่านเข้าร่วมโครงการวิจัย เราจะใช้ตัวเลขเป็นรหัสในเอกสารทั้งหมดให้ท่าน ในระหว่างการเก็บข้อมูลในประเทศไทย ข้อมูลจะถูกเก็บรักษาไว้อย่างปลอดภัยในสถานที่ทำงานของนักศึกษาวิจัยโดยมีเพียงเฉพาะนักศึกษาวิจัยเท่านั้นที่สามารถเข้าสถานที่ทำงานนี้ได้ ข้อมูลทั้งหมดจะถูกเก็บโดยใช้รหัสลับของคอมพิวเตอร์หรือเก็บไว้ในลิ้นชักตู้ที่มีเฉพาะนักวิจัยเท่านั้นที่สามารถเข้าถึงข้อมูลได้ เมื่อสิ้นสุดการศึกษาเอกสารที่เป็นกระดาษ(ใบยินยอมเข้าร่วมการวิจัยและแบบสอบถาม)จะถูกเก็บไว้ในสถานที่มีการป้องกันรักษาอย่างดี ในตู้เก็บเอกสารในโรงเรียนพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นเวลา 5 ปี หลังการดำเนินการวิจัยสิ้นสุดลง แล้วเอกสารจะถูกทำลายภายใต้ระเบียบและวิธีการของมหาวิทยาลัยนิวคาสเซิลส่วนข้อมูลอิเลคทรอนิคส์ต่างๆที่เกี่ยวข้องกับการศึกษาจะมีการเก็บไว้อย่างปลอดภัยในระบบคราวน์คอมพิวเตอร์ของมหาวิทยาลัยนิวคาสเซิล สำเนาเอกสารของการเก็บข้อมูลทั้งหมดเฉพาะนักศึกษาวิจัยและคณะอาจารย์ที่ปรึกษาเท่านั้นที่จะสามารถเข้าถึงข้อมูลได้

ผลการวิจัยจะถูกดำเนินการอย่างไร?

ผลการวิจัยจะถูกนำไปตีพิมพ์เผยแพร่ในวารสารทางวิทยาศาสตร์และนำเสนอในเวทีวิชาการตามความเหมาะสม ทุกรายงานและการตีพิมพ์เผยแพร่ของงานวิจัยชิ้นนี้จะถูกสรุปผลในภาพรวม

ท่านสามารถเห็นผลการวิจัยได้หรือไม่

ผลการวิจัยจะไม่สามารถถูกระบุถึงตัวท่านได้ ถ้าท่านต้องการทราบผลการวิจัยกรุณาติดต่อนักศึกษาวิจัยตามที่อยู่ของจดหมายอิเลคทรอนิคส์ที่แจ้งไว้ข้างบนใบพิทักษ์สิทธิ์นี้ ผลการวิจัยจะถูกสรุปและเผยแพร่ตีพิมพ์หลังจากสิ้นสุดการศึกษาในปีถัดไป

อะไรคือความเสี่ยงหรือประโยชน์ของเข้าร่วมการวิจัยในครั้งนี้

ท่านไม่มีความเสี่ยงจากการเข้าร่วมการวิจัยในครั้งนี้ ประโยชน์ของการศึกษาวิจัยในครั้งนี้จะทำให้ได้เครื่องมือที่มีมาตรฐานในการวัดระดับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวช รวมทั้งผลการศึกษาจะถูกนำไปใช้ในเป็นการให้ข้อมูลแก่หน่วยงานของรัฐบาลเกี่ยวกับกลวิธี กระบวนการและแหล่งสนับสนุนในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในชนบทต่อไป

อะไรคือวัตถุประสงค์ของการให้ของขวัญแทนคำขอบคุณในการวิจัยครั้งนี้

ในการเข้าร่วมการวิจัยในครั้งนี้ท่านจะได้รับปากกาเป็นของสมนาคุณ

อะไรคือสิ่งที่ท่านควรปฏิบติในการเข้าร่วมวิจัย?

ก่อนลงนามเข้าร่วมการวิจัยโปรดอ่านข้อมูลต่างๆในเอกสารฉบับนี้อย่างละเอียดและแน่ใจว่าท่านเข้าใจในข้อมูลดังกล่าวอย่างถ่องแท้ก่อนการตกลงเข้าร่วมการวิจัย หากมีข้อสงสัยหรือข้อคำถามเกี่ยวกับการวิจัยโปรดติดต่อผู้วิจัย นางสาวเกษราภรณ์ เคนบุปผา ตามที่อยู่ข้างบนนี้ หากท่านตกลงเข้าร่วมการวิจัยขอความ

กรุณาท่านตอบทุกข้อคำถามในเครื่องมือดังกล่าว ในกรณีที่ท่านตอบคำถามในเครื่องมือนี้หมายถึงท่านได้ยินยอมสมัครใจเข้าร่วมการวิจัยในครั้งนี้โดยปริยาย และความร่วมมือท่านส่งแบบสอบถามกลับคืนนักศึกษาวิจัยด้วยซองจดหมายที่ติดแสตมป์ตามที่อยู่ที่แนบมาพร้อมนี้

การสอบถามข้อมูลเพิ่มเติม

ในกรณีที่ท่านมีข้อสงสัยเกี่ยวกับการวิจัยในครั้งนี้ กรุณาติดต่อคณะผู้วิจัยตามโทรศัพท์ที่ให้ไว้ตามที่อยู่ข้างบน

ขอบพระคุณอย่างยิ่ง

นางสาวเกษราภรณ์ เคนบุปผา และ

ดอกเตอร์ Isabel Higgins, หัวหน้าคณะผู้วิจัย

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดยโสธร อ.เมือง จ.ยโสธร 35000 โทรศัพท์ 045-712233 ต่อ 135 หรือ 136 email: ubon_sri@hotmail.com

APPENDIX 17: Informed Consent of the Research Project (Thai version)

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ใบพิทักษ์สิทธิผู้เข้าร่วมโครงการวิจัยเรื่อง
"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย:
การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"
เอกสารผ่านการปรับปรุงครั้งที่ 2 ; 5/12/2558
ผู้ให้บริการในสถานบริการปฐมภูมิในจังหวัดอุบลราชธานี
การสนทนากลุ่ม

- ข้าพเจ้าตกลงจะเข้าร่วมโครงการครั้งนี้และให้ความยินยอมโดยสมัครใจ
- ข้าพเจ้าเข้าใจว่าการดำเนินการวิจัยจะเป็นไปตามที่ให้ไว้ในใบชี้แจงการวิจัยดังกล่าว
- ข้าพเจ้าเข้าใจสิทธิในการออกจากการศึกษาวิจัยครั้งนี้ได้ตลอดเวลาโดยไม่ต้องชี้แจงเหตุผล
- ข้าพเจ้ายินยอมเข้าร่วมการสนทนากลุ่มในเวลา 1-1.5 ชั่วโมง และยินดีให้บันทึกการสนทนากลุ่ม
- ข้าพเจ้าเข้าใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูกเก็บเป็นความลับจากนักวิจัย
- ข้าพเจ้ามีโอกาสได้รับการตอบคำถามจากนักวิจัยทุกๆคำถามที่สงสัย
- ข้าพเจ้ายินยอมที่จะเก็บบทสนทนากลุ่มเป็นความลับ

ลงนามผู้ให้ความยินยอม:_____ลายเซ็นต์_____
วัน/เดือน/ปี_____โทรศัพท์_____
ที่อยู่ปัจจุบัน _____

การร้องเรียนเกี่ยวกับการวิจัย

การวิจัยนี้ได้รับการพิจารณาจากคณะกรรมการการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย (The University's Human Research Ethics Committee) ใบอนุมัติเลขที่ H-2015-0379 ซึ่งท่านควรได้รับการคำนึงถึงสิทธิมนุษยชนต่อการเข้าร่วมวิจัยหรือท่านมีข้อร้องเรียนต่อการปฏิบัติหรือมารยาทที่ได้รับอย่างไม่เหมาะสมในการวิจัย ท่านสามารถร้องเรียนมายัง The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email:Human-Ethics@newcastle.edu.au. และการติดต่อในประเทศไทยได้ที่กลุ่มงานการแพทย์และสุขภาพจิต สำนักงานสาธารณสุขจังหวัดอุบลราชธานี อ.เมือง จ.อุบลราชธานี 34000 โทรศัพท์ 045-262692 ต่อ 3200 email: mentalhealthubon@gmail.com

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amanda.wilson@newcastle.edu.au

ใบพิทักษ์สิทธิผู้เข้าร่วมโครงการวิจัยเรื่อง
"การส่งเสริมภาวะพฤตพลังในผู้สูงอายุที่ป่วยเป็นโรคทางจิตเวชในสถานพยาบาลปฐมภูมิของไทย: การพัฒนาและทดสอบคุณสมบัติของเครื่องมือประเมินผล"
เอกสารผ่านการปรับปรุงครั้งที่ 2 ; 5/12/2558
ผู้เชี่ยวชาญ

- ข้าพเจ้าตกลงจะเข้าร่วมโครงการครั้งนี้และให้ความยินยอมโดยสมัครใจ
- ข้าพเจ้าเข้าใจว่าการดำเนินการวิจัยจะเป็นไปตามที่ให้ไว้ในใบชี้แจงการวิจัยดังกล่าว
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- ข้าพเจ้ายินยอมเข้าร่วมทดสอบและให้คำแนะนำร่างเครื่องมือประเมินที่พัฒนาขึ้นนี้
- ข้าพเจ้าเข้าใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูกเก็บเป็นความลับจากนักวิจัย
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ที่อยู่ปัจจุบัน _____

การร้องเรียนเกี่ยวกับการวิจัย

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ผู้ให้บริการในสถานบริการปฐมภูมิในจังหวัดอุบลราชธานี
ความเที่ยงตรงกับกลุ่มเป้าหมาย

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วัน/เดือน/ปี_____โทรศัพท์_____
ที่อยู่ปัจจุบัน _____

การร้องเรียนเกี่ยวกับการวิจัย

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- ข้าพเจ้าเข้าใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูกเก็บเป็นความลับจากนักวิจัย
- ข้าพเจ้ามีโอกาสได้รับการตอบคำถามจากนักวิจัยทุกๆคำถามที่สงสัย
- ในกรณีที่ข้าพเจ้าต้องการทราบผลการวิจัย เรายินดีจะส่งข้อมูลให้ท่านหรือให้ท่านรับผลการวิจัยได้ที่หน่วยบริการปฐมภูมิแห่งนี้

ลงนามผู้ให้ความยินยอม:_____
ลายเซ็นต์/ลายนิ้วมือ_____**วัน/เดือน/ปี**_____
โทรศัพท์_____ **ที่อยู่ปัจจุบัน** _____
พยาน_____**ลายเซ็นต์**_____

การร้องเรียนเกี่ยวกับการวิจัย

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การทดสอบนำร่อง

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ลงนามผู้ให้ความยินยอม:_____ลายเซ็นต์_____
วัน/เดือน/ปี_____โทรศัพท์_____
ที่อยู่ปัจจุบัน _____

การร้องเรียนเกี่ยวกับการวิจัย ?

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APPENDIX 18: Verified cross-language validity

Department of English Langauge and Literature

Faculty of Liberal Arts, Ubon Ratchathani University

Ubon Ratchathani Province, Thailand, 34190

29th December 2016

To whom it may concern,

My name is Songpon Intasian, a lecturer in English as Foreign Language at the Faculty of Liberal Arts, Ubon Ratchathani University, Ubon Ratchathani Province, Thailand. I graduated with a Bachelor of Arts majoring English from Khon Khaen University, Thailand in 1996, a Masters of Arts in English Language Teaching from University of Canberra, Australia, in 2003. I have worked at Ubon Ratchathani University for longer than 20 years.

I have reviewed the following translated documents from English to Thai language, namely, Information Statement, Inform Consent, 7 questions for Focus group interviews. I have also reviewed the translated document from Thai to English language of the final survey instrument. These documents are a part of the research study entitled "Promoting active ageing in older people with mental disorders in Primary Care Units in Thailand: The development and psychometric testing of an assessment tool". I verify that all Thai documents and English version of the final survey instrument are translated accurately and appropriately.

Please do not hesitate to contact me if you would need more information.

(Songpon Intasian)

LA 101/1, Department of English Langauge and Literature

Faculty of Liberal Art, Ubon Ratchathani University

Ubon Ratchathani Province, Thailand, 34190

Email:songpon.i@ubu.ac.th

APPENDIX 19: The integrative review of this research proposal

Title: Promoting active ageing in older people with mental disorders living in the community: methodological considerations of an integrative review

The integrative reviews of this part for developing the research proposal of this thesis was to critically synthesise the evidence from previous studies related to promoting active ageing in older people with mental disorders living in the community from January 2002 to March 2015. This integrative review was submitted to the International Journal of Nursing Practice on 17th August 2016. The first revision was resubmitted on the 11th August 2017, with the search updated to include January 2002 to March 2017.

AIM OF THE INTEGRATIVE REVIEW

The main aim of this integrative review was to critically synthesise the evidence from previous studies published in English and Thai in relation to promoting active ageing in older people, including those with mental disorders. This integrative review also aimed to synthesise previous studies in terms of 1) impact of mental disorders on active ageing and related concepts, and 2), issues related to active ageing, working with older people and mental health problems in the community.

METHODS

This part of the review of the literature was conducted by the PhD student using a five-stage approach established by Whittemore and Knafl (2005) which included: problem identification, literature search, data evaluation, data analysis, and presentation. The inclusion criteria were research articles that defined the promotion of active ageing and related concepts, active ageing and related concepts associated with mental disorders, the perspective of older people regarding active ageing, and issues related to work with older people and mental health problems in communities. Older people were defined as

those 60 years and older in this review (WHO, 2017a). The main search terms are presented in Table 1.

Table 1: Main search terms

Active ageing	Mental disorders	Primary care staff	Issues
Healthy ageing	Mental illnesses	Doctors	Impact
Successful ageing	Depression disorder	Dentists	Effect
Productive ageing	Schizophrenia	Nurses	Concern
Ageing well	Cognitive impairment	Social workers	Influence
Optimal ageing	Dementia	Primary care providers	Barrier
	Anxiety disorder	Pharmacists	Facilitator

There were three steps to the search strategy. First of all, an initial limited search of CINAHL, MEDLINE, EMBASE, PsycINFO, and Thai LIS and manual searching were undertaken to identify keywords which contained in the title or abstract to identify studies not identified in the computer search of the literature published in English and Thai during January 2002, which is the year of the World Health Organization launched 'Active Ageing-A Policy Framework' (WHO, 2002) to March 2017. Then, index terms were used to describe relevant articles. Boolean operators with AND, and OR were used to combine words and phrases for narrowing and expanding of the search strategy. Secondly, all identified keywords and index terms were used to undertake an extensive search. During the third step, reference lists and bibliographies were searched to find further relevant articles. Finally, articles that contained insufficient information, discussion papers, systematic reviews, specific reviews, and poorly designed studies were excluded from the selected of literature (Bettany-Saltikov, 2010; Kable et al., 2012).

Methodological quality was assessed using a checklist developed by the Joanna Briggs Institute and based on the work of the Cochrane Collaboration and Centre for Reviews and Dissemination (The Joanna Briggs Institute(JBI), 2016) (see Table 2-1). The mixed

method appraisal tool (MMAT) was also used to examine the methodological quality of mixed method studies (National Collaborating Centre for Methods and Tools, 2015) (see Table 2-1).

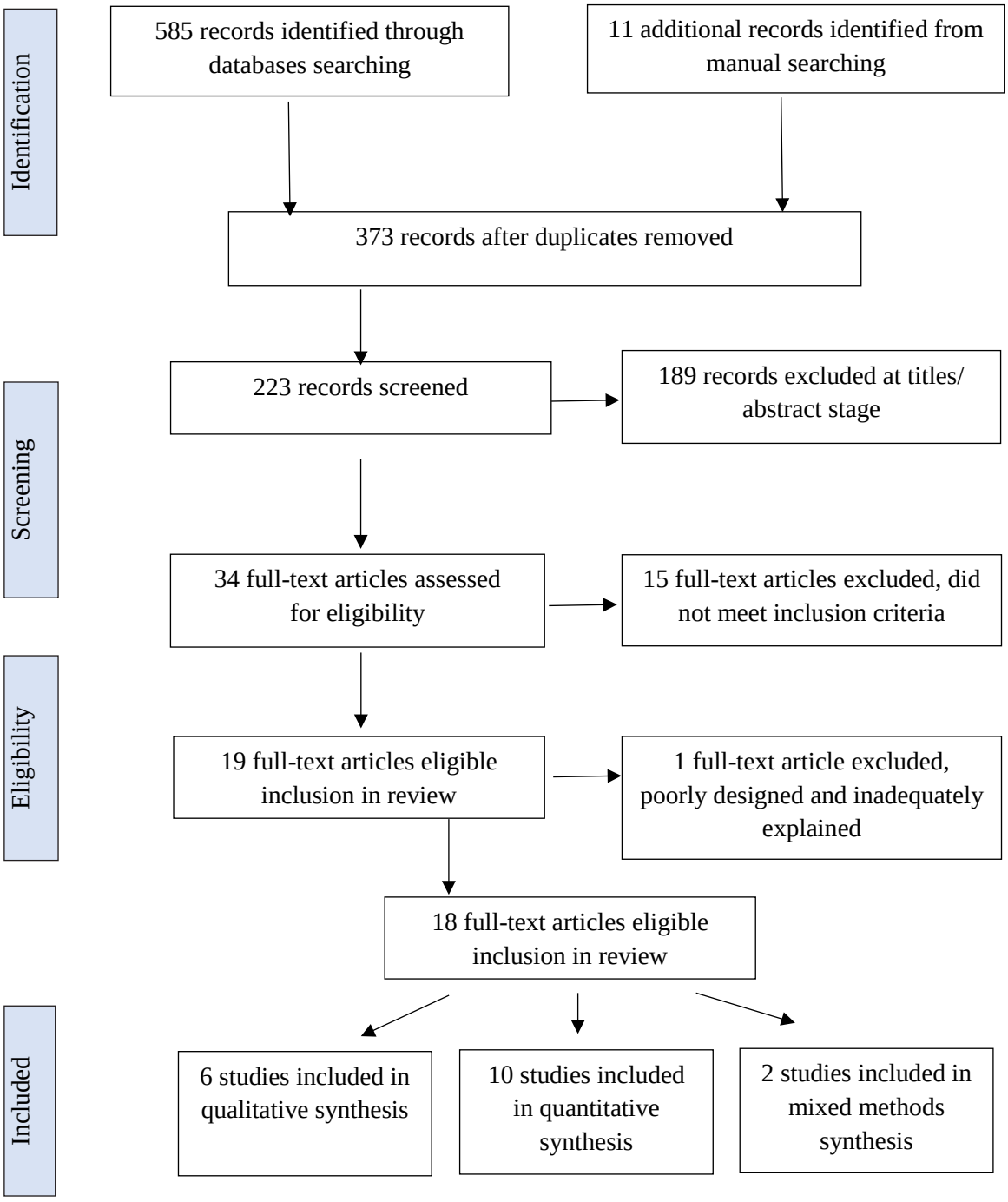

Figure 1: PRISMA flow diagram

RESULTS

The total number of articles included in this integrative review accounted for 18 papers. The results included studies from the UK (4), the USA (3), Sweden (3), Mexico (2), Spain (2), Australia (1), Scotland (1), Taiwan (1), and Korea (1). Five of the articles were from a nursing perspective while the other studies were from medical and multidisciplinary perspectives. The evidence selected for this review was organized into various themes as follows.

The promotion of active ageing and related concepts

Only an earlier study from Taiwan evaluated the policies and practices relevant to the promotion of active ageing, and this focused only on older people in general or healthy older adults (Lin et al., 2013). The results indicated that promotion of active ageing in non-profit organisations prioritised strategies relating to physical health. For example, exercise and health education, mental health, family association, learning new skills, being respected, and participation in the community. The most popular activities of promoting active ageing for older people were leisure activities including tourism, neighbourhood friendships, healthcare study programmes, participating in, and watching talent shows, health promotion, and lifelong education. The problems faced by older people wanting to participate in activities of active ageing included transportation, a lack of incentives, excessive distances, a lack of companions and safety concerns. Barriers for service providers were resources, staffing issues, lack of volunteers and transport and older people being unwilling to attend. Human and financial resources were the most significant factors for promoting active ageing (see Table 2-2).

Others previous studies were quasi-experimental studies and randomized control trials of the promotion of active ageing and related concepts and were mainly conducted in older

people in general or healthy older people, and older people with mental disorders were not recruited in these previous studies (Caprara et al., 2016; Mendoza-Ruvalcaba & Arias-Merino, 2015; Mendoza-Ruvalcaba & Fernández-Ballesteros, 2016). For example, a randomized controlled trial to evaluate the effectiveness of a programme of promotion of active ageing called “I am active” was conducted in Mexico (Mendoza-Ruvalcaba & Arias-Merino, 2015). The main aim of this programme was to improve depressive symptoms and cognitive impairment in older people. However, this study recruited only healthy older persons (see Table 2-2). A recent study conducted using a quasi-experimental design with two experimental conditions to determine the effectiveness of the programme for promoting active ageing was found (Mendoza-Ruvalcaba & Fernández-Ballesteros, 2016). In this study, participants were seventy-six older persons aged 60 years and older from a senior centre in Mexico who were healthy (see Table 2-2). In additional, Caprara et al. (2016) examined the effect of a psycho-educational multimedia programme designed to promote successful ageing in older adults from Spain. The findings revealed that the older people in the experimental group mentioned better health, higher frequency of cultural, intellectual and social activities, more physical exercise and healthier diets. They also had better memory functioning and felt fewer negative emotions (see Table 2-2). Lastly, the study evaluated the effect of life review based on remembering specific positive events to improve life satisfaction, increase specific memories, and reduce depressive symptoms, but again, older people with mental disorders were not included in the program (Latorre et al., 2015) (see Table 2-2).

Impact mental disorders on active ageing and related concepts

Previous studies showed that people, including older people, experiencing mental disorders are negatively associated with successful ageing (Ibrahim et al., 2010; Jeste et

al., 2013; Vahia et al., 2010). A previous study from the USA found that depression disorder was negatively associated with successful ageing (Vahia et al., 2010) as older women with depression had poorer scores on measures of successful ageing (mean = 6.7) than the sub-threshold depression group (mean = 7.9) which in turn had lower scores than the non-depressed group (mean = 8.5) (see Table 2-2). A previous study also examined rates of successful ageing between older adults with and without schizophrenia living in the community (Ibrahim et al., 2010). The results indicated that those with schizophrenia were less likely to achieve successful ageing compared with those without ($p<0.001$). Fewer negative symptoms and a higher quality of life index were two variables in the schizophrenia group associated with successful ageing (see Table 2-2). A previous study from the USA also examined the association between self-rated successful ageing and psychological factors, including physical health, among older people living in the community (Jeste et al., 2013). The main findings were that psychological factors including well-being, resilience, optimism, and an absence of depression played an important role in enhancing successful ageing in older people. The most important factors for successful ageing were promoting resilience and the prevention of depression (see Table 2-2).

The perspective of older people in relation to active ageing

Previous studies were found which explored the opinion of older people living in communities or institutions in relation to active ageing. Overall findings indicated they believe that support by health care providers would help them engage in active ageing and improve their quality of life (Buys et al., 2008; Grundberg et al., 2014; Kim, 2009). For instance, Grundberg et al. (2014) explored health-promoting dialogues from the perspective of older people who lived in Stockholm, Sweden. This research found that

older people with multi-morbidities wanted to be able to talk about their mental health matters. The researchers recommended that health care and social service providers should initiate this type of dialogue in order to improve mental health in this group. Further, they believe that social support and dialogue are vital factors in promoting mental health in older people with multiple chronic diseases (see Table 2-3). Kim (2009) examined the expectations of older people relevant to their physical and psychological health status as they aged and identified the mediating effect of health-promoting behavior using a cross-sectional design, correlational study. The main findings indicated that older people with higher expectations about ageing were more likely to maintain better levels of physical and mental health (see Table 2-2). Buys, Boulton-Lewis, Tedman-Jones, Edwards, Knox, Bigby (2008) explored issues of active ageing from the opinion of older people with lifelong intellectual disabilities in Australia. The results showed that older people experiencing intellectual disabilities wanted and needed the same things as those in the general population or healthy people. The most important factors for achieving active ageing were being empowered, having independence and having a meaningful role. However, Buys et al. (2008) also found they lacked appropriate support from health providers to achieve these (see Table and 2-3).

The perspective of primary care staff working with older people and mental health problems at the community level

Several researchers found that there are a variety of barriers and facilitators for health care professional in order to care and work with older people, including those with mental disorders, at the community level or in primary care (Goodman et al., 2011; Runciman et al., 2006; Wilhelmsson & Lindberg, 2009). For example, Runciman et al. (2006) studied how community nurses contribute to health promotion for older people living in the

community in Scotland. The findings showed that health promotion, including, diet, exercise, mental health, and positive ageing among community-dwelling older people was a low priority or was unrecognized by the nurses. Community nurses mainly focused on the physical health of older people rather than activities of health promotion. Biomedical policies from policymakers were prioritised over non-biomedical policies for those working in health services. The nurses mentioned they lacked skills to perform health promotion in older people living in the community. These results raise issues around the need for appropriate policy, practice and education of health service providers to manage health promotion for older people living in the community (see Table 2-2).

Goodman et al. (2011) explored nurse-led interventions to promote activity for older people and examined the knowledge and attitudes of primary care nurses regarding the health benefits of activity promotion for older people in the UK. This research found that the nurses were a committed, interested, and had opportunities to support older people in their physical activities, and these were considered to be a crucial element for healthy ageing. However, there were barriers to promoting activities, such as lack of time, organisational restrictions and limited opportunities for referring patients to suitable services. The study suggested primary care nurses should be supported to undertake specialist training and establish formal links with appropriate services for older people with complex needs (see Table 2-2).

Wilhelmsson and Lindberg (2009) identified district nurses' opinion in terms of the facilitators and barriers to health promotion in Sweden. The findings showed that the nurses were interested in the concepts of health promotion and active ageing. Specialized knowledge of health promotion, and public health in the area of primary care centres; common goals, guidelines, and resources for working with health promotion; distinctive

features in term of attitude, characteristics, and freedom of choice for health promotion were important facilitators to promote active ageing and health promotion. They found a lack of coordination, resources or organisation, interest, and support from management who viewed prevention and health promotion as low priorities were vital barriers to organising health promotion for primary care nurses (see Table 2-1 and 2-3). Furthermore, Murray et al. (2006) stated that co-existence of physical illness and mental illness are widely recognised in older people however these are barriers for primary care staff when they need to identify and treat people with mental health problems, in particular, older people with mental disorders (Murray et al., 2006) (see Table 2-3). It is believed they lack the training to care for people with mental health problems (Haddad et al., 2005). They also need education programs to improve their understanding and skills for detecting psychological problems, managing depression and anxiety, provide interventions in a crisis and to increase medication compliance (Haddad et al., 2005) (see Table 2-2).

The majority of primary care staff felt the care of people with severe mental illnesses was too specialised for routine primary care (Lester et al., 2005) however, patients with mental disorders' prefer to consult primary care staff rather than health professionals who are specialists in mental health (Lester et al., 2005) (see Table 2-3). Lack of resources, such as no guidelines or structured goals for mental health care in their settings and lack of a structured forum for collaboration between healthcare providers and their patients with mental health problems, were also barriers for district nurses working at the community level (Grundberg et al., 2016). They also needed more knowledge regarding interview techniques and assessment instruments for mental health problems (Grundberg et al., 2016) (see Table 2-3).

DISCUSSION

Various methodologies were used in the quantitative studies and the qualitative studies. Only two studies were cross-sectional analytical studies which compared people without mental disorders and people with mental disorders, namely depression disorders (Vahia et al., 2010) and schizophrenia (Ibrahim et al., 2010) in the USA. The first study used a survey questionnaire with a self-rated assessment to compare successful ageing among older women classified into three groups: non-depressed persons, sub-threshold depression, and depression disorder (Vahia et al., 2010). The results suggest that people with depressive disorders are negatively associated with successful ageing. Meaning, people with mental disorders are less likely to achieve active ageing and well-being.

All of the qualitative studies used descriptive design to explore the perspectives of older people in terms of active ageing and primary care providers rationale for working with older people with mental disorders in communities. The data represented the perspectives of participants and contributed to understanding the issues relating to active ageing; the service needs gaps for older people with mental health problems in rural areas, and the facilitators and barriers for working with older people in communities. Participants of these studies included were primary care providers such as district nurses, multidisciplinary teams in community health services, older people living in community, and older people with mental disorders (Goodman et al., 2011; Grundberg et al., 2014; Kim, 2009; Lester et al., 2005; Lin et al., 2013; Muir-Cochrane et al., 2014; Murray et al., 2006; Wilhelmsson & Lindberg, 2009).

The concept of active ageing, promoting active ageing and enhancing the well-being of older people was launched by WHO 2002 (WHO, 2002) however there is little research on how to promote active ageing in older people with mental disorders. A study from

Taiwan used a mixed method design to examine the policies and practices for adopting the promotion of active ageing (Lin et al., 2013). However, this study focused on older people in general and not specifically those with mental health issues. Previous studies both experimental or quasi-experimental in relation to the promotion of active ageing or related concept were also recruiting only healthy older people and excluded older people with mental health problems from their studies (Caprara et al., 2016; Mendoza-Ruvalcaba & Arias-Merino, 2015; Mendoza-Ruvalcaba & Fernández-Ballesteros, 2016). More importantly, the Latorre study was to evaluate the effect of life review to reduce depressive symptoms however older people with mental illnesses living in the community were not recruited into this experimental study (Latorre et al., 2015). This integrative review points out the important issue that older people with mental disorders are under-recognised not only by healthcare professionals but also by researchers.

The findings of this integrative review also raise issues around the need for appropriate policy, practice and education of service providers to promote active ageing in older people, in particular, older people with mental disorders. This is because they are less likely to achieve successful ageing compared with healthy older people (Ibrahim et al., 2010; Jeste et al., 2013; Vahia et al., 2010). However, there are several issues in promoting active ageing in communities and with primary care providers who need to focus on enhancing and supporting older people especially older people with mental disorders (Runciman et al., 2006). The findings show barriers to health promotion based on the concept of active ageing, particularly mental health problems in primary care, including lack of time and organisational constraints (Runciman et al., 2006). Furthermore, those wishing to promote active ageing should be concerned about the barriers for older people participating in active ageing activities in communities, or in primary care (Grundberg et al., 2014; Lin et al., 2013). Older people need empowerment

from primary care providers, and the social support from their relatives to engage in active ageing (Grundberg et al., 2014; Kim, 2009). The findings of this review recommend primary care providers be supported to undertake specialist training and to establish formal links with appropriate services for older people with complex needs (Goodman et al., 2011), particularly older people with mental disorders (Murray et al., 2006). They also need to be supported with resources, guidelines and have better collaboration with mental health services (Grundberg et al., 2016). Interestingly, primary care staff complained that the important issue they found with serious mental illnesses was that it is very difficult for them to deal with these tasks without support from the experts (Lester et al., 2005).

REVIEW LIMITATIONS

This review retrieved the papers from five databases used English and Thai languages the CINAHL Complete, MEDLINE, PsycINFO, and EMBASE, which are important databases relate to nursing, medicine, and health. Thai LIS or Thai Digital Collection, is a database that includes all full papers and dissertation from universities in Thailand. It is acknowledged that there may be relevant studies published in other languages and databases that have not been identified.

CONCLUSION

This integrative review provided insight into the promotion of active ageing in older people with mental disorders in primary care settings determining that action is urgently needed because there are no previous studies. Older people experiencing mental illnesses are less likely to achieve active ageing without supportive from a healthcare professional. However, primary care providers need specialist skills, knowledge, and resources to promote active ageing in older people with mental disorders living in the community. Mental health problems, particularly serious mental disorders, may be too difficult for

primary care staff to deal with these problems. The mental health services who specialise in these illnesses should support and train primary care staff to enhance their skills in mental health conditions. Health policy should urgently support primary care staff to promote active ageing in older people with mental disorders and provide the budget and resources. The curriculum of education programs for primary care providers should cover the knowledge about detecting mental health problems, manage mental illnesses symptoms and instigate a referral system from primary care to specialise in mental health services. Future research should be conducted with a large sample to examine the perspectives of primary care providers in promoting active ageing in older people with mental disorders.

Furthermore, there is an urgent need to provide evidence about the best ways for primary care providers to promote active ageing in this group. To date, an instrument measuring how older people with mental disorders living in the community have had active ageing promoted, and what factors influence the promotion of active ageing in this group has not been developed. This review shows that such an instrument is urgent to find solutions for promoting active ageing in older people with mental disorders living in the community.

APPENDIX 20: The Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD) (English version)

Instruction: You will be asked to complete the enclosed survey instrument that is designed to assess the promotion of active ageing in older people with anxiety, depression or similar issues in primary care units in Thailand. Completing this should take up to 10-15 minutes.

Section 1 General information and familiarity with the concept of active ageing

Items	Questions	Recommend
1.	**Sex** ( ) Male ( ) Female	
2.	**Age**.....Years	
3.	**Marital Status** ( ) Single ( ) Married ( ) Divorced ( ) Windowed ( ) Separated ( ) Others	
4.	**Occupation** ( ) General practitioner ( ) Pharmacist ( ) Registered nurse ( ) Health officer ( ) Assistant health officers ( ) Dental assistant ( ) Aids ( ) Assistant pharmacist ( ) Nurse assistant ( ) Other_____	
5.	**Education** ( ) Lower than diploma ( ) Diploma ( ) Certificate ( ) Bachelor degree ( ) Master degree ( ) Higher than master degree ( ) Other, please specify.....	
6.	**Do you work in a :** ( ) Health promotion hospital ( ) Primary care unit of district hospital	

Items	Questions	Recommend
7.	How long have you worked in this primary care unit? .....Years	
8.	**Have you ever for cared older people with mental disorders?** ☐ No **<u>Go to item 10</u>** ☐ Yes, How long? .....years ☐ N/A	
9.	**How confident are you in caring for older people with mental disorders?** ☐ A Little ☐ Moderately ☐ Quite confident ☐ Very confident	
10.	**What education or training in psychiatric or mental health care have you received?** ☐ None ☐ Informal such as on the job training, supervision ☐ Formal such as certificate, degree diploma, please specify …….	
11.	**What education or training regarding how to care for older people have you received?** ☐ None ☐ Informal such as on the job training, supervision ☐ Formal such as certificate, degree diploma, please specify …….	
12.	**What education or training on how to care older people with mental disorders have you received?** ☐ None ☐ Informal such as on the job training, supervision ☐ Formal such as certificate, degree diploma, please specify……..	

Items	Questions	Recommend
13.	**Are you familiar with the following concepts?** 13.1 Healthy ageing ☐ No ☐ Yes 13.2 Successful ageing ☐ No ☐ Yes 13.3 Ageing well ☐ No ☐ Yes 13.4 Productive ageing ☐ No ☐ Yes 13.5 Positive ageing ☐ No ☐ Yes 13.6 Optimal ageing ☐ No ☐ Yes 13.7 Active ageing ☐ No ☐ Yes	
14.	**Do you understand the concept of promoting active ageing in older people with mental disorders?** ☐ No ☐ Yes, please give examples of interventions	

Section II: Activities promoted or offered to older people with mental disorders

The concept of active ageing was developed by the WHO in 2002. The three pillars of this concept are participation, health, and security. Participation means older people have the opportunity to participate in activities in communities. Health means both physical and mental health for older people. Security means they have security, both financial and safety in their day to day lives.

Please, indicate with a √ if your primary care units or you or your staff promoted o roffered activities of promoting active ageing in older people with mental disorders the following activities:

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
	1. Participation					
1.	Religious activities: 1.1 Making merit					
	1.2 Others, please give information…….……					
2.	Cultural activities: 2.1 Respect older people in Songkran festival					
	2.2 Others, please give information……..					
3.	Neighbourhood friendship activities: 3.1 Visit each other in villages					
	3.2 Follow and support postpartum care					
	3.3Follow and support patients care					
	3.4Others, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
4.	Political activities: 4.1 National election					
	4.2 Local election					
	4.3 Other, please give information……					
5.	Senior clubs: 5.1 Senior associations					
	5.2 Meetings of senior associations					
	5.3 Other, please give information……					
6.	Thai wisdom activities: 6.1 Basketry					
	6.2 Weaving					
	6.3 Fortune telling					
	6.4 Thai herbal					
	6.5 Other, please give information……					
7.	Volunteer activities: 7.1 Community cleaning					
	7.2 Meal delivery services					
	7.3 Other, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
	2. Education					
8.	School of older people					
9.	Health education in primary care units					
10.	Life skills education: 10.1 Agriculture					
	10.2 Mushroom cultivation					
	10.3 Sewing					
	10.4 Healthy cooking					
	10.5 Woven mats					
	10.6 Other, please give information……					
	3. Health					
11.	Promotion of physical health activities: 11.1 Exercise					
	11.2 Other, please give information……					
12.	Assessment of physical health and screening health problems: 12.1 Annual health examination					
	12.2 Assessment attached to the bed					
	12.3 Assessment of Body Mass Index					
	12.4 Other, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
13.	Assessment of mental health problems: 13.1 Depression					
	13.2 Suicide risk					
	13.3 Dementia					
	13.4 Other, please give information……					
14.	Home visits: 14.1 Older people with mental disorders					
	14.2 Older people with disability					
	14.3 Other, please give information……					
15.	Health education for physical health: 15.1 Nutrition for older people with chronic diseases					
	15.2 Other, please give information……					
16.	Health education for mental health: 16.1 Observe mental health problems					
	16.2 Stress management					
	16.3 Other, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
17.	Health education for family of older people in physical health promotion: 17.1 Nutrition					
	17.2 Medication administration					
	17.3 Other, please give information……					
18.	Health education for family of older people in mental health promotion: 18.1 Respectful of older people					
	18.2 Other, please give information……					
19.	Promotion activities for improving family relationship 19.1 Family therapy					
	19.2 Family counselling					
	19.3 Other, please give information……					
20.	Teeth health activities: 20.1 Teeth examination					
	20.2 Education on oral hygiene					
	20.3 Other, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
	4. **Leisure**					
21.	Recreation activities in the community: 21.1 Local dancing					
	21.2 Other, please give information……					
22.	Recreation activities outside the community: 22.1 Religion tourism in another city					
	22.2 Travel in another city					
	22.3 Other, please give information……					
23.	Promotion of suitable recreation activities: 23.1 Reading book					
	23.2 Caring for animals					
	23.3 planting trees					
	23.4 Other, please give information……					

Items	Activities promoting active ageing in older people with mental disorders	How often do you promote the following activities?				
		Never	Sometime	Often	Usually	Always
	5. **Security**					
24.	Welfare for older people: 24.1 Monthly living cost					
	24.2 Welfare of community for supporting older people					
	24.3 Other, please give information……					
25.	Suggestion for saving money					
26.	Promotion activities for supporting income of older people: 26.1 Selling products from older people (trees, vegetables, basketwork)					
	26.2 Other, please give information……					
27.	Health education for living safety: 27.1 Healthy environments suitable for older people and older people living with diseases					
	27.2 Other, please give information……					
28.	Activities for improving health environment for older people living safety: 28.1 Destroying breeding mosquitoes					
	28.2 Other, please give information……					

Section III: Factors that influence promotion of active ageing in older people with mental disorders

1 = Strongly disagree, 2 = Disagree, 3 = Moderately agree, 4 = Agree, and 5 = Strongly agree

Items	Questions	Score					Recommend
		1	2	3	4	5	
	Facilitators						
1.	Having a national policy for older people with mental disorders.						
2.	Having a health service policy for older people with mental disorders.						
3.	Having been taught or on the job training from mental health services.						
4.	Having supervision from mental health services.						
5.	Having a counselling system of care from mental health services.						
6.	Having collaboration with other government services, such as local government, police, schools.						
7.	Having co-operation with older people with mental disorders.						
8.	Having cooperation from families of older people with mental disorders.						
	Others idea……						
	Barriers						
9.	The policy for mental disorders in older people does not cover all diseases.						
10.	The job description of primary care providers for promoting active ageing in older people with mental disorders is not clear.						
11.	Health policy gives priority to care for physical health rather than mental health.						
12.	There is high workload in working in primary care units.						
13.	Mental health illnesses are stigmatised in Thai culture.						
14.	There is a lack of cooperation from older people with mental disorders.						
15.	There is a lack of cooperation from families of older people with mental disorders.						
16.	There is a lack of knowledge about how to promote active ageing in older people with mental disorders.						

Items	Questions	Score					Recommend
		1	2	3	4	5	
17.	There is a lack of knowledge and insight into mental health problem of older people.						
	Others idea……						
	Knowledge						
18.	Knowledge the principles for promoting active ageing in older people with mental disorders						
19.	Knowledge how to assess and screen older people with mental disorders						
20.	Knowledge how to care for older people with mental disorders						
21.	Knowledge how to rehabilitate older people with mental disorders						
22.	Knowledge how to manage psychiatric medication and potential side effects						
23.	Knowledge common mental health problems in older people						
24.	Knowledge symptoms and severity of mental disorders in older people						
25.	Knowledge how to advise their family in supporting older people with mental disorder						
	Others idea……						
	Skills						
26.	Having skills in promoting active ageing in older people with mental disorders.						
27.	Having skills in assessing and screening older people experiencing mental disorders.						
28.	Having skills in basic counselling for older people with mental disorders.						
29.	Having skills to care for older people with mental disorders.						
30.	Having skills to rehabilitate older people with mental disorders.						
31.	Having skills to communicate with older people with mental disorders.						
32.	Having skills to communicate with families of older people with mental disorders.						
	Others idea…….....						

Items	Questions	Score					Recommend
		1	2	3	4	5	
	Resources and support						
33.	Increasing human resources for promoting active ageing in primary care units.						
34.	Improving potential of primary care providers to address mental health in older people.						
35.	Increasing budget for supporting older people with mental disorders						
36.	Supporting media and technology to promote active ageing in older people with mental disorders.						
37.	Supporting media and technology for caring for older people with mental disorders.						
	Others idea…….						

Suggestions for further improvement

.....

.....

.....

APPENDIX 21: The Promoting Active Ageing in Older People with Mental Disorders Scale (PAA-MD) (Thai version)

<u>คำชี้แจง</u> ท่านจะถูกเชิญชวนให้ข้อเสนอแนะและตอบคำถามในเครื่องมือเพื่อประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาทางสุขภาพจิตและจิตเวช ได้แก่ ภาวะวิตกกังวล โรคซึมเศร้า หรือปัญหาสุขภาพจิตอื่นๆที่มารับบริการในสถานบริการปฐมภูมิของไทย การตอบคำถามจะใช้เวลาประมาณ 10-15 นาที

ส่วนที่ 1 แบบสอบถามข้อมูลส่วนบุคคล

ข้อ	ข้อคำถาม	ข้อเสนอแนะ
1.	**เพศ** ( ) ชาย ( ) หญิง	
2.	**อายุ**.....ปี	
3.	**สถานภาพสมรส** ( ) โสด ( ) คู่ ( ) หย่าร้าง ( ) หม้าย/ม่าย ( ) แยกกันอยู่ ( ) อื่นๆ (โปรดระบุ)	

ข้อ	ข้อคำถาม	ข้อเสนอแนะ
4.	**อาชีพ / ตำแหน่ง** ( ) แพทย์ ( ) ทันตแพทย์ ( ) เภสัชกร ( ) พยาบาลวิชาชีพ ( ) นักวิชาการสาธารณสุข ( ) ผู้ช่วยสาธารณสุข ( ) เจ้าหน้าที่บันทึกข้อมูล ( ) ผู้ช่วยเหลือคนไข้ ( ) ผู้ช่วยทันตแพทย์ ( ) เจ้าหน้าที่ทันตภิบาล ( ) เจ้าพนักงานเจ้าหน้าที่เ/ภสัชกร ( ) อื่นๆ โปรดระบุ.....	
5.	**ระดับการศึกษา** ( ) ต่ำกว่าอนุปริญญา ( ) อนุปริญญา ( ) ปริญญาตรีหรือเทียบเท่า ( ) ปริญญาโทหรือเทียบเท่า ( ) สูงกว่าปริญญาโท ( ) อื่นๆ โปรดระบุ.....	
6.	**ลักษณะของสถานพยาบาลปฐมภูมิที่ท่านทำงาน** ( ) โรงพยาบาลส่งเสริมสุขภาพประจำตำบล ( ) สถานพยาบาลปฐมภูมิภายใต้โรงพยาบาล	
7.	**ระยะเวลาในการทำงานในสถานพยาบาลปฐมภูมิแห่งนี้.....ปี**	
8.	**ท่านเคยให้การพยาบาลดูแลหรือให้คำแนะนำผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชหรือไม่** □ ไม่เคย **<u>ข้ามไปตอบข้อ 10</u>** □ เคย **ระบุระยะเวลานานเท่าไหร่.....ปี** □ ไม่มีข้อมูล	

ข้อ	ข้อคำถาม	ข้อเสนอแนะ
9.	**<u>ในกรณีที่ท่านเคยให้การดูแลรักษาบริการผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช</u>** ท่านมีความมั่นใจในการให้การดูแลรักษาบริการผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชมากน้อยเท่าไหร่ ☐ มั่นใจเล็กน้อย ☐ มั่นใจปานกลาง ☐ มั่นใจค่อนข้างมาก ☐ มั่นใจมากที่สุด	
10.	**ท่านเคยได้รับการศึกษาหรืออบรมเกี่ยวกับการดูแลผู้มีปัญหาสุขภาพจิตและจิตเวชหรือไม่** ☐ ไม่เคย ☐ เคย ได้รับการสอนงานจากผู้รับผิดชอบงานสุขภาพจิตหรือหน่วยงานสุขภาพจิตเฉพาะทางหรือ ได้รับการนิเทศงาน เป็นต้น ☐ เคย ได้รับการอบรมจากหน่วยงานต่างๆ หรือ ได้รับประกาศนียบัตร กรุณา ระบุ.....	
11.	**ท่านเคยได้รับการศึกษาหรืออบรมเกี่ยวกับการดูแลผู้สูงอายุหรือไม่** ☐ ไม่เคย ☐ เคย ได้รับการสอนงานจากผู้รับผิดชอบงานผู้สูงอายุหรือหน่วยงานเฉพาะทางหรือ ได้รับการนิเทศงาน เป็นต้น ☐ เคย ได้รับการอบรมจากหน่วยงานต่างๆ หรือ ได้รับประกาศนียบัตร กรุณา ระบุ.....	

ข้อ	ข้อคำถาม	ข้อเสนอแนะ
12.	**ท่านเคยได้รับการศึกษาหรืออบรมเกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชหรือไม่** ☐ ไม่เคย ☐ เคย ได้รับการสอนงานจากผู้รับผิดชอบงานสุขภาพจิตหรือหน่วยงานเฉพาะทางจิตเวชหรือ ได้รับการนิเทศงาน เป็นต้น ☐ เคย ได้รับการอบรมจากหน่วยงานต่างๆ หรือ ได้รับประกาศนียบัตร กรุณา ระบุ.....	
13.	**ท่านเคยได้ยินหรือทราบเกี่ยวกับแนวคิดดังต่อไปนี้หรือไม่** <u>13.1 แนวคิด “สูงวัยอย่างมีสุขภาวะ” หรือ “Healthy Ageing”</u> ☐ ไม่เคย ☐ เคย <u>13.2 แนวคิด “การสูงวัยที่ประสบความสำเร็จ” หรือ “Successful ageing”</u> ☐ ไม่เคย ☐ เคย <u>13.3 แนวคิด “การสูงวัยอย่างสมบูรณ์ที่สุด” หรือ “Ageing well”</u> ☐ ไม่เคย ☐ เคย <u>13.4 แนวคิด “การสูงวัยที่ยังประโยชน์” หรือ “Productive Ageing”</u> ☐ ไม่เคย ☐ เคย	

ข้อ	ข้อคำถาม	ข้อเสนอแนะ
	13.5 แนวคิด “การสูงวัยอย่างดีที่สุด” หรือ “Positive Ageing” ☐ ไม่เคย ☐ เคย 13.6 แนวคิด “การสูงวัยอย่างเหมาะสมที่สุด” หรือ “Optimal Ageing” ☐ ไม่เคย ☐ เคย 13.7 แนวคิด “ภาวะพฤฒพลัง” หรือ “Active Ageing” ☐ ไม่เคย ☐ เคย	
14.	ท่านคิดว่าการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชควรทำอย่างไร ☐ ไม่ทราบ ☐ ทราบ กรุณาให้ตัวอย่าง.....	

<u>ส่วนที่ 2 แบบประเมินการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช</u>

ภาวะพฤฒพลัง หมายถึง การที่ผู้สูงอายุยังคงมีกิจกรรมต่างๆร่วมกับครอบครัว สังคม และชุมชนในด้านเศรษฐกิจ วัฒนธรรม การเมืองการปกครอง และการทำงาน ไม่ใช่เพียงแค่มีการมีกิจกรรมทางกายหรือการออกกำลังกายเท่านั้น แนวทางการพัฒนาผู้สูงอายุที่เสนอโดยองค์การอนามัยโลก (WHO, 2002) ได้ระบุว่า องค์ประกอบสำคัญ 3 ประการของการพัฒนาผู้สูงอายุควรประกอบด้วย การพัฒนาสุขภาพ การส่งเสริมความปลอดภัย และการสร้างความมีส่วนร่วมในครอบครัวและชุมชน (Participation, Health, and Security)

<u>คำชี้แจง</u> โปรดทำเครื่องหมาย √ หน้าข้อความ**เกี่ยวกับการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชในชุมชนของท่าน โดยท่านหรือหน่วยงานของท่านได้มีการจัดกิจกรรมกระตุ้นให้ผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชหรือให้คำแนะนำและเข้าร่วมกิจกรรมดังกล่าว** ดังรายละเอียดในแบบสอบถาม

<u>มีการแบ่งระดับคะแนนในแต่ละข้อดังนี้</u>

0 หมายถึง ไม่เคยมีการดำเนินการ

1 หมายถึง มีการดำเนินการเป็นบางครั้ง

2 หมายถึง มีการดำเนินการค่อนข้างบ่อย

3 หมายถึง มีการดำเนินการค่อนข้างสม่ำเสมอ

4 หมายถึง มีการดำเนินการสม่ำเสมอ

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
	1. ด้านการมีส่วนร่วม (Participation)						
1.	มีการจัดกิจกรรมทางศาสนาสำหรับผู้สูงอายุ: 1.1 การทำบุญทางศาสนาพุทธ เช่น ทำบุญตักบาตรวันพระและวันสำคัญทางศาสนา งานบุญ งานบวช						
	1.2 อื่นๆ โปรดระบุ.....						
2.	มีการจัดกิจกรรมทางประเพณี วัฒนธรรม: 2.1 รดน้ำดำหัวผู้สูงอายุในวันสงกรานต์						
	2.2 อื่นๆ โปรดระบุ.....						
3.	มีกิจกรรมเสริมสร้างความสัมพันธ์ระหว่างเพื่อนบ้าน: 3.1 มีการเยี่ยมบ้านเพื่อถามสารทุกข์สุกดิบซึ่งกันและกัน						
	3.2 มีส่วนร่วมในการเยี่ยมหญิงหลังคลอด						
	3.3 มีส่วนร่วมในการติดตามเยี่ยมคนป่วยในชุมชน						
	3.4 อื่นๆ โปรดระบุ.....						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
4.	มีกิจกรรมทางการเมือง 4.1 ระดับประเทศ เช่น การเลือกตั้งสมาชิกสภาผู้แทนราษฎร						
	4.2 ระดับท้องถิ่น เช่น การเลือกตั้งกำนัน/ผู้ใหญ่บ้าน/องค์การบริหารส่วนตำบล						
	4.3 อื่นๆ โปรดระบุ.....						
5.	มีกิจกรรมของชมรมผู้สูงอายุ: 5.1 ประชุมเพื่อวางแผนจัดกิจกรรมของชมรม						
	5.2 การจัดกิจกรรมของชมรม						
	5.3 อื่นๆ โปรดระบุ.....						
6.	มีกิจกรรมสืบสานภูมิปัญญาไทยสำหรับผู้สูงอายุ: 6.1 เครื่องจักรสาน						
	6.2 งานฝีมือ						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
	6.3 หมอดู						
	6.4 สมุนไพรไทย						
	6.5 อื่นๆ โปรดระบุ.....						
7.	มีการจัดกิจกรรมอาสาสมัคร 7.1 การทำความสะอาดภายในหมู่บ้าน						
	7.2 การทำอาหารเลี้ยงคน						
	7.3 อื่นๆ โปรดระบุ.....						
	2. ด้านการศึกษา (Education)						
8.	มีโรงเรียนสำหรับผู้สูงอายุ						
9.	มีห้องเรียนรู้ด้านการดูแลสุขภาพของโรงพยาบาลส่งเสริมสุขภาพประจำตำบล						
10.	มีกิ่อบรมความรู้เพื่อเพิ่มทักษะ: 10.1 การเกษตรกรรม						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
	10.2 การเพาะเห็ด						
	10.3 การเย็บเสื้อผ้า ทอผ้า เย็บผ้า						
	10.4 การประกอบอาหารสุขภาพ						
	10.5 หัตถกรรมทอเสื่อ						
	10.6 อื่นๆ โปรดระบุ.....						
	3. ด้านสุขภาพ (Health)						
11.	มีกิจกรรมส่งเสริมสุขภาพ 11.1 การออกกำลังกาย						
	11.2 อื่นๆ โปรดระบุ.....						
12.	มีกิจกรรมการประเมินสุขภาพกายและคัดกรองโรคทางกาย 12.1 การตรวจสุขภาพประจำปี						
	12.2 ประเมินภาวะติดเตียง						
	12.3 ประเมินดัชนีมวลกาย (BMI)						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
	12.4 อื่นๆ โปรดระบุ.....						
13.	มีกิจกรรมการคัดกรองประเมินภาวะสุขภาพจิต 13.1 ภาวะซึมเศร้า						
	13.2 ความเสี่ยงต่อการฆ่าตัวตาย						
	13.3 โรคสมองเสื่อม						
	13.4 อื่นๆ โปรดระบุ.....						
14.	มีกิจกรรมการติดตามเยี่ยมบ้าน 14.1 โรคทางจิตเวช						
	14.2 พิการ เดินไม่ได้ ปัญหาติดเตียง						
	14.3 อื่นๆ โปรดระบุ.....						
15.	มีกิจกรรมการให้ความรู้ด้านสุขภาพกาย 15.1 การรับประทานอาหารให้เหมาะสมกับโรคประจำตัวต่างๆ						
	15.2 อื่นๆ โปรดระบุ.....						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริมภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
16.	มีการกิจกรรมการให้ความรู้ด้านสุขภาพจิต 16.1 การสังเกตุอาการทางสุขภาพจิตและจิตเวชเบื้องต้น						
	16.2 การจัดการกับความเครียด						
	16.3 อื่นๆ โปรดระบุ.....						
17.	มีกิจกรรมการให้ความรู้แก่ครอบครัวในการดูแลผู้สูงอายุเพื่อส่งเสริมสุขภาพกาย 17.1 โภชนาการ						
	17.2 การรับประทานยา						
	17.3 อื่นๆ โปรดระบุ.....						
18.	มีกิจกรรมให้ความรู้แก่ครอบครัวในการดูแลผู้สูงอายุเพื่อส่งเสริมสุขภาพจิต 18.1 การให้ความสำคัญเห็นคุณค่าของผู้สูงอายุด้วยการเคารพยกย่องนับถือด้วยการเชื่อฟังคำสั่งสอน และข้อเสนอแนะจากผู้สูงอายุ						
	18.2 อื่นๆ โปรดระบุ.....						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริมภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
19.	มีกิจกรรมเกี่ยวกับการส่งเสริมความสัมพันธ์ในครอบครัว 19.1 การทำครอบครัวบำบัด						
	19.2 การให้คำปรึกษาครอบครัว						
	19.3 อื่นๆ โปรดระบุ.....						
20.	มีกิจกรรมเกี่ยวกับสุขภาพฟัน 20.1 การตรวจสุขภาพฟันและรักษา						
	20.2 การให้สุขศึกษาเกี่ยวกับช่องปาก						
	20.3 อื่นๆ โปรดระบุ.....						
	4.ด้านนันทนาการเพื่อการพักผ่อน (Leisure)						
21.	มีกิจกรรมนันทนาการภายในชุมชน 21.1 ดนตรี การฟ้อนรำ						
	21.2 อื่นๆ โปรดระบุ.....						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริมภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
22.	มีกิจกรรมนันทนาการภายนอกชุมชน 22.1 การเดินทางไปทำบุญนอกสถานที่						
	22.2 การเดินทางท่องเที่ยวต่างจังหวัด						
	22.3 อื่นๆ โปรดระบุ.....						
23.	มีกิจกรรมส่งเสริมการทำงานอดิเรกที่เหมาะสม 23.1 อ่านหนังสือ						
	23.2 เลี้ยงสัตว์						
	23.3 ปลูกต้นไม้						
	23.4 อื่นๆ โปรดระบุ.....						
	5. ด้านความมั่นคงปลอดภัย (Security)						
24.	มีสวัสดิการสำหรับผู้สูงอายุ 24.1 เงินประจำเดือนผู้สูงอายุหรือเบี้ยยังชีพ						

ข้อ	กิจกรรมการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช	ความถี่ในการส่งเสริมภาวะพฤฒพลัง					คำแนะนำ
		0	1	2	3	4	
	24.2 สวัสดิการชุมชนเพื่อการดูแลผู้สูงอายุ						
	24.3 อื่นๆ โปรดระบุ.....						
25.	มีการให้ความรู้และคำแนะนำเกี่ยวกับการออมเงิน						
26.	มีกิจกรรมส่งเสริมการสร้างรายได้ 26.1 ขายผลิตภัณฑ์ที่ผู้สูงอายุผลิตขึ้น เช่น ต้นไม้ ผักสวนครัว เครื่องจักสาน						
	26.2 อื่นๆ โปรดระบุ.....						
27.	มีการให้สุขศึกษาด้านอนามัยสิ่งแวดล้อม						
28.	มีกิจกรรมการช่วยจัดสิ่งแวดล้อมของที่อยู่อาศัยให้ปลอดภัย 28.1 การทำลายแหล่งเพาะพันธ์ยุงลาย						
	28.2 อื่นๆ โปรดระบุ.....						

<u>ส่วนที่ 3</u> แบบสำรวจความคิดเห็นเกี่ยวกับปัจจัยที่มีผลต่อการส่งเสริมภาวะพฤฒพลังของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช

<u>คำชี้แจง</u> โปรดทำเครื่องหมาย √ หน้าข้อความตามระดับความคิดเห็นของท่านในแบบสอบถามที่ท่านคิดว่าปัจจัยที่มีผลต่อการส่งเสริมภาวะพฤฒพลังของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช

ระดับความคิดเห็น	**ค่าคะแนน**
ระดับมากที่สุด	5
ระดับมาก	4
ระดับปานกลาง	3
ระดับน้อย	2
ระดับน้อยที่สุด	1

ข้อ	ข้อความ	ระดับความคิดเห็น					คำแนะนำ
		1	2	3	4	5	
	ปัจจัยสนับสนุน						
1.	มีนโยบายระดับชาติเกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาทางสุขภาพจิตและจิตเวชที่ระบุเป็นลายลักษณ์อักษรอย่างชัดเจน						
2.	มีนโยบายระดับหน่วยงานเกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาทางสุขภาพจิตและจิตเวชที่ระบุเป็นลายลักษณ์อักษรอย่างชัดเจน						
3.	มีการสอนงานจากหน่วยงานเฉพาะทางจิตเวชหรือหน่วยงานที่เกี่ยวข้อง						
4.	มีระบบการนิเทศติดตามงานจากหน่วยงานเฉพาะทางจิตเวชหรือหน่วยงานที่เกี่ยวข้อง						
5.	มีระบบการให้คำปรึกษาในการดูแลผู้สูงอายุที่มีปัญหาทางสุขภาพจิตและจิตเวชจากหน่วยงานเฉพาะทางจิตเวชหรือหน่วยงานที่เกี่ยวข้อง						
6.	ได้รับความร่วมมือจากหน่วยงานภาครัฐต่างๆ เช่น รัฐบาลท้องถิ่น ตำรวจ โรงเรียน เป็นต้น						
7.	ได้รับความร่วมมือจากผู้สูงอายุที่มีปัญหาสุขภาพจิต						
8.	ได้รับความร่วมมือจากครอบครัวของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
	อื่นๆ โปรดระบุ.....						
	ปัจจัยที่เป็นอุปสรรค						
9.	นโยบายการดำเนินงานโรคทางสุขภาพจิตและจิตเวชของผู้สูงอายุไม่ครอบคลุมทุกกลุ่มโรค						
10.	บทบาทการทำงานของเจ้าหน้าที่ในสถานบริการปฐมภูมิด้านการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวชไม่ชัดเจน						
11.	นโยบายสาธารณสุขเน้นด้านโรคฝ่ายกายมากกว่าโรคฝ่ายจิตเวช						
12.	มีภาระงานมากในการทำงานในสถานบริการปฐมภูมิ						

ข้อ	ข้อความ	ระดับความคิดเห็น					คำแนะนำ
		1	2	3	4	5	
13.	ปัญหาโรคทางสุขภาพจิตและจิตเวชยังเป็นตราบาปในสังคมไทย						
14.	ขาดความร่วมมือของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
15.	ขาดความร่วมมือของครอบครัวผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
16.	ขาดความรู้ในเรื่องการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
17.	ขาดความรู้ ความเข้าใจในเรื่องปัญหาสุขภาพจิตและจิตเวชในผู้สูงอายุ						
	อื่นๆ โปรดระบุ……						
	ปัจจัยด้านความรู้ของเจ้าหน้าที่						
18.	มีความรู้เกี่ยวกับหลักการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิต และจิตเวช						
19.	มีความรู้เกี่ยวกับการประเมินคัดกรองผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
20.	มีความรู้เกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
21.	มีความรู้เกี่ยวกับการฟื้นฟูสมรรถภาพของผู้สูงอายุที่มีปัญหาทางสุขภาพจิตและจิต เวช						
22.	มีความรู้เรื่องยาทางจิตเวชและผลข้างเคียงของยาทางจิตเวชสำหรับผู้สูงอายุ						
23.	มีความรู้เรื่องปัญหาสุขภาพจิตและจิตเวชที่พบได้บ่อยในผู้สูงอายุ						
24.	มีความรู้เกี่ยวกับลักษณะอาการและระดับการเจ็บป่วยทางจิตเวช						
25.	มีความรู้ในการให้คำแนะนำเกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาสุขภาพจิต และจิตแวชและครอบครัว						
	อื่นๆ โปรดระบุ……						
	ปัจจัยด้านทักษะของเจ้าหน้าที่						
26.	มีทักษะในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
27.	มีทักษะการประเมินคัดกรองผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
28.	มีทักษะเบื้องต้นในการให้คำปรึกษากับผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						

ข้อ	ข้อความ	ระดับความคิดเห็น					คำแนะนำ
		1	2	3	4	5	
29.	มีทักษะในการดูแลผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
30.	มีทักษะในการฟื้นฟูสมรรถภาพของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
31.	มีทักษะในการสื่อสารกับผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
32.	มีทักษะในการสื่อสารกับครอบครัวของผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
	ปัจจัยด้านทรัพยากรและการสนับสนุน						
33.	เพิ่มจำนวนบุคลากรให้เพียงพอกับภาระงานในการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหา สุขภาพจิตและจิตเวช						
34.	เพิ่มศักยภาพของบุคลากรให้มีความรู้ และทักษะในการปฏิบัติงานด้านสุขภาพจิตและจิตเวชในผู้สูงอายุ						
35.	เพิ่มงบประมาณสนับสนุนเกี่ยวกับการดูแลผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช						
36.	มีสื่อและเทคโนโลยีเกี่ยวกับส่งเสริมสุขภาพจิตและจิตเวชในกลุ่มสูงอายุ เช่น วิธีการส่งเสริมภาวะพฤฒพลังในผู้สูงอายุที่มีปัญหาสุขภาพจิตและจิตเวช เป็นต้น						
37.	มีสื่อและเทคโนโลยีเกี่ยวกับการดูแลผู้สูงอายุที่ปัญหาสุขภาพจิตและจิตเวช						
	อื่นๆ โปรดระบุ…… ……						

ข้อเสนอแนะเพื่อการปรับปรุง

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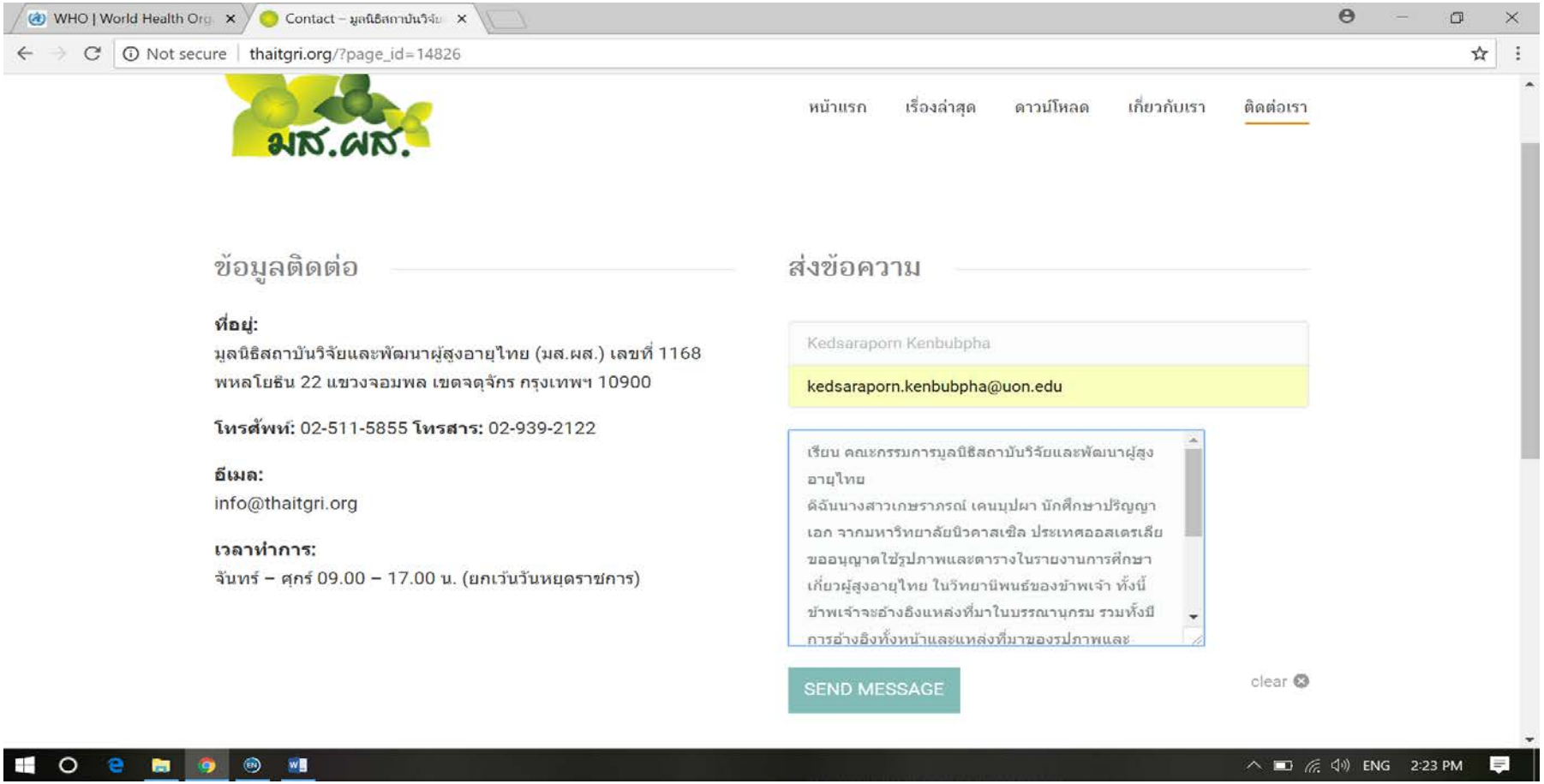
APPENDIX 22: Permission for using and publishing figures and tables from original sources



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