

The psychological and behavioural impact of the Early Self-Assessment Tool for older people: an evaluative case study

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Abstract

Title: The psychological and behavioural impact of the Early Self-assessment Tool for older people: an evaluative case study.

Background: Early Intervention (EI) is a computerized self-assessment for older people. It is available with or without assistance in Stratford-upon-Avon, UK, and results in resources to enhance health and independence.

Objectives and question: Evaluate EI to enhance and implement it for a larger audience, maintaining health and independence for older people internationally. The research question is: How do users and facilitators of the Early Intervention judge its practical use and its psychological and behavioural impact on its users and on the health care system?

Methods: An evaluative case study containing ten interviews with EI's users and a group interview with two facilitators. Users: having used EI and its first evaluation. Facilitators: having a professional attachment to EI, having assisted older people while conducting the assessment. Discourse analysis contained a single- and multiple case analyses by finding themes using a matrix approach.

Results: Promotion was limited, computer use and the content acceptable, and assistance appreciated. Main motivation was to assist the researcher. The impact was limited: minimal recollection and use of resources.

Conclusions: EI's practical use was well received. Impact was limited, due to limited intervention promotion, lack of understanding its concept, and motivations to help the researcher instead of themselves, possibly leading to minimal recollection and no usage of resources. Those understanding EI's concept did benefit by knowing where to find resources if needed.

Recommendations: Further studies with hard copies of resources, extended promotion, and a larger and more diverse sample size. Additionally, it is suggested to study digitalised self-assessments with or without assistance, and EI's effect on those with memory loss.

Keywords: Computerized Self-Assessment, Older People, Health and Independence, Evaluation, Case Study.

Samenvatting

Titel: De psychologische - en gedragsveranderingen bij ouderen door invloed van een zelfanamnese 'Early Intervention', een evaluatie.

Achtergrond: Early Intervention (EI) is een gedigitaliseerde zelfanamnese voor ouderen. Het is beschikbaar met en zonder assistentie in Stratford-upon-Avon, UK. De anamnese resulteert in een advies bestaande uit contactgegevens van organisaties die iets kunnen betekenen voor de gebruikers.

Doel en Onderzoeksvragen: EI evalueren, verbeteren en implementeren in een groter gebied om de gezondheid en zelfstandigheid van ouderen internationaal te verbeteren. De onderzoeksvraag is: Hoe beoordelen gebruikers en aanbieders van EI de bruikbaarheid en de psychologische en gedragsveranderingen van EI voor gebruikers en de gezondheidszorg?

Methoden: Een evaluatieve case studie bestaande uit tien individuele interviews met gebruikers en een groepsinterview met twee aanbieders participeerden. Gebruikers: zij die EI hebben gebruikt en meegedaan hebben aan de eerste evaluatie hiervan. Aanbieders: degenen die een professionele band hebben met EI en ouderen hebben geassisteerd tijdens de anamnese. Analyse bestond uit een single- en multiple case analyse met matrixen.

Resultaten: Het adverteren van de interventie was minimaal, computergebruik en inhoud waren acceptabel en assistentie werd gewaardeerd. De belangrijkste motivatie voor participatie was het helpen van de onderzoeker. Men kon het advies niet herinneren en had er geen gebruik van gemaakt.

Conclusie: EI's bruikbaarheid is positief ervaren. Minimale impact door weinig adverteren, verkeerd begripen van het concept en motivaties om de onderzoeker te helpen. Dit kan geleid hebben tot minimaal gebruik van advies. Degenen die EI's concept begrepen waren positief, omdat zij weten waar zij advies kunnen inwinnen als dit nodig is.

Aanbevelingen: Evaluaties met uitgeprint advies, uitgebreidere advertentie en grotere en meer diverse groepen bestaande uit deelnemers met persoonlijke motivatie. Daarnaast kunnen gedigitaliseerde zelfanameses met en zonder assistentie worden bestudeerd, alsook het effect op mensen met geheugenverlies.

Trefwoorden: Gedigitaliseerde zelfanamnese, Ouderen, Gezondheid en zelfstandigheid, Evaluatie, Case studie.

Introduction

Promoting health, as a state of physical, psychological and mental wellbeing [1], and independence for older people is a global priority [2-6]. In 2002 delegates of 160 governments discussed long-term care for older people, agreeing on stimulation of independence, participation in society, self-fulfillment and dignity [7].

Nurses play a key role in care delivery for older people in many settings, and should be well equipped with innovations and knowledge to meet care needs and deliver high-standard care [8, 9]. Their and other professionals' practice begins with an assessment describing health needs of their client [10]. Self-assessments require users to assess their own needs, with no or minimal assistance from a health professional [11]. They seem most valid for people with low care needs, and less for those with medium or high needs [11], defined as independent with self care, having some problems with self-care and unable to wash or dress themselves, respectively [12]. Accuracy, effectiveness and experience of self-assessments were reviewed using studies from the last thirty years, showing no evidence of behavior change due to self-assessments, however there is some evidence that users experienced them positively [13].

Early Intervention (EI) is a computerized self-assessment, derived from the holistic geriatric assessment EASY-care [5]. EASY-care was studied through a randomized controlled trial in the Netherlands with 151 participants [14, 15], resulting in positive outcomes for wellbeing and functional status for older people, and in diagnosing dementia. The self-assessment EI seeks to stimulate health and independence for community-dwelling older people of 60 years or above [16]. It is user initiated and accessible in Stratford-upon-Avon at two GP offices, Stratford library, Stratford Council District Offices, one pharmacy, internet, and through the Age UK Charity Warwickshire Case worker, and a flu jab nurse. In some of these settings assistance is available [17]. EI contains: seeing, hearing and communicating, looking after yourself, getting around, safety, accommodation and finance, staying healthy, mental health and wellbeing [17]. Users can choose which domains to use based on current concerns. Afterwards, they received resources to follow-up, printed or emailed on request.

EI was implemented from September-December 2011 in Stratford-upon-Avon (UK). An ongoing evaluation started in November 2011 with a first evaluation directly after the assessment, containing a survey regarding user's characteristics, and EI's usability and content [12]. The first evaluation does not address longer term reflection on EI and its impact on users and the health system.

Rationale

There is limited knowledge regarding self-assessments' practical usability and psychological and behavioural impact [11, 13]. For EI these aspects need to be evaluated, to inform its further development and implementation. Since this is not addressed in the first evaluation a follow-up seemed appropriate.

Aims and research question

The aims were to evaluate the Early Intervention's practical usability and psychological and behavioral impact on older people in Stratford-upon-Avon to inform enhancements and a broader implementation, to maintain health and independence for older people internationally. The research question was: How do users and facilitators of the Early Intervention judge its practical use and the psychological and behavioral impact on users and the health system?

Methods

Design

A qualitative, evaluative case study comprehensively evaluates programmes [18-21], and is therefore suitable to evaluate EI. Older people who used EI before May 2012 (users) were individually interviewed, and professionals who assisted users with the assessment (facilitators), such as researchers from the first evaluation, or the pharmacist facilitating EI, participated in a group interview.

Setting and participants

User's inclusion criteria were: having used EI and having participated in the first evaluation. This first evaluation was targeted towards older people with low care needs, but others were also welcomed. Their inclusion criteria were everyone who wanted or needed to use EI and was able to do so, meaning that those unable to give consent or speak English would be excluded. Participants were recruited through promotional events at nursing homes, public places, internet, and sites where EI was available in Stratford-upon-Avon (17). Facilitator's inclusion criteria for the follow-up study were: professional attachment to EI, having assisted users with the assessment. Exclusion criteria for both groups were: inability to speak English, or to give written informed consent.

Literature does not present a preferable sample size and Yin [18] calls it a judgment choice. Given the topic saturation seemed reachable by interviewing 10-15 users,

with facilitators providing additional information. A convenience sample was used [21], where participants of the first evaluation were invited to a follow-up study, making results from both evaluations comparable by other research team members. An information pack was posted and the participation form was to be returned to make an appointment (Figure 1). Due to low response, the last potential participants were given the information packs personally, giving a 100% response. Additionally, the researcher called those not responding using an at-random list of approached participants until saturation was reached. A small sample size for the first evaluation and a low response rate for the follow-up study made purposive sampling impossible. Contact with the seven facilitators was done by email.

| Figure 1|

Parameters

The parameters are: (1) practical usability containing people's experiences using EI as a self-assessment, and (2) EI's impact on health, health perception, and service use.

Ethical aspects

All participants received information sheets and consent forms approved by the Biomedical Research Ethics Committee of Warwick University. Users also received a participation form to express their cooperation. Written informed consent had to be given before the interview, and the participant received a copy.

Data collection

Individual user interviews were planned 1-9 weeks after the assessment, to detect psychological and behavioural changes [22], and to study influences of time between the assessment and interview. Each interview of 45-90 minutes was semi-structured as many topics had to be addressed [23]. Information from the user's interviews fed the group interview of 90 minutes, attended by facilitators only. All interviews were tape recorded, and performed according to an earlier prepared guide (Box 1) [24]. These guides were evaluated by peer reviewers and adjusted accordingly before data collection. The researcher evaluated the user's interview guide after each interview and adjusted it when necessary [25]. The researcher's interview skills were evaluated through notes [24] and meetings with the supervisor [25]. Interviewees did not receive the questions before the interview, to encourage spontaneous responses. Member checks [21] were to prevent misunderstandings, since the researcher is not a native English speaker. One participant gave consent to omit the member check due to limited eyesight. The group interview ended with a discussion summary, a 'member check in situ' [21]. Additionally the researcher wrote

field notes reflecting on interviews, personal feelings, methodology, and analysis. Demographic data was collected from users only, since facilitators connections with EI are based on comparable professions.

| Box 1|

Analysis

All interviews were transcribed verbatim, except for one due to background noise on the tape. However, a summary was written and used for analysis. Data was anonymised and managed using NVIVO9 and Microsoft Word. Discourse analysis as described by Silverman [25] was conducted, meaning analyzing activities presented in talk, and for this study these activities were related to EI. Thematic analysis identified themes from the data [26], which was summarized using a matrix approach [24] to conduct a single-case and cross-case analysis. Data was compared with hypotheses and rival hypotheses to find relationships, to strengthened internal validity [18, 25]. Similar opinions in the data were counted to gain understanding, although the meaning of the individual opinions was of superior importance [27]. The first two interviews were analysed independently by both authors and compared to review inter-rater reliability. Other data was analysed by the first, and supervised by the second author.

Results

With ten users saturation was reached and inclusion was ended (Figure 1). Saturation was not reached for facilitators because two of seven facilitators participated, others did not respond to emails, were sick, or unwilling to participate.

| Table 1|

In Table 1 user's demographics are presented, showing that half of the participants is male. The age ranges between 56 and 94, with five participants over 80 years old. Nonetheless, a majority (n=8) has a low care level. The education level is high with five participants having attended university, and computer use is diverse. Most participants live alone (n=8), however most live in a sheltered accommodation with a warden.

Both attending facilitators were researchers from the first evaluation, assisting older people with the assessment before carrying out their survey, and have been involved with EI since the beginning. One of them assisted 25 people during the test phase; the other facilitator assisted fifteen people during the pilot.

| Box 2|

The results are presented per parameter using themes derived from the data. Quotes to support the findings are presented in Box 2.

Practical use

The themes describing participant's experiences regarding EI's practical use are: intervention promotion, digitalisation, assistance, and content.

Intervention promotion

This contains three subthemes: recruitment, setting, and the name Early Intervention. Recruitment such as letters, coffee mornings, and flyers on care homes' notice boards, was well received. Additional promotion was suggested, such as presentations at the University of the Third Age.

Settings included people's homes, coffee mornings in nursing homes or public places such as the Town Hall. One participant was unhappy with a public room setting, preferring more privacy.

The name 'Early Intervention' was mentioned by the fifth participant, finding it an emotive word, not covering EI's concept (Quote 1). For the following interviews this question was incorporated, and some participants agreed it made them expect something was to be done to them, whereas the tool is aiming to have people do things for themselves (Quote 2). However, others did not express concerns.

Facilitators mentioned time for promotion was limited, resulting in a low uptake and misunderstanding of EI by users. Several settings, such as GP offices, pharmacy, and garden centres did not attract users because people did not want to be disturbed during their activities. Facilitators also noticed a negative attitude change towards EI within professionals such as GP's, for unclear reasons. During their interaction with users, facilitators also heard complaints regarding EI's name.

Digitalisation

Digitalisation focuses on using a desktop, laptop or touch-screen. Participants were familiar with computers to different degrees (Table 1) and all participants had a positive attitude towards it, even when unfamiliar with them. Participants with hand problems preferred a digitalized assessment above pen-and-paper versions (Quote 3). Which version was preferred seemed influenced by what they were familiar with. Some participants expressed concerns about those not using computers, being excluded from new developments (Quote 4).

Facilitators mentioned user's mindsets influenced their reactions to using a computer, mostly by lacking confidence and therefore needing encouragement, even though their skills were fine.

Assistance

Nine participants were assisted by a researcher from the first evaluation. Assistance was sometimes unnecessary, but appreciated. Most participants found available support encouraging, (Quote 5), appreciating the possibility to talk to someone. However, three of ten participants preferred independence above assistance to give them ownership. For two participants assistance was necessary due to limited eyesight or a phone-assessment.

Facilitators noticed some older people having confidence issues using computers and needing encouragement (Quote 6), even though they could do it independently. However, facilitators found this older generation valuing the possibility to talk to someone. Therefore, response rates for assisted self-assessments were higher than for unassisted self-assessments.

Content

Overall, EI's content was well received. Questions were understandable, and it was easy to use. However, one participant found the small screen too full, causing difficulty in conducting the assessment (Quote 7). A few participants were uncomfortable with some questions, however these questions differed strongly. Two participants mentioned the resources were incomplete. Five participants mentioned concerns regarding how to express their individuality in the tool. Some of them found the answer options limited and therefore not always applicable to their situation (Quote 8). Others were concerned about resources not matching their individual request.

Facilitators mentioned that participant's feedback during the first evaluation was used for further development.

Impact

EI's psychological and behavioural impact is represented by: comprehension of concept, motivations, recollection, and benefit.

Comprehension concept

Most participants did not understand EI's concept and were not looking for resources. There were willing to help and more focussed on giving feedback (Quote 9). Additionally, some are peer reviewers testing new developments for different organisations and not necessarily for themselves, possibly influencing how they approached EI. Several users mentioned EI would be useful for others instead of themselves (Quote 10). Four participants fully understood EI's concept, whereas others, some suffering from memory loss, did not.

Facilitators recognised participants felt the tool was more useful to others than themselves (Quote 11). Facilitators mentioned that extended intervention promotion and explanation of EI could result in a better understanding of it.

Motivations

Motivations for participation were mainly to support research (Quote 9), instead of needing resources for personal concerns.

Facilitators mentioned that more participants conducted an assisted self-assessment than one without assistance, in which their motives were unclear, although users seemed appreciative of the possibility for conversation.

Recollection

Whereas all participants remembered answering questions, there was limited recollection of the resources, due to: motivations for participating (Quote 9), they felt it was not applicable to them (Quote 10), memory loss, no impression was made (Quote 12), concept was unclear, or because of a mix of these reasons. Four participants remembered receiving resources, but could not give specific details. One participant received resources in writing as requested just before the interview, and therefore this question was not applicable to his situation. All participants thought a hard copy of the resources would be beneficial to them, however they did not receive this due to lack of printer availability or because they did not acknowledge the necessity at the time.

Facilitators did not have contact with users after the first evaluation and could not comment on this.

Benefit

This leads to benefit, divided into practical and non-practical benefit. The first contains benefit for personal health, health perception and service use. Non-practical benefit contains all other benefits mentioned by participants.

Because resources were not used, service use and health did not change accordingly. However, practical benefit was reached in other ways. Three of four participants understanding the concept, mentioned willingness to use EI if health concerns would occur (Quote 13), however one of them felt EI did not provide new information. Two participants, suffering from memory loss, said the questions made them think structurally, giving them a health overview (Quote 14), but both of them did not remember the resources. One of them said his health perception changed by giving him a reality check. The other participant mentioned intentions to visit the doctor more often. A few others also said the questions made them think about their personal situation. Most people gained non-practical benefit by feeling heard and appreciated (Quote 15).

The facilitators added that practical benefit can only be reached if resources are used, which is usually influenced by their (lack of) understanding of the tool.

Discussion

This study evaluated EI's practical use and psychological and behavioural impact with users and facilitators. Generally, users experienced the practical use positively. Although intervention promotion was limited, computer use seemed acceptable, and the content was generally well received. Participants appreciated assistance, and based on the findings it can be assumed that this was a main reason for users to experience EI positively. Data suggests that the current older generation appreciates encouragement while using computers, and to have someone to talk to. It remains unclear whether this is similar for next generations, who are used to digitalisation.

EI's impact on health, health perception, and health service use is limited, possibly due to user's motivations to participate, and their lack of understanding EI's concept. This could be due to limited intervention promotion. Participants wanted to support researchers instead of using the tool for personal concerns, feeling 'too healthy' to need resources. Additionally, assistance stimulated user's willingness to participate. All this might have resulted in recollection of questions, but limited recollection of resources. No hard copy of the resources might have influenced recollection also. Time between conducting EI and

the interview did not show relationships. Those participants who understood EI's concept did remember the resources, although not explicitly.

Participants are supposed to make a voluntary decision about participation after understanding what this comprehends [28, 29]. Those suffering from memory loss were capable to do so, but could forget this later on. Therefore, they received a copy of the signed consent form, and if needed, a phone call was used to reaffirm consent.

The first recruitment strategy using post for recruitment proved unsuccessful. Therefore, researchers of the first evaluation handed out the forms personally, resulting in better responses. Those people not responding to their post received a phone call from the researcher, also resulting in more participants. Similar to findings by Burns et al. [30], a personal approach seems to result in higher response rates.

The studies strengths are: achieved saturation with users, and member checks with those capable (n=9) resulting in minor changes. Studies limitations are: low uptake resulted in a small sample size, containing only white participants from in and around Stratford-upon-Avon. Therefore, the results are context specific and caution should be taken when generalising the findings to others. Additionally, the studies sample has an atypical educational history (Table 1). Half of the participants have attended university, which does not represent the older population's educational background. The convenience sample possibly lead to inclusion bias [21], for instance older people not using computers might not have participated. A recent study [31] including 123 interviews with older people, mentioned older people's ICT use remains limited due to unbelief it can improve lives. Lastly, saturation was not reached with facilitators due to low attendance. Attending facilitators, researchers from the first evaluation, mentioned that involved professionals lost enthusiasm for EI during the process, for unclear reasons.

Self-assessments have been evaluated, showing their potential as preventive tools [11]. EI is trying to use this, aiming to prevent health problems for older people. Similar to our finding, the study [11] concluded that more effective service use was not yet evident. Griffiths et al. [13] published a comprehensive review on self-assessments for older people managing health and social care needs, finding weak evidence for older people positively experiencing self-assessments, especially assisted ones. However, although people are willing to answer questions, no evidence was found on behavioural changes. They also found assessments providing feedback to users can increase benefit by giving face-to-face feedback. Lastly, users have to understand the self-assessment's purpose to make it a worthy experience [13]. The review included topic specific to broad health assessments,

including pen-and-paper versions, algorithms, and web-based systems with feedback, such as EI. It mostly included professional initiated assessments [13], whereas EI is user initiated. Nonetheless the findings are similar. Boustani et al. [32] found people preferred not to be screened on memory loss. However, some participants with memory loss found EI to make them think structurally about their health, including mental health.

To improve EI hard copies of resources should be provided, and extended intervention promotion should be given to enhance understanding of its aim and concept. Evaluations should preferably have a larger and diverse sample size, including people with different educational backgrounds, care levels, and age since this study included mostly those above 70 years old. Because purposeful sampling was impossible, EI's effectiveness for people with low, medium and high care levels remains unclear. Additionally, participants should only be included if they need EI for personal concerns, not only based on their willingness to participate. An evaluation could be conducted with professionals, such as GP's and pharmacists, to study their change in attitude towards EI. Research should also focus on the difference between digitalised self-assessments with and without assistance, for this and next generations, to inform EI's delivery now and in the future. Lastly, it is suggested to study EI's effect on those with memory loss conducting the assessment with family to make optimal use of the resources.

Conclusion

EI's practical use was generally well received. Psychological and behavioural impact proved to be limited, due to limited intervention promotion, lack of understanding its concept, and motivations to help researcher instead of themselves. These findings possibly lead to a lack of recollection of resources, resulting in no usage of them. Those understanding EI's concept did benefit by knowing where to find resources if needed.

Key points

- The practical use of EI, a computerised self-assessment, was generally positively experienced by older people.
- Psychological and behavioural impact of EI is limited due to: inadequate promotion, participant's misunderstanding of the concept, motivations for participation, or lack of recollection.
- Understanding EI's concept leads to a positive opinion about using it when resources are needed.

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Authors' contribution

The study was conducted and reported by the first and supervised by the second author.

Conflict of interest

Nothing to report.

Ethics approval

Approved by Biomedical Research Ethics Committee of Warwick University.

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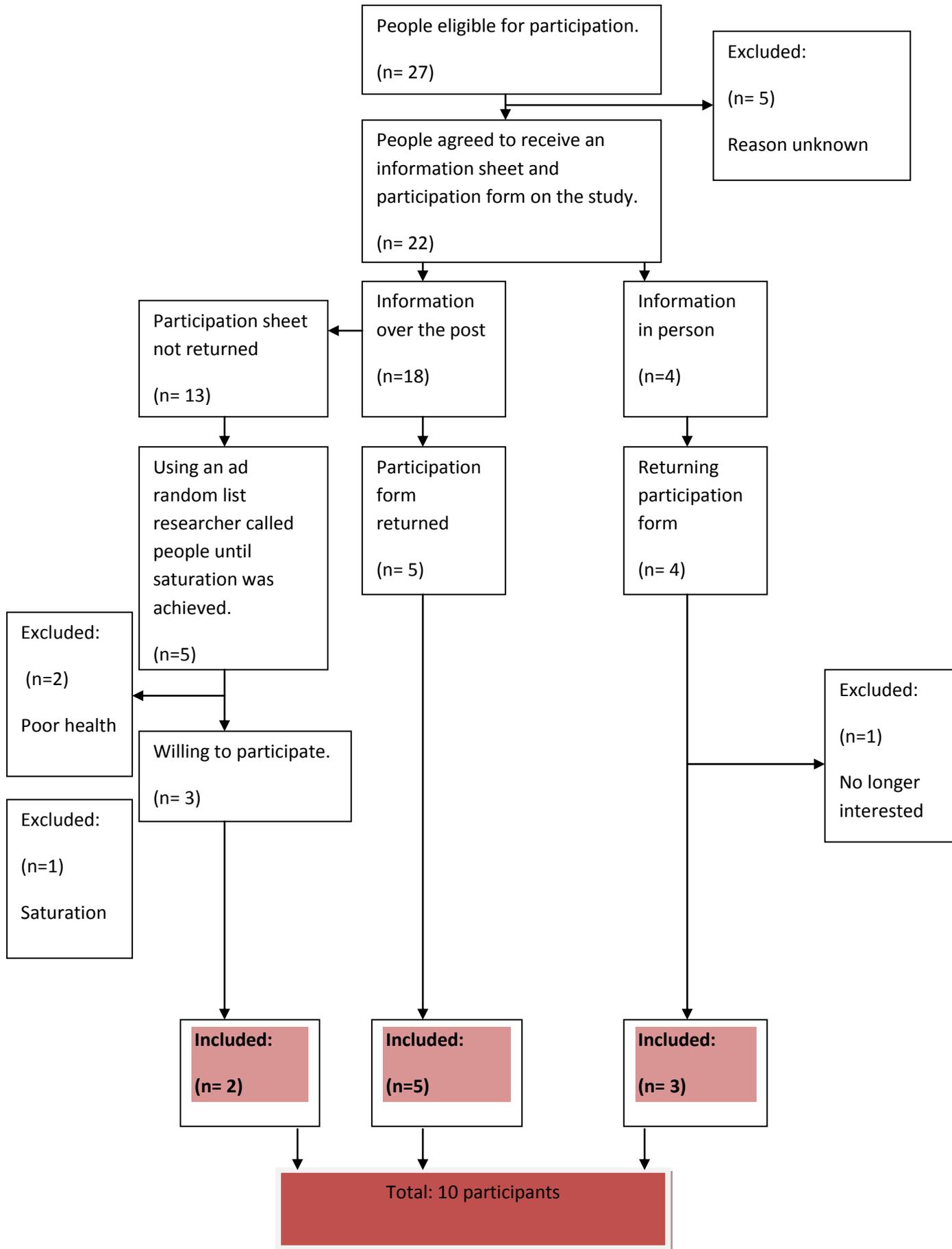


Figure 1: Recruitment of the users of EI

Box 1: Interview guides

Users

1. Experience and recollection of EI.
2. Practical use of EI
3. Influence regarding health, health perception and health care use
4. Recommending EI and main benefit

Facilitators

1. Reasons to be involved in EI
2. Practical use of EI for older people
3. Influence regarding older people's health, health perception and health care use
4. Improvement of EI

Table 1: Demographic data of included users.

Participant	Age	Gender	Care level	Highest level of education	Use of computers in daily life	Living situation
1	76	Male	Low	University	++	With partner
2	56	Male	High	College	++	With partner
3	72	Female	Low	University	+	Alone, housing with care
4	74	Male	Medium	Unknown, he was an engineer	+/-	Alone, sheltered housing, supported housing
5	80	Female	Low	University	+	Alone, housing with care
6	94	Male	Low	Unknown, did practical work.	-	Alone, next to daughter
7	85	Male	Low	University	-	Alone, sheltered housing, supported housing
8	86	Female	Low	A-levels	++	Alone, sheltered housing
9	65	Female	Low	College	+/-	Alone
10	83	Female	Low	University	++	Alone

Low care level: people who have no problems with self care [3].

Medium care level: people who have some problems washing and dressing [3].

High care level: people who are unable to wash or dress themselves [3].

Computer use:

++: daily

+: around three 3 times a week

+/-: less than that

-: no us

Box 2: Quotes

1	“ That intervention word snaps to me as personalisation of you, yourself, giving information out that you don’t want to give. So I wondered what it would mean. And I was happy to find that it didn’t mean what I thought it would mean.” (p5)
2	“ Intervention is something, is more helpful, is somebody gonna do something for you. Whereas this is really not somebody doing something for you. It’s you doing it for yourself. So I think it was a bit misleading in that. It gave you the idea that someone was going to intervene for you and do something” (p9)
3	“ For me, god sent, absolutely. God sent, cause I can’t, I can hold a pen very lightly, but I am not to write for too long. So it was god sent, very useful to me, very useful.” (p2)
4	“ I went to the club and I was telling them all about that I’d been down and done it and that. And uhm, () telling them about it and in fact my friend, as I was telling you, doesn’t even know how to turn a computer on. She said: oh that won’t do for me.” (p9)
5	“ I think you have got to be prepared to help. Especially when they are not used to the system. (...) I mean, you don’t throw a child in the middle of the pool and say swim, do you. Which is what, in effect you are doing.” (p5)
6	“ Because I am there, I think it is a case of, they want reassurance, so you know, they do ask: what’s next, what do I do next?” (f1)
7	“ I mean, tremendous number of little blue squares and things and A and B and C and D, you know and it was too much for me to really get my finger on any point.” (p8)
8	“ So no two people are the same. And it’s very, there are not enough options. They can’t give you an accurate response to the question really.” (p2)
9	“ No it was for the researchers, totally and utterly to help the researchers. And, you know, as I say to get me involved in things and doing things. So that was basically more, more I suppose, than actually wanting the information maybe. Which is why perhaps I didn’t act on it” (p9)
10	“ I can’t, no I, you see I can remember thinking: a lot of this I don’t feel applies to me, but I can see how it might apply to other people”. (p2)
11	“ They don’t feel this is for them because they associate the assessment with people who are, like older old people and who are more needy. Whereas they see themselves as active and going out.” (f1)
12	“ Now it didn’t make a deep enough impression. If I had taken some notes it might have, but the interview itself didn’t make the impression in me euh, that I could hold it in my head, come back and think about it.” (p8)
13	“ I think the benefit was in having, on hand, a range of contact sources should I need them in the future.” (p3)
14	“ No no, my mental health stayed what it was. It is still like that, but the realization of it had changed.” (p1)
15	“ Somebody was taking an interest and I think that is important.” (p2)

p = participant user f = participant facilitator

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