

ResearchSummary



Self-assessment of health and social care needs by older people

Self-assessment is a form of assessment that is completed by the subject of the assessment without the immediate involvement of professionals, or a professionally-employed layperson. It is a mechanism that holds out considerable promise in terms of increased participation and engagement for potential users of health and social care services. However, whereas user involvement in professionally led assessment has been relatively well explored, self-assessment has not, particularly in health care.

This research summary presents the main findings of a review of self-assessment in health and social care (Griffiths, 2005), commissioned by the NHS Service Delivery and Organisation Research and Development Programme (SDO). It was carried out by a team led by Professor Peter Griffiths at King's College London. It reveals the complexity of the topic and the pitfalls of adopting a simplistic approach. While the review focused on older people, its findings apply to other groups. This research summary will be of interest to those in health and social care who are seeking to introduce or improve collaborative approaches to assessing potentially complex needs.

Key messages

- 'Self-assessment' is widely advocated but not clearly defined or understood.
- As a minimum, self-assessment has the following ingredients: self-report, self-completion and self as beneficiary.
- In terms of cost, self-assessment is likely to be cost-neutral.
- Self-assessment is not necessarily more user-centred than other approaches.
- There are many types of self-assessment, and great potential in their use and development, but the evidence of their effectiveness is limited.

Background



What is self-assessment?

Simply put, the term 'self-assessment' refers to *"an assessment that is completed by the subject of the assessment without the immediate involvement of professionals, or a professionally-employed layperson."*

Beyond this, there is little agreement among groups of researchers or practitioners about the precise meaning of the term. Occasionally, self-assessment is used to refer to self-report, that is, to information a user provides, for example, a subjective assessment of their own wellbeing. However, given the variety of methods currently being used, it is more helpful to consider self-assessment as consisting of a number of factors of which self-report is but one, albeit essential.

How is self-assessment being used?

Self-assessment for health and social care needs has been used over a considerable period of time and for purposes as diverse as case finding for depression (where diligent efforts are made to locate and treat persons at risk) to assessment of housing options. Self-assessment usually involves the use of short scales and questionnaires but can also include physiological tests (such as testing urine for glucose) or complex, computerised systems designed to support users in making decisions.

Self-assessment is increasingly being advocated as a way of actively involving and empowering service users. For example, the National Service Framework (NSF) for Older People (Department of Health, 2001) has specifically emphasised person-centred care, the

main goals of which have been identified as:

- appropriate assessment of potentially complex needs
- integration of assessment
- sharing of information between services and with users
- active involvement in care, including self care, of older people in both health and social care services.

In order to achieve these goals, the Single Assessment Process (SAP) – a person-centred assessment to which different disciplines contribute – has been identified as a key tool (Department of Health, 2002). It is expected that user involvement and self-assessment will be integral aspects of the SAP.

Elements of self-assessment

For the purpose of the study, the research team proposed that self-assessment of care needs must have, as a minimum:

- self-report – as distinct from examination and observation
- self-completion – by the individual concerned rather than a professional, layperson or family member
- self as the potential beneficiary of the assessment – as distinct from provision of a survey response for population needs assessment.

In addition, self-assessment can include one or more of the following:

- be self-initiated – rather than prompted by a professional
- be self-interpreted – where the user is able to draw their own conclusions
- be a prompt to self-care actions.

Self-assessment thus lends itself to various, sometimes complex, combinations of elements (see Box 1). Accordingly, care should be taken to avoid seeing the process in over-simplified ways. For instance, not all forms of self-assessment are necessarily 'client-centred'; equally, not all approaches that are client-centred are to be considered as 'self-assessment'. It is also important to bear in mind that some self-assessments are interventions in themselves, such as monitoring of blood glucose for people with diabetes.

Box 1. The 'self' in self-assessment		
Essential	with or without	Optional
Self-report		Self-initiated
Self-completion/direction		Self-interpreted
Self as beneficiary		Self-care

Practical findings

How is self-assessment used?

Self-assessment has been used in many ways and for many groups of people. Purposes range from targeted screening for specific medical conditions through to approaches designed to help individuals make decisions in relation to major life events such as changing accommodation. The review grouped together different types of self-assessment as follows.

● Focused health-related

(Specific health issues.) Self-assessment substitutes for (or adds to) professional assessment, and in most cases is simply a way to administer a screening test without having face-to-face contact. Paper-and-pencil-based medical screening is probably the most commonly represented approach.

● General health-related

(Range of health care issues.) Frequently the goal is to improve management of health care in general and to mediate relationships with professionals. Although fewer in number than focused assessments, there is more variety. Examples include paper-and-pencil questionnaires, self-assessment algorithms (e.g. flow charts that guide the user through questions and options for action) and internet-based systems with feedback. Some examples found were entirely user directed from initiation to action.

● Social care/life skills

Limited examples were found but with more variety than other types. Self-assessments here are more likely to be user initiated and interpreted and to aid decision making on behalf of the user. One reason for this is that they cover issues that would not routinely be addressed by a professional assessment, e.g. driving ability, moving home, life strengths.

Social care and life skills

The HOOP (Housing Options for Older People) self-assessment stands out as providing a vehicle that enables older people to make their own decisions, about whether or not to move home, based upon their own wishes and perceptions of need. The interpretation of the assessment can be carried out by the user alone or with the help of another person (professional or non-professional), but the role of the other person is very much as a facilitator, helping the older person interpret the assessment findings for themselves, rather than telling them what their responses mean. Older people reported that working through the self-assessment had enabled them to take control of the decision-making process. This was particularly useful for older people who were feeling pressurised into making a decision by family or friends.

(The HOOP study can be downloaded at: www.housingcare.org)

Source: Heywood, 1999

● Comprehensive

Most examples found in the UK related to the SAP. While there has been considerable innovation in terms of user involvement in development and in modes of delivering comprehensive assessments, few examples of self-assessment were identified.

The value of an assessment lies not just in its ability to gather information but also in what happens afterwards. Even the most innovative self-assessment requires appropriate action, often by professionals.

Although paper-and-pencil questionnaires remain common, the use of the internet for self-assessment is becoming increasingly popular. The internet offers a possible way both to disseminate self-assessment questionnaires and to encourage users to initiate assessment themselves. However, the development of such methods for older people may be inhibited by a misguided perception that they lack the necessary skills.

How accurate is self-assessment?

Self-assessment relies on a single, subjective source. The accuracy of self-assessment tools varied considerably, with some assessments performing well. Tools found to be more accurate tended to be in areas where the reference standard was well developed, e.g. mental health, and where there is closer overlap between the content of the self-assessment and the diagnostic criteria.

Evidence of accuracy of general health care self-assessment was limited. No evaluations were found of the accuracy of social care/life skills or comprehensive types of self-assessments, although the subjective aspects of these do not lend themselves to this type of evaluation.

As regards focused health care assessment, several tools have at least modest accuracy in identifying older people with depression. Other areas where potentially useful self-assessment tools exist include screening for osteoporosis and screening for mobility problems. Areas where the accuracy of self-assessment tools remains unclear include dental health, nutrition and hearing. Visual self-assessment is at present unsuitable as a screening tool.

Self-assessment tools vary in terms of how specific and sensitive they are, and hence how accurate they may be. For example, tools for self-assessing osteoporosis and mobility problems may identify a high proportion of people with such problems but also a high number of 'false positives' (results which suggest a problem when one is not there). The potential costs of this need to be taken into account when developing a screening programme. Conversely, the majority of screening tools, including general health self-assessments, may not be sensitive or specific enough to identify many older people who may have problems.

How effective is self-assessment?

Most studies identified were of general health-related assessments, including health checks, self-care books and a system which gives feedback to both client and care provider. Approaches such as those based on this latter system seem most beneficial (see *Dartmouth COOP clinical improvement system*, below). It is likely that benefits will be maximised if information gained from the self-assessment is used during subsequent face-to-face consultations.

There is no direct evidence for evaluating effectiveness of focused self-assessment based screening programmes for older people compared to not screening at all, or to other approaches to screening. Unless self-assessment is clearly linked to additional action on behalf of the client it would seem unlikely to have benefits over and above those of other types of assessment in which professionals take a more active role at an earlier point. Thus self-assessment is probably effective under the same circumstances as other screening programmes: that is, where assessment is accurate and resources exist to follow up and deliver effective treatment.

Results of studies to evaluate effectiveness of self-assessment on reducing drug reactions or interactions are positive but there is no evidence of clients' actual behaviour change.

Where self-assessments are targeted at those aged over 75, non-responses are more likely than not to suggest unmet needs and unidentified problems. Strategies acting on this assumption are likely to yield more beneficial results for clients.

There is a large evidence base for self-care approaches, including algorithms, but it is weak and inconclusive. Although the evidence is promising, self-care

does not necessarily lessen the demand for health care.

No evidence was found relating to effectiveness of comprehensive assessment.

Experience of self-assessment

Evidence of how older people feel about self-assessment is weak or limited. Although older people are generally willing to complete self-assessment screening questionnaires, there is little evidence of whether or not they perceive this to be useful or that it will lead to any action as a consequence.

Users' responses to a self-assessment largely depend on their knowing who it comes from and what purpose it serves. If a self-assessment comes from a respected and known source, such as a family practitioner, then this seems to result in high participation. An opportunity to complete the assessment with professional input as needed/wanted is also important, rather than the client being 'left to get on with it'.

Supported self-assessment can be a positive experience for older people. Simply giving or sending the questionnaire to an individual in advance of an assessment meeting may also help users engage in the assessment process although care must be taken that the format is suitable and the process properly explained.

Other findings

- The length and complexity of a self-assessment questionnaire does not necessarily put older people off. What matters more is that the tool is easy to use and the items correspond to issues they consider important.
- There is some evidence that older people are satisfied with a user-initiated and user-interpreted self-assessment.
- There is a large gap in current knowledge on how older people feel about comprehensive assessment, within which self-assessment is increasingly incorporated.

Dartmouth COOP clinical improvement system

The Dartmouth Primary Care Cooperative Information Project (COOP) clinical improvement system in the United States was one of the more innovative self-care programmes for older people identified by the review. Users are invited to complete self-assessments across a range of areas (function, emotional status, pain, daily activities and social support) plus a number of focused questions on general health, common health problems (e.g. incontinence, medications) and preventive care (e.g. influenza vaccine). Tailored feedback in terms of health information is triggered by responses. Feedback may also be given to care providers although in some implementations such feedback is optional. This also sets the Dartmouth approach apart from the many other health checks.

For more information about the system visit the Dartmouth COOP Project website at: www.dartmouth.edu/~coopproj/index.html

Source: Griffiths, 2005

Making best use of questionnaires

An extensive review of best practice in the use of questionnaires in surveys of health service patients and staff identified numerous factors that affect response rate. These include pre-notification contacts, the nature of the covering letter, the perceived relevance of the survey to the potential respondent and, not least, the ability of the person to complete it.

Source: McColl, 2001

Key lessons

Lessons for practice

There is limited evidence of accuracy and effectiveness of self-assessment. The more positive message is that self-assessment can enhance user involvement and prevent common pitfalls in assessment practice generally. Self-assessment can thus be cautiously advocated and is unlikely to prove unacceptable to users. Moreover, many of the lessons learned from using self-assessment tools with older people are applicable to many other care groups and vice versa.

- Where self-assessment forms part of a client's interaction with a service, professionals need to demonstrate to the client's satisfaction that they value the information provided.
- More effective types of self-assessment not only deliver information to professionals but also, crucially, give feedback to users, including information about how they can care for themselves.
- Where initiated by professionals, the use of self-assessment demands professional expertise and involvement to maximise benefits and avoid a perception of neglect.
- Results of self-assessments for health conditions are not definitive: they can serve to provide focus in an individual's assessment but cannot fully replace it.
- From the weak evidence available, it appears that older people are comfortable with self-assessment, including user-initiated and user-interpreted assessments.
- Many people may prefer to have some professional support with the process. The use of self-assessment for identifying health and social needs may be a more positive and helpful exercise for older people if supported by a known health professional.
- The use of computer-based questionnaires may be a positive development for older people but format, ease of use and access are crucial.
- The design, content and layout of self-assessment material is crucial and active involvement of potential users in the process may be beneficial.

Lessons for policy

- Knowledge about use of self-assessment among older people is underdeveloped despite longstanding guidance reinforcing the importance of users' views in assessment, patient involvement in care and person-centred care.
- The variety of practices identified indicates that there is considerable scope to further advance policy directives regarding self-assessment, provided that this is found acceptable by clients.
- The small number of self-assessments included in the review directed by older people were considered to be useful and acceptable.
- Self-assessment should not be equated with user involvement and partnership. Greater clarity is required when advocating self-assessment and the benefits it brings should not be automatically assumed.
- Most self-assessments are designed to be initiated, interpreted and acted upon by professionals, not by older people. Self-assessments of this kind are potentially useful but the partnership is embedded in how the assessment is used, not the assessment alone.
- Involving users in developing self-assessment methods is potentially valuable but professional expertise in terms of performance of specific tests should not be neglected.



Future research

- Although there is evidence for the accuracy of self-assessments, particularly in the field of specific health issues, this area is under-researched.
- In terms of specific health issues, more studies are required on the accuracy of self-assessments of functional status in everyday practice as opposed to for research purposes only.
- Where self-assessment is intended to have an impact on health behaviour more evidence is required to determine actual behavioural change.
- Self-care approaches seem promising but further research is required in the UK context.
- Given the widespread implementation of the SAP, there is an urgent need to explore older people's experiences of the self-assessed component of comprehensive assessment.
- Further research should directly investigate the experience of self-assessment rather than rely on inferences based on assumptions from indirect sources, notably response rates.

About the study

This review aimed to address the following objectives:

- the scope of self-assessment – in what ways and for whom it has been used
- the accuracy of self-assessment (where it is used in a screening or diagnostic manner)
- the effectiveness of self-assessment in terms of service- and person-related outcomes, including accessing services appropriate to need (such as social support and medical treatments), uptake/engagement and satisfaction
- the acceptability of self-assessment from the perspective of both older people and professionals.

The review consisted of:

- a survey of the scope of approaches toward self-assessment based upon a comprehensive review of literature and a survey of practice
- a systematic review of studies of accuracy comparing the results of self-assessments with appropriate gold standard assessments
- a systematic review of controlled trials of effectiveness of self-assessment
- a review of qualitative evidence of self-assessment focusing on the experience and acceptability of self-assessment from the perspective of both the older person and professionals.

The literature review examined and summarised evidence from published and unpublished literature (both UK and international) up to and including Spring 2004. Review findings were reported according to scope, accuracy, effectiveness and experience of self-assessment and recommendations. A total of 35 studies met the criteria for inclusion in the reviews of accuracy (n=26) and effectiveness (n=9). Seventeen studies provided some direct evidence of user experience. The research team also benefited from the advice of 'key informant' professionals and from an older person's reference group.

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Further information

The full report, this research summary and details of current SDO research in the field can be downloaded at: www.sdo.lshtm.ac.uk

The report and related material can also be accessed from the Nursing Research Unit page on the King's College London website at: www.kcl.ac.uk/schools/nursing/nru/user/userled.html

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