

Using information technology to communicate about health and wellbeing, assessment and review: Audio computer-assisted self-interviewing (A-CASI).

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Introduction

The development and growth of information technology in the past decade has changed the face of communication at both a personal and an organisational level. As young people and practitioners become more familiar with its applications, it seems pertinent to think about how it can be applied more widely in relation to health and wellbeing in residential child care settings. An increasing number of local authorities are introducing audio computer assisted self-interviewing (A-CASI) as a method for improving communication with young people in their care. Self-completion methods in general are viewed as advantageous, in comparison to other approaches, in terms of being cheaper and quicker to administer and also in terms of minimizing the under-reporting of issues that could be sensitive (De Vaus, 1996). A-CASI approaches have been identified as being of particular benefit in conducting research with particular groups, such as children and young people and have also been associated with aiding literacy difficulties, with an enhanced sense of privacy and with increased disclosure of sensitive information (De Leeuw et al., 1997; Borgers et al., 2000; Borgers et al., 2004). In addition, its use is thought to decrease respondent error or fatigue and allows the relatively easy use of more complicated questionnaires, providing richer data than other self-completion approaches (Tourangeau and Smith, 1996).

This paper will look at A-CASI as a method for helping young people to communicate about issues of health and wellbeing. It will describe the use of Viewpoint Interactive A-CASI, which is the most frequently used software system in Britain, being used by over 130 local authorities in the UK. Finally, it will raise some of the challenges facing practitioners who wish to implement such systems.

Research on Viewpoint Interactive A-CASI

Morgan and Fraser (2009) reviewed the literature about Viewpoint Interactive A-CASI. They concluded that

in particular, it has proved useful for collecting data about sensitive or stigmatising subjects... The basic problem with trying to gather information on stigmatising behaviours is that people do not want to talk about them. A-CASI is a methodology that in part addresses this dilemma in collecting data from subjects who may be reluctant to explore and share their views in face-to-face interviews, but who can be less resistant when using an apparently more neutral, less threatening, audio-enhanced computer

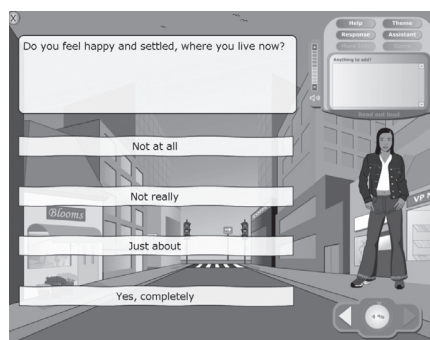
(Morgan and Fraser, 2009, p. 2).

In this same paper Morgan and Fraser reported on a study based in two local authorities in England. The study contrasted how the A-CASI methodology is experienced by children and young people and by child care managers, and explored how A-CASI had contributed to the participation of young people in the delivery and management of their care. Morgan and Fraser reported that the young people who responded to their survey understood the value of expressing their views using A-CASI.

They (the young people) believed quite clearly that A-CASI is a useful, relatively risk-free and efficient way, amongst other ways, to register their opinions... One young person wrote 'I can write my thoughts and feelings down better than what I can say them', ...and another one young person commented, 'I can put in what I want and click on what I think and it won't tell me what to do' (Morgan and Fraser, 2009, p. 6).

Viewpoint Interactive A-CASI in residential child care

In Scotland, Viewpoint A-CASI is now being used within some local authorities for LAC reviews. A range of practitioners were asked for their views about how the use of A-CASI was progressing. Children and young people aged from 5 years to 15 years participate, using tailored, age-appropriate questionnaires. The Viewpoint A-CASI software delivers questionnaires to young people, using colourful graphics. It also has speech functions allowing all text to be read aloud, time-limited breaks for computer games and animated on-screen assistants. Typically, children and young people will complete fifty or more questions using the technology.



An example of the Viewpoint Interactive interface

For those concerned with young people's health and wellbeing, the individual responses from young people provide an opportunity to identify those who require particular further attention. Questions usually include the following:

- Do you have any worries or concerns about your health?
- Can you say what worries you?
- Do you have any problems with sleeping?
- Do you have a health care record or plan?
- Do you have someone to talk to about your health?
- What makes you happy?
- What makes you sad?
- How often do you exercise or play sport?

When asked if they have worries or concerns about their health, the overwhelming majority of young people report no worries or concerns. However, some concerns have been disclosed by young people which they have not felt able to mention before. Some examples include *'being overweight'*, *'being breathless'* or *'having a rash, painful joints'* or a *'painful lump'*. It appears that questions on the Viewpoint interactive A-CASI can provide an opportunity to the young person to 'signal' that there is something to be discussed further, which may not otherwise have been mentioned and would probably not have been mentioned in the context of the review meeting.

It was reported that it is also not uncommon for children and young people to report sleeping problems and for young people to describe themselves as *'sad'* *'depressed'* or *'unhappy'*. While this is not the majority of young people, there are individuals who are signalling that their health and wellbeing needs more attention.

Young people are also asked, *'Are there ever times when you get angry or frustrated?'* This is an area where the pattern of responses in Scotland appears to mirror similar findings in an English study which examined the views of 281 children and young people (Butler, 2006). In this study, 40 per cent indicated that they felt angry or frustrated 'all' or 'most of' the time. Butler (2006) reported that,

The most telling question asked of this age group (who, by and large, express satisfaction with their circumstances) was in relation to how settled and how safe they felt... It should be noted that over two-thirds of children (70 per cent) answered that they felt 'completely' settled and nearly 80 per cent that

they felt 'definitely' safe... Of the minority who were not feeling 'settled' and 'safe', the girls were more likely to indicate problems with 'safety' and the boys with feeling 'settled.' Analysis of the responses of the children in the 'safe and settled' group found that they were generally very positive about their care experience

(Butler, 2006, p. 11).

It was found that there was a significant subgroup of the 'not settled and safe' group (61 per cent) who indicated that they felt angry or frustrated 'all' or 'most' of the time, compared to less than a third (29 per cent) in the 'safe and settled' group. The two-thirds of children in the 'not settled and safe' group (61 per cent), who felt angry or frustrated 'most' or 'all of the time' gave similar answers to the rest of the 'not settled and safe' group to many of the questions. There were two questions, however, where the responses were significantly different:

1. In each group around three-quarters of the respondents indicated that they 'knew they had a Care Plan'. However, a much lower percentage of those who felt angry or frustrated indicated that they were helped to understand it (41 per cent as opposed to 70 per cent);
2. The other area of particular dissatisfaction was that those who indicated that they became angry or frustrated were not able to see their friends as much as they wanted. Less than 10 per cent were completely happy with the arrangements compared to 76 per cent of the rest of the 'less settled or safe group.' Nearly half indicated they 'could not' or 'not really' see their friends.

Butler concludes that there would seem to be a *prima facie* case for focused attention on this group.

Discussion

The evidence suggests that using computer-based questionnaires helps young people inform reviews and provides valid and reliable data about the health and wellbeing of children and young people who are looked after away from home. Young people may report circumstances that have not been raised before and provide health and other practitioners with opportunities to address individual needs. A-CASI methodology can also be used to support initial assessment processes, providing opportunities for young people to work through key questions about their health and wellbeing at their own pace and in confidence. Young people have time to consider their own circumstances, find themselves prompted to think about different issues and have the opportunity to consider if they will mention something. Significantly, research suggests that there will be higher disclosure of sensitive or embarrassing information that may be felt to be stigmatising.

In Morgan and Fraser's study (2009), managers who had experience of the use of A-CASI supported these points, as the following quotes from managers included in the study indicate:

(It provides) independence from an adult, allows time and control to be with the child, no-one else can see their answers. It can talk etc and communicate in ways which are inclusive and the child is in control of these

It encourages the active inclusion of children, as opposed to telling them what their plan is

It can highlight issues that are worrying children that they find it hard to raise

(Morgan and Fraser, 2009, p. 8).

Additionally, the use of computers means that data collected for individual assessments or reviews can be aggregated to identify particular patterns or trends. As described by Butler (2006), it is possible to identify certain key questions that may be important in distinguishing young people who need particular additional support and attention. Research appears to support this conclusion, with studies finding that computer-assisted approaches are advantageous for data collection, collation and reporting, as responses can be automatically saved to a database and no additional coding is required (Fricker and Schonlau, 2002).

While A-CASI methodologies provide demonstrable benefits to the disclosure and monitoring of issues around health and wellbeing in assessment and review processes, it appears that the adoption of the use of computers in these processes progresses only slowly. Despite the emerging evidence provided by research, and by the direct experience of young people, practitioners and managers, there is resistance to the adoption of these technologies. In Morgan and Fraser's study, the role of service managers was identified as important.

Where the use of A-CASI was left to the discretion of social workers or to professionally unqualified assistants, without sufficient reinforcement at a senior level, usage could decline significantly. Managers do need to provide encouragement to practitioners and understand the improved quality of information and communication that can be brought about. A-CASI is a tool to enhance these processes and it cannot replace the interaction between practitioner and child or young person

(Morgan and Fraser, 2009, p. 7-8).

Practitioners may struggle to become fully committed to systems such as A-CASI. Morgan and Fraser highlighted how such methods can contribute to relationship –building and the participation of young people in determining their health and wellbeing needs. For the vast majority of practitioners, the

use of computers in interaction with young people will represent a totally new area of practice. Morgan and Fraser stated that ‘technophobic reactions may be common’ (p. 15), and could contribute to under-use. An investment in technology, and in training and understanding is essential. Practitioners need to be committed to hearing directly from children and young people. In the case of A-CASI, they need to experience enthusiasm for its use from children and young people and from their managers. If practitioners (and managers) can be open to such enthusiasm, a wider use of such methods is more likely.

The Scottish Executive (2006) argues that effective listening and work with children require ‘not just honed micro-skills, but a commitment to child-centred and inclusive practice’. The effective application of A-CASI approaches within assessments and reviews can support this process, and can provide additional opportunities for enhancing communication and relationship building.

Conclusion

Viewpoint Interactive A-CASI is a relatively new technology. It is a methodology more familiar to children and young people than to practitioners in health and social care. Research evidence and practice experience demonstrates that this methodology helps young people communicate, particularly about sensitive, stigmatising and embarrassing issues. As the methodology is unfamiliar (and uncomfortable) to many practitioners, young people’s opportunities to access this new technology may be limited. However, assessments of health and wellbeing must include direct involvement of children and young people. It is to be hoped that new technologies will increasingly be applied to these processes, to the benefit of children, young people and managers.

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