A structured health needs assessment tool: acceptability and effectiveness for health visiting

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Background. There is, nominally at least, a universal health visiting service in Great Britain, although the frequency of contacts may be severely restricted. Debates about whether home visiting should be universal or selective, therefore, focus on whether health visitors should use professional judgement or structured assessment tools to target attention within their caseload. Research attention has focused mainly on unstructured needs assessments and professional judgment or the development of assessment tools, so that the views of practitioners using structured instruments and their clients are not known.

Methods. A two-phase qualitative study examined the acceptability and effectiveness of a structured health needs assessment tool (HNAT) implemented in London. Views about the tool were elicited from 30 health visitors through telephone interview, and then 21 assessments were observed and tape-recorded; 19 clients were interviewed after the event. Data were evaluated for adequate coverage of views across the target population and analysed using the framework approach.

Findings. A range of views were expressed, but the HNAT caused anxiety and distress to, particularly, the most vulnerable clients. The structured format of the tool appeared to encourage the health visitors to question instead of listen. It did not help to identify all the needs and intruded into normal practice in an insensitive and unhelpful way.

Limitations. This study investigated only one form of structured HNAT. These are commonly used to prioritize undifferentiated needs of clients who have been offered an unsolicited, health promoting service. Our findings therefore do not apply to validated instruments used for screening or specific diagnostic purposes where a client has requested help with a problem.

Conclusions. Given the problems in use and potential for harm, this form of structured assessment tool appears unsuitable for routine use to determine the intensity of health visiting contacts.

Keywords: health visiting, home visiting, structured health needs assessment, universal vs. selective, vulnerable families, consumer views

Introduction

Health visitors in Great Britain offer an unsolicited public health service based on the provision of health promotion and preventive care to families and communities. They maintain a caseload of all families in a local area who have children under the age of 5 years, delivering their service through a combination of individualized home visiting, clinic contacts and community-based activities in the neighbourhood.

The internal market introduced into the British National Health Service (NHS) in the early 1990s increased pressure on health visitors to explain their practice in terms that correlate with the language of service level agreements and financial units. More recently, policy attention has turned to the problem of health inequalities, with a commitment to reducing the gap through a series of targets designed to improve the lot of the worst off in society (Secretary of State for Health 1998, 2000, Department of Health 2001). Health inequalities are particularly marked and widening within the capital city, London (Greater London Authority 2002), which is the site of the study reported here.

The study offers an opportunity to reflect upon fierce debates about two particular issues that arise from attempts to change the organization and practice of health visiting to improve efficiency and reduce inequalities. The first area of debate concerns whether universal provision should continue, or whether health visiting services should be offered on a 'selective' or 'targeted' basis to certain areas or particular families only. Charged with identifying suitable strategies for reducing health inequalities, the Acheson Report (Independent Inquiry into Inequalities in Health 1998) singled out home visiting as one of the most significant and well-evidenced activities to be developed. However, the report commented neither on whether visits should be offered to all families, nor on methods for identification of families if a selective approach is used. The second area of debate, to which this paper offers a contribution, concerns the mechanisms through which such decisions are reached: by professional judgement or through a structured form of health needs assessment.

There is an increasing literature about the 'universal vs. selective' side of the debate. Evidence of the effectiveness of home visiting is increasing, although most of this comes from studies carried out in North America rather than Great Britain. Five systematic reviews of note have been carried out in the last decade (Olds & Kitzman 1993, Roberts *et al.* 1996, Guterman 1997, Elkan *et al.* 2000, Ciliska *et al.* 2001). The earliest of these reviews led to recommendations that universal home visiting be implemented in the United States (Gomby *et al.* 1993, Krugman 1993). Authors of two of the other reviews also went on to press the case for a universal home visiting service (Guterman 1999, Elkan *et al.* 2001), with Guterman noting the marked increase in provision in North America since the earlier recommendations.

These systematic reviews identified a range of experiments, mostly in the USA, involving clearly specified programmes of home visits to particular areas or identified risk groups. Instead, in Great Britain, a 'universal service' for all families exists nominally, but the meaning of the term varies in practice. 'Universality' may be interpreted as the provision of a single home visit to a family after the birth of a child. This standard was adopted for health visiting by an earlier government (National Health Service Executive 1996) following a recommendation by the Audit Commission (1994) that, to maximize efficiency, more frequent contacts should be provided only in response to specific problems, and not for supportive health promotion. It is on this basis that the 'structured assessment vs. professional judgement' literature has developed.

Pressure to reduce the amount of time spent on home visiting was soon followed by increased attention to targeting disadvantaged groups or families. Together, these two priorities gave rise to a heavy emphasis on the notion of assessing health needs when health visitors first meet families, in order to decide the frequency of future contact. There is neither a single accepted approach for such needs assessment, nor agreement about the suitability of different approaches through which decisions about the level and type of service provision should be reached. Some researchers have argued for professional judgement to determine the frequency of contact with individual families (Elkan *et al.* 2001). There is a growing literature about the processes embedded within health visitor needs assessment when professional judgement is the key mechanism for determining how much contact a client should be offered (Chalmers 1993, Williams 1997, Bryans & McIntosh 2000, Cowley *et al.* 2000, Appleton 2002).

However, much less empirical attention has been paid to the use of structured assessment approaches. Notwithstanding this, most of the NHS trusts that employ health visitors have developed some form of structured guidance through which they are supposed to reach an assessment and decision about the frequency of future contacts (Appleton 1997). Although the validity of most of the identified guidelines was criticized in Appleton's (1997) national survey, it showed that they were used to define service contracts in about one-third of the responding trusts, whilst another third anticipated that this would soon be the case for their organization. In a more recent constructivist study, Appleton (2002) identified that most health visitors who

were issued with guidelines still used their professional judgement to assess families, often disregarding the official format. A small number of descriptive papers have identified the development, content and intentions of some of the more rigorous structured assessments, particularly those intended for use in relation to child protection (Browne 1995, Naughton & Heath 2001).

We were unable to trace any studies identifying how useful or acceptable the tools appeared either to health visitors asked to implement them, or to clients whose needs were assessed through their use. Experimental studies of home visiting have reported difficulties in engaging and retaining families (Gomby *et al.* 1999), and therefore it seemed relevant to discover whether the use of a structured instrument might, in itself, either help or hinder the process.

Health needs assessment tool

This paper reports a study undertaken in a single London NHS trust that, in common with many others, had devised a structured health needs assessment tool (HNAT) for use by health visitors in the course of contacts with families on their caseload (see Appendix 1). The HNAT was developed by a working party of health visitors using a series of focus groups with staff at different levels, including some consultation with consumers. A programme of professional development accompanied its implementation with new parents and families entering a health visitor caseload for the first time.

The aim for the tool was to capitalize on the professional skills of the health visitor, who would decide when to introduce the assessment and ensure that all clients were given the same opportunity to reveal their needs. On completion of the assessment, and in discussion with the family, some estimate was to be made of whether the family had low, medium or high health needs and the results were to be recorded. Families could refuse to complete the form without affecting their right to receive health visiting intervention, but practitioners were required to implement the new approach in their practice. There was some controversy about the approach within the trust, with health visitor opinions being sharply divided about the suitability of the HNAT for their practice. Service managers, therefore, checked that health visitors returned an accurate monthly record of assessments.

The study

Aim

The study aimed to explore the extent to which the health visitor assessment process using the HNAT implemented in this NHS trust promoted the health of the families involved. Other aspects of the study are reported elsewhere (Mitcheson 2001, Houston & Cowley 2003), but this paper focuses on one objective that does not feature in the others. This was to assess the effectiveness and acceptability of the approach from the perspective of health visitors and service users.

Methods

A 12-month, two-phase study was planned.

Stage 1 – contextual data and telephone interviews

To understand the context and recruit the sample, we held a series of meetings and formal and informal conversations with staff; detailed field notes were recorded following each interaction. This fieldwork continued until the majority of staff engaged in the development and use of the HNAT had been contacted and given an opportunity to discuss the process the study would follow, participate in general discussions and provide their views. Written information, with consent forms attached, was provided at these meetings, so that health visitors could volunteer confidentially (by returning the signed form by post) to participate in telephone interviews.

The trust employed about 90 health visitors (full- and part-time), although numbers fluctuated through the year due to staff turnover. Formal, tape-recorded, semi-structured telephone interviews (Carr & Worth 2001) were completed with 30 volunteer health visitors recruited from face-to-face group meetings to explain the study across the trust. The health visitors were invited to talk about their caseload, involvement in development of the HNAT, beliefs about health promotion and empowerment and attitude to the assessment process followed within the trust. This approach achieved the aim of eliciting a wide range of views about the HNAT (from positive to negative), and tapping into the varied experience and ethnicity among the health visitors.

Stage 2 – case studies

These data formed a base from which to draw the second-stage sample, consisting of five in-depth case studies of the use of the HNAT in practice, each from a different organizational division (Primary Care Group) within the geographical area served by the trust. Case study health visitors were selected to reflect the range of attitudes expressed about the HNAT in the first phase: two disliked it, two liked it, and one liked the idea of needs assessment but had some difficulty with the model itself. The participating health visitors were asked to introduce at least two families who would be willing to have their interaction with the health visitor observed and participate in a separate follow-up interview. Most intro-

Table 1 Data collected

Phase 1: Whole trust
• Field work across the whole trust: meetings; general discussions
• Twenty-seven field notes from formal and informal interactions with staff across the trust
• Thirty tape recorded, semi-structured telephone interviews with health visitors drawn from across the trust
• One focus group ($n = 4$ health visitors)
Phase 2: Five in-depth case studies from different geographical areas of the trust
• Five health visitors (three white, one Black, one Asian)
• Twenty-one clients: observed use of health needs assessment tool (included: White British, White American, Chinese, Asian (Gujarat as first language) Asian (Urdu as first language) high and low caste Asian families. white Scottish, white Irish, Spanish, Black Caribbean, and Arabic)
• Twenty-five home visits to clients (use of interpreting services involved multiple contacts with some clients)
• Nineteen tape-recorded interviews with clients after completion of the health needs assessment

duced more than the minimum, enabling much rich and detailed data to be collected, as summarized in Table 1.

As with stage 1, a range of experiences and ethnicity was sought and obtained amongst the case study health visitors and referred families. In such a small sample, not all potential variations could be encompassed and no specific quotas were sought. Instead, in both stages, data collection aimed to achieve a maximum variation sample (Morse 1991, Sandelowski 1995). This approach makes use of selective sampling to ensure that the whole variety of views and possible perspectives are reflected in the data, rather than seeking a random or a statistically representative sample. It is ideal in situations where the potential sample is very heterogeneous or too small to generate statistically significant results, both conditions that pertained here.

Ethical considerations

Approval for the study was gained from the relevant Local Research Ethics Committees. In the light of the controversy surrounding introduction of the HNAT and the small numbers involved, it was very important for the participating health visitors, as well as their clients, to be assured that their participation in the study (especially in the case study phase) would remain confidential. Potential participants were informed about the process of study at least a day before being asked to sign a consent form. Where feasible, prior telephone contact was made, but return visits to clients' homes were needed in some instances to allow enough 'thinking time'. The trust made their interpreter service available so that clients who were unable to speak English could participate. Arrangements were made for the researcher to refer clients for further services if new needs were revealed that they preferred not to discuss with their own health visitor, or there might be a risk to family members. Counselling and supervision support were essential and were provided for the researcher (and on occasion for the interpreter also) because of the extent of distress encountered (Houston & Cowley 2003).

Data analysis

Filemaker-pro 4 software (Filemaker Inc. 2000) was used to aid filing, sorting and categorising the large amount of unstructured data, which were analysed using the 'framework' approach (Ritchie & Spencer 1994). This approach allows within and across case analysis. Themes and categories were developed, and then systematically mapped and charted to display emergent analytic typologies that formed the basis of the report.

Ensuring data adequacy

The diversity of the 500 000 multi-ethnic population served by the trust was mirrored in the staff profile and sample obtained (see Table 1). As the maximum variation sampling strategy used volunteer health visitors and nominated clients, two further checks were made on the final sample. Data were scrutinized to see if the views expressed by clients about the HNAT mirrored those of the health visitors who referred them to the study. That was not the case, although health visitors who disliked the tool introduced more clients into the study. However, whether positive or negative, the views of the health visitor did not predict the opinions expressed by clients. Also, at the end of the data collection period a questionnaire was distributed to ask why staff did not volunteer, in case the sample was somehow exceptional. The main reasons given for non-participation were workload and time pressure; one person was critical of the research design and chose not to participate. Others offered reasons captured in the data elsewhere, which supported our impression that the full range of views had been elicited.

Findings

Using the health needs asssessment tool

Both phases of the study revealed that the health visitors were in favour of the idea of assessing families' health needs as a basis for planning future work with them.

However, for many, it was difficult to implement the tool in the way envisaged by the working party and their managers. Health visitors talked of 'comfort', with some wanting to avoid either themselves or clients feeling 'uncomfortable', given what they perceived as the intrusive nature of the questions:

to hand them a form almost, that to me I do not feel comfortable in doing, I do not think that helps build a relationship, that I come in almost as an assessor, with a piece of paper, and equally the questions some of them I think would upset people on the first occasion.

In some cases, this discomfort was because, in their view, their workload was such that a choice of when to introduce the HNAT was inhibited. This meant that both the very direct nature and the timing of questions could seem insensitive:

Because, well, it is too direct, the questions are too intrusive and they are asked whether the client is actually ready to share that information or not.

Those who valued the HNAT liked the consistency of using the same approach for all, and regarded it as a mechanism for raising questions that, otherwise, they might lack the confidence to ask:

I feel it gives me a lot more…how can I put it…it gives me a lot more confidence, I would not say confidence, but more ideas of approaching things and also it gives the clients some basis for discussion…I do ask the questions. HV17f

A staff development programme accompanied the introduction of the HNAT; even so, the observations revealed that some staff asked the questions but appeared not to listen or respond to the answers, moving on instead to the next question. Both 'listening' and 'non-listening' practice was observed, with the latter being particularly noticeable when the HNAT was being used in the visit. The extent of questioning within the visits was high, with health visitors asking between 31 and 135 questions in a single visit (median 43), whereas the maximum number asked by clients was eight, ranging down to none (median 1). Analysing the conversational detail revealed that the structured assessment tool seemed to interrupt and intrude into the normal flow of health visitor/client interaction, both setting the agenda and encouraging a high level of questioning.

There was no standardized method of introducing the HNAT, but the combination of interviews and observations showed that there was sometimes a mismatch between what was said and what was done. There was agreement, for example, that the HNAT was not intended for use as a 'checklist' and the questions were only a guide. However, in almost all observed examples, the questions were read from the form as if a structured questionnaire was being administered.

Practitioners developed different strategies to introduce the HNAT, the most common being to 'distance' themselves from it by stressing that it was something required for management purposes, rather than as a means of ensuring delivery of an appropriate service to the particular family. Some practitioners used humour, while others left the HNAT with clients so that they could prepare for the questions. Some health visitors chose not to use the HNAT in some circumstances, although the extent to which they felt able to report their dissent varied:

This is something that my employers have asked me to fill in. Obviously, I don't agree with every question and you might find some of the questions odd, but nevertheless I have been asked to do it. I do say, 'I don't like it' and I would not have written the assessment like that, but it has been written like that and that is obviously what they are telling me to use.

Clients' views of the health needs assessment tool

Clients also expressed a range of views about the HNAT, but even those ($n = 9$) who were broadly happy with it made some negative comments:

I think there were two or three [questions] that were actually just too direct…it was too direct in some terms.

In some cases, acceptance of the HNAT related to health visitor charisma, with some clients saying they hated the assessment tool, but speaking warmly of their health visitor. In a couple of instances, clients seemed unable to criticize the HNAT; being so appreciative of the health visiting service, they did not want to appear ungrateful, or to say anything that would reflect negatively on their health visitor:

It is right, because the person is very upset and she cannot talk to anyone, one is grateful for asking those kinds of questions…because you are helping us, not yourself, you are helping us, so we have to be very grateful to you…I cannot say anything wrong, or anything bad about the health visitor because they are helping me. Verbatim quote via interpreter

This high level of goodwill towards the health visiting service was evident throughout the trust, with most clients expressing gratitude for the support and help they had received. However, for some the converse was true, with the HNAT being adversely linked with the way they viewed the health visiting service:

I felt the whole visit was a bit, I was blinded with information, there was too much stuff being told to me in one go and I remember sitting

here with…[baby] on my own. It was one of the first times I had actually been on my own, my partner had gone back to work and it was sort of like bang, bang, bang, this, this, this, and I was like, I can't take it all in, you know. [...], and at the end of it I just kind of…when she went I just went 'oh my God'.

Clients who were unconcerned about use of the HNAT were often those with few problems:

I think it is because I have nothing [no problems] It did not bother me, I feel fine them asking the questions.

Although such clients seemed more likely to find the HNAT acceptable, some still commented that the questions were very direct and that a very good health visitor–client relationship would be needed before asking them. The nature of the questions seemed to raise suspicions about why they had been asked, what was being done with the information and who would be told of the clients' responses:

I thought it was a bit intrusive really. Even if the health visitor were to ask me that I think I would have to know them pretty well before I opened up to that extent and to think that it would be stuffed on a form somewhere in a file, I did not like the idea of that really.

Some clients felt the wording or the questions themselves were inappropriate, whilst others rationalized that they must have a purpose, even if this was not immediately obvious:

Well, the certain questions I found a bit weird when they said, 'How do you feel towards your husband and how do you feel about the baby', but mind you afterwards…I thought about it and I thought, yes maybe if those questions were not asked…because it was mainly aimed at me to see how I feel as a mother, as a new mother, because if I did have any depression or anything it would affect the way I was bringing up…[baby]…I suppose, so I thought it was relevant at that time when it was asked. So yes, it was alright actually.

Others, however, were more wary about how their responses would be interpreted, pointing to what seemed the judgemental nature of the questions:

You might just be a little bit suspicious of what does that mean if I say yes to one of these things, will it make me a bad person and potentially a bad parent or something like that.

There you go again, you are judging me again like you are judging me really, what kind of mother I am…very, fairly or bad, you know.

Concerns about being judged were more often expressed by clients with a high level of need. This group was far more likely to dislike the HNAT, sometimes expressing great anger or hostility about it. Some of this stemmed from the apparently intrusive nature and timing of the questions. For others, asking questions (for example, about housing or their financial situation) raised expectations of resolving difficulties that were not in the power of the service to address, which then led to the client feeling frustrated and anxious about why they were asked about these matters in the first place:

…Something should be done if they are asking this kind of questions and they are not doing anything then why ask? If she is going to do something about it, then she can ask me, but if nothing is done and she is just putting it in the record so she can just have the record…because it is like I am being interviewed or something and I don't think…why should she start coming to interview me…when she kind of questions like…she will think 'oh she didn't want that child' anything can happen and it is then like 'why did you have the baby then?

For some clients, the sense of frustration was so great that they expressed quite violent feelings towards their health visitor. Others, despite their anger and distress, tried to work out why this was happening and who was to blame:

You sympathise with the health visitor obviously to an extent that she is explaining the rush there and then and there have been some emotional times when…[wife] has been reduced to tears. She [HV] has gone we have been left in an emotional state and it is not really…[HV]'s fault but it was a thing we could have done without and in that case you have to say, who's fault is it, why are we in this predicament, why are you upset? You can't really blame…[HV] then who?…[HV's] boss? We can't go running round saying look what they have done.

It was noticeable that, perhaps because they were so vulnerable, clients whose needs were most marked were also the ones who were most likely to have been caused distress by the HNAT. The sample was too small for generalizability, but six of the 19 clients revealed during our interviews health needs that had not been divulged to the health visitor or elicited through the HNAT. Comments made by one client reflected debates in the literature about the suitability of structured assessment processes or professional judgement:

I felt that if there was something wrong you are much more likely to get to the nub of it quickly through having a conversation, talking around issues rather than trying to categorise things into boxes… whereas if you had a properly trained health visitor who was mature and experienced enough to know that when somebody tells you one thing that they may be trying to say something else. It seemed like a bit of a distraction in a way. You know, we would be happily having a conversation and then we have to fill in this thing.

In summary, the most vulnerable clients seemed the least likely to have their needs identified through the HNAT. The

unrealistic raising of expectations led to a sense of injustice and frustration and, in many cases, a feeling that clients were being judged or blamed rather than helped. This latter feeling was particularly difficult to dispel, with clients wondering anxiously why they had been singled out to be asked such personal questions. Overall, use of the structured HNAT, despite positive intentions, appeared to encourage health visitors to ask questions rather than to listen or respond to expressed needs. It did not ensure that all needs were identified but did intrude into normal practice, impeding rather than improving it.

Discussion

Although the use of structured needs assessment tools appears to be increasing (Appleton 1997, Goddard *et al.* 1999), we believed this to be the first study that has sought views about the process from both health visitors using them and their clients. Qualitative research of the kind reported here is not intended to elicit generalizable information. However, the findings provide insights for service providers planning to adopt a similar process, or to inform the expectations and programme specifications of researchers designing experiments in the field.

Even where programmes of home visiting have been established assuming a certain level of contact, mainly in the USA, difficulties are reported in achieving a consistently high level of contact (Gomby *et al.* 1999). The nominally universal service offered by British health visitors may involve too few contacts to reach the levels of effectiveness shown in some of the trials identified in the literature review. The combined effect of financial pressures and commitment to targeting the worst-off in society has led to a proliferation of assessment tools designed to identify which families are most 'needy' and, therefore, deemed likely to benefit from a home visiting service. It should be noted that there is no empirical basis for assuming that it is possible to identify 'target' families in this way. Indeed, both Guterman (1999) and Elkan *et al.* (2000) are at pains to point out the long history of failed attempts to identify suitable screening tools and their potential for increased harm. Additional problems are the possible stigmatising of those who receive the service (Hall & Elliman 2003) and exclusion of an unknown number of families who might have benefited had they not been missed by an invalid screening process.

It is most unlikely that any structured questionnaire could have the flexibility and sensitivity required to elicit the individual, often hidden, unrecognized and undifferentiated health needs of all families. Health visitors in this study were advised to vary the wording of questions according to circumstances and not use them as a 'checklist', but the structured format seemed to create an almost irresistible pressure to use it as if it were a structured interview schedule.

In the light of this finding, the study was extended to carry out a more detailed conversational analysis of the use of this and another structured assessment tool in a different trust. Details of this further study are reported elsewhere (Mitcheson 2001), but similar usage was identified with both different HNATs. Indeed, the average number of questions asked by health visitors was even higher in the second area than in the one reported here. Researchers studying such sensitive topics would use an open-ended, conversational style and in-depth interviews to elicit data (Bowling 1997), methods that are compatible with the skilled communications needed for health visiting practice and demonstrably effective when used appropriately (Davis & Spurr 1998).

Furthermore, providing a list of structured questions to health visitors, even with instructions that they can be varied to suit particular circumstances, sends a strong message to practitioners and clients about the nature of needs that are 'approved' for service provision. The rather perverse aim of 'screening out' families not sufficiently needy to deserve health visiting attention goes against the main principles of health visiting, health promotion and empowerment (Houston & Cowley 2002). These principles emphasize the importance of offering services according to needs defined and expressed by clients themselves, rather than expecting them to match their health needs to a standard form of provision (Kendall 1998, Raeburn & Rootman 1998).

Finally, the idea that objectivity and consistency of service provision will reduce health inequalities needs to be challenged. Instead, the most vulnerable members of society should have not the same service, but one more sensitively tailored to meet the requirements of vertical equity (Carr-Hill 1994). Our study shows that asking all clients the same questions using a structured needs assessment tool is inequitable, as it ignores their vulnerability and the complexity of their situation. It both discriminates against those in greatest need and has the potential to cause them actual harm. Instead of the unconditional listening and support that has been found to be so beneficial (Davis & Spurr 1998), we found that individuals who are already feeling threatened by adverse circumstances are likely to feel judged, victimized and, therefore, under increased stress, if subject to close questioning. Furthermore, a client taken by surprise at a question about, say, domestic violence or her own childhood experiences, may deny such problems for a whole range of psychological and practical reasons. She is then placed in a worse position than if she had not been asked the question, as

What is already known about this topic

- Health visitors in the UK provide a universal home visiting service to families with young children but levels of contact may be too limited for effectiveness, raising questions about how to identify families for additional provision.
- Most research in this field has concentrated on the place of listening and partnership in needs assessment, combined with understanding how professional judgement informs the selection process.
- Health visitors may be required to use a structured approach to health needs assessment, but the value of this approach in practice has not been studied.

What this paper adds

- The study provides insight into the impact on practice, for both health visitors and clients, of a structured health needs assessment tool.
- The tool appeared to encourage health visitors to ask questions instead of listening to their clients, who tended, therefore, not to reveal their own needs or concerns.
- Questions that are acceptable to some clients may be considered deeply insensitive by others, because of their wording or the time of asking them.
- This structured form of needs assessment appears neither acceptable nor effective as a means of selecting target clients for health visiting from an undifferentiated caseload.

the need to admit an apparently 'untrue' response at an earlier time may inhibit raising the topic in future or approaching the service about any other health need.

In summary, the use of a structured HNAT to determine the level of health visiting provision, even if it has been developed and implemented with great care and the best of intentions, is not supported by our findings. The approach is not valid or reliable as an epidemiological instrument and is not effective for eliciting health needs, especially for the most vulnerable clients. It focuses attention on the organization's agenda rather than that of clients, and on practitioners asking questions instead of listening to answers. Above all, the approach has the potential to cause the most vulnerable clients increased stress and anxiety and inhibit their use of health services, which is not only discriminatory, but the attendant distress may cause them actual harm. We therefore recommend that health visitors should not use this kind of general, structured HNAT to determine the frequency of future contacts in routine practice.

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Appendix 1. Health visiting assessment tool

HV's NAME ———————————————— CHILD MPI ————————————————
HV's BASE ———————————————— FAMILY MPI ————————————————

This index of need is to be completed in consultation with parents (unless parents refuse, and then please indicate at end of sheet). It should be based on the parents' self report, and the health visitor's professional opinion of known factors. Please score as follows: (H) – High impact on family life; (M) – medium impact on family life; (L) – low impact on family life.

SECTION A: INDEX OF NEED

		DATE	
HEALTH		Only score if YES	H/M/L
A	You or your partner have a serious illness or concerns about an hereditary condition(s) in your family.		
B	Your baby or child (a) was premature, (b) has a serious illness or (c) was separated from you at birth		
C	You or your partner have a child with special needs		
D	You or your partner have experience mental health/psychological problems or depression		
E	You or your partner feel that you have a dependency for drugs or alcohol		
ENVIRONMENT			
F	You have concerns about your housing or environment		
G	You are dissatisfied with your level of support from family and friends		
SOCIAL			
H	You have experienced a major change in your family situation: 1. a bereavement 2. acquired refugee status or an asylum seeker 3. separation from a partner 4. had frequent changes of address 5. become homeless 6. other, please specify ————————		
I	This is not a good time for you to be a parent		
J	You or your partner had difficult experiences as a child which has affected your parenting		
K	There is an adult in the house with violent tendencies		
L	You or your partner have difficulties in understanding English		
M	You or your partner have serious financial worries		
COMMENTS:			

SECTION B: ASSESSMENT INTERVIEW WITH PARENT/CARER

This section to be completed for EACH child in the family. Questions to be completed with the parent/carer (additional sheets are available for each child):

1. How loving do you feel towards your baby/child? Very loving (L) Fairly loving (M) Not loving (H)
2. How happy are you with your child's behaviour? Very happy (L) Fairly happy (M) Not happy (H)
3. How confident do you feel being a parent? Very confident (L) Fairly confident (M) Not confident (H)
4. How happy are you with your child's progress? Very happy (L) Fairly happy (M) Not happy (H)

SECTION C: INTUITIVE ASSESSMENT

Questions to be completed by health visitor:

5. Are there any factors that have led you to instinctively think that this family may need more or less input?(Please make a note of these factors underneath.

In discussion with the parent(s) now decide whether this family is 'high-need', 'medium-need' or 'low-need'. Enter 'H', 'M' or 'L' as appropriate in the box opposite Please give reasons for your level of classification:

DATE:	
CATEGORY:	

Parent(s)' refusal – please tick ☐