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An empowerment approach to needs assessment in health visiting practice

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Summary

• This paper examines the usefulness of an integrated approach to needs assessment using an empowerment framework, within a health visitor/client interaction, in the home setting.

• It is intended to demonstrate the existence of a flexible approach to assessing need that is based on research about necessary processes for carrying out health visiting.

• The design of the tool described in this paper allows the use of professional judgement as well as fulfilling commissioning requirements to address health outcomes.

• Health promotion and empowerment are central to health visiting practice and should be reflected in the way needs are assessed.

• Many NHS trusts have introduced a system of targeting and prioritizing health visiting through a system of questioning to assess needs. This may reveal the work that health visitors do, but may also inhibit the open, listening approach required for client empowerment.

• Different methods of assessing need can be used that do not compromise the commissioning requirements, the health visitor's duty of care or professional accountability.

• The empowerment approach is key to the philosophy of health visiting.

• There are ways of approaching needs assessment that do not compromise the ethos of partnership-working in a health promoting way.

Keywords: empowerment, integration, needs assessment, needs assessment tool, outcomes, priority care.

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Background

In the United Kingdom, health visitors aim to provide a preventive, health promoting service that has always

tended to be heavily influenced by government policy. In consequence, it seems that health visiting practice has lost much of its autonomy in the last 15 years, having been substantially medicalized in its orientation and deflected from its primary preventive function (Robinson, 2000). The advent of a new Labour government in 1997 and rejection of previous New Right policies brought, for the first time in 18 years, the prospect of change in the health visiting service. It was suggested that health visitors, in common with their nursing and midwifery colleagues, were to be seen as:

> Public health workers, focusing on whole communities as well as individuals, fulfilling the public health functions of community profiling, health needs assessment, communicable disease control and community development (DoH, 1999a, p. 60)

Many health visitors felt that recognition of the importance of promoting health, alongside the proactive element of the health visiting service, in working with children, families and communities, was a long awaited change in government attitude. At the same time, the public health terminology created confusion regarding the remit of health visitors. In practice, the policy agenda provoked a sense of excitement mixed with anxiety. How could health visitors implement the many new ideas emanating from government? Craig & Smith (1998) reminded us that community development tends to be used for all or part of the work of health visiting. In that case, were these really new ideas, or a return to a lost path?

Also, whilst promoting a modern approach to delivering health care (Department of Health [DoH], 1997, 1999a, 2000, Home Office, 1998), echoes of the past administration lingered. Provision of services based on systematic assessment of need, a starting point for resource allocation (Institute of Public and Environmental Health, 1994), continues to be considered good practice. The strategy for nursing, midwifery and health visiting, for example, proposes that:

> Understanding and responding to local health needs and working with local communities will become an increasingly significant aspect of professional practice (DoH, 1999a, p. 16)

The idea of obtaining accurate and appropriate information before deciding on a care plan is seen as a commendable part of the process of care delivery for individuals. Defining objectives and identifying the means by which those same objectives might be met is also part of the care plan following assessment (Robinson & Elkan, 1996). However, the above quote draws attention to the dual expectation of health visitors, that they can deliver information about local health needs for organizational purposes, whilst maintaining the ethos of health visiting in their practice with individuals, which remains a challenge.

Much has been written about how health visitors can assess needs across their local populations, particularly for purposes of assessing workload, or weighting caseloads (Shepherd, 1992; Rowe *et al.*, 1995; Horrocks *et al.*, 1998). Many NHS trusts have developed guidance of some kind through which health visitors are supposed either to assess needs or prioritize the families they visit, largely for organizational purposes (Appleton, 1997, 2000). Far less attention has been paid to the need to ensure that health visiting practice maintains its primary function of promoting health, whilst carrying out these additional functions. That is the focus of this paper.

In the first half of the paper, the concept of empowerment will be unravelled in relation to health promotion and needs assessment, and a range of qualitative research will be used to locate the features of empowerment in established models of health visiting. The second half of the paper is devoted to describing how these features were applied, by using a 'field of words' explicitly developed in practice for the purpose of assessing needs through an empowerment approach. This model was applied alongside a prioritizing approach that enabled health visitors to meet some of the organizational needs, without sacrificing the central ethos of health visiting.

Empowerment

EMPOWERMENT AND HEALTH PROMOTION

Empowerment has its roots in the radical socialist thought of 30 years ago: 1970s feminism, self-help and collective consciousness-raising. Empowerment is a political concept as well as being based in individual and group work (Kendall, 1998). The World Health Organization (WHO, 1986) has long accepted that 'actively empowered communities' are necessary to generate health. Empowerment is a process, defined as:

> …a mechanism by which people, organizations and communities gain mastery over their affairs (Rappaport, 1987, p. 122).

Many practitioners express their dislike of the term 'empowerment', suggesting that it is a 'vogue' expression that has become so tired and overused that it no longer has meaning in health terms. Such doubts have been echoed in critiques that suggest that the term can be interpreted in so many ways that it is not clear what purpose it serves (Brown & Piper, 1995). However, whilst it has been likened to a 'holy grail' in health promotion (Rissell, 1994), empowerment is a concept that has become inextricably

linked with health promotion ideals and principles. Tones suggests that:

> Perhaps the single most important feature of health promotion is empowerment (Tones, 1991, p. 17).

Kalnins *et al.* (1992) demonstrate the proximity of empowerment to health promotion, setting out three principles of importance:

- health promotion must address problems that people themselves define as important;
- health promotion must involve public participation alongside experts;
- health promotion will be most effective when combined with healthy public policy.

Empowerment is not simply about transfer of power from one individual to another (Rodwell, 1996; Kendall, 1998; Kuokkanen, 2000). In a sense you cannot empower someone else; they can only do that for themselves. However, a health professional might show them the way. In understanding empowerment, one must understand who or what one has authority over. Built into this is the:

> Quality of the relationship between a person and his or her community, environment or something outside one's self (Rappaport, 1987, p. 130).

In a nursing context the word 'power' is associated with a hierarchical organizational structure and authoritative leadership, with 'one person restricting another's freedom of action' in a setting of coercion and domination (Kuokkanen, 2000, p. 236). She suggests that the key tools for generating power are 'creation of opportunities, effective information, and support' ideas that are equally relevant in community settings for the work of health visitors.

The central purpose of health visiting is to promote health; the goal is to focus on primary prevention. These aims have been achieved in the past through an integrative process where assessment of need is part of an ongoing pattern of care, with both need and care being intertwined (Cowley *et al.*, 2000). This approach has tended to leave much of the process implicit and therefore open to criticism because it could not be readily scrutinized by outside observers, managers or service commissioners.

As in any managed service, health visitors are required to articulate what they do in terms that ensure that the service they offer can be accounted for and financed. Dingwall & Robinson (1993) highlighted the difficulty of understanding what is accomplished in home visiting, which led to the legitimacy of the service being questioned. Reporting a study concluded in 1986, before the drive towards explicitly assessing need and at a time when primary prevention was not regarded as important by government, Dingwall and Robinson said of the home visit:

> The encounter is not used to conduct any clear and systematic health assessment or health education, although these goals may be pursued covertly or opportunistically (Dingwall & Robinson, 1993, p. 169).

Whilst being critical of the service for its lack of clarity and focus, they also highlighted the positive aspects associated with health visiting practice, which

> Is in effect, the systematic ethnographic study of community by an expert in public health (p. 171).

It is also worth noting that systematic reviews of health visitor home visiting carried out more recently have found this approach to be very effective at targeting a wide range of needs (Elkan *et al.*, 2000; Ciliska *et al.*, 2001). However, it has proved surprisingly difficult to promote that message, despite the force of a high-profile recommendation that health visitor home visiting should be strengthened to reduce inequalities in health (Acheson, 1998), which is a key government target (DoH, 1999b).

The implicit and hidden nature of needs assessments carried out in the home appear to be viewed with great suspicion by at least some managers and commissioners of health visiting, who wish to receive auditable accounts of the needs being identified by the services they fund. Dingwall & Robinson (1993) point out that the contract-driven language of the quasi-market in health care, introduced in 1990, excluded views of health need that could not be readily packaged or counted. This lay at the heart of the difficulty for many health visitors, who wished to provide a service based on the principles of health visiting (CETHV, 1977), within a philosophy of empowerment.

EMPOWERMENT APPROACH TO NEEDS ASSESSMENT

Arnstein's (1969) classic work depicts the idea of a 'ladder of citizen participation' that demonstrates the many stages between citizen empowerment and manipulation of the powerless. Arnstein (1969) talks about the blocks to achieving participation as being, on the powerholder side, 'racism, paternalism and resistance to power re-distribution'. On the have-not side, the issues are 'inadequacies of socio-economic infrastructure and knowledge base … alienation and distrust' (p. 21). Arnstein (1969) suggests that, on the partnership rung of the ladder, power is redistributed through negotiation between citizens and power holders; it is through give-and-take and sharing plans that decision-making occurs. Therefore, in the 'empowerment approach' the assessment process is seen as

an opportunity to promote and develop what Kieffer (1984) has dubbed 'participatory competence' on the part of the client, whose position is described in terms of citizenship and empowerment.

Highlighting the benefits gained from using an empowerment approach in the 'Family Matters Programme', for example, Cochran (1986) suggested that it was possible to show with some certainty the families who would benefit most from the programme. However, programme planners decided to avoid targeting only those families (mainly single parents) because it would lead to stigma by implying that not all citizens are equal. Importantly, they believed that 'targeting' moved the consumer's role from an 'active partner to a passive recipient' (p. 29) within the process. Cochran suggests that empowerment is 'an interactive process involving mutual respect' (1986, p. 15). Other key features of empowerment involve:

1. Exploring how clients can harness their own health creating potential and capacity, which involves giving control of the interaction to the client.
2. Exploring health in a participatory way that allows judgements to be made, but not in isolation of the client.
3. Approaches to enhancing health may extend beyond the particular individual or family, to encompass the situation in which the family lives.

Allowing professional judgement and flexibility within practice is an important issue. It is not about offering a closed choice of possible needs chosen by professionals and offered to the client to ratify. Highlighting the deficits inherent in checklist-type assessment scores, Elkan *et al.* (2001, p. 118) state that 'professional judgements of health visitors are crucial to any assessment of priority'. In an empowerment approach to needs assessment and service provision, the enabling role of the health visitor is one of facilitator and resource, where the client leads the interaction and thus the assessment process. There is a wealth of qualitative research about activities and purposes embedded within the health visiting process that help to explain how this can happen in practice (Table 1).

EMPOWERMENT IN HEALTH VISITING PRACTICE

Current government policy is seeking to involve the consumer (DoH, 1999a,c, 2001) and practitioners are seeking ways to make this happen. As a model of practice, empowerment involves being prepared to accept shifts in the direction of conversation to maintain open agreement between health visitor and client about the purpose of the contact (Cowley, 1991). This fits with Kuokkanen's (2000) view that empowerment should be an 'interactive process'. In practice, client-centredness requires the 'fringe work' that lies outside normal organizational agendas, like arranging appointments at times to suit the client rather than the clinic (de la Cuesta, 1993). These research examples echo the early ideas of Arnstein (1969), where negotiation, give-and-take and shared decision-making were regarded as important.

Luker & Chalmers (1990) detail the complex processes and amount of time needed to accomplish what they call 'entry work', whereby health visitors offer their service, presenting themselves in a way that enables them to understand fully and engage with the client's situation. Health visitors aim to identify which needs are high on the client's agenda by listening and responding to small cues

Table 1 Empowerment approach: the field of words

Relevant health visiting research	Health visiting practice	Intent for client
1. Enabling relationships (Pearson, 1991; Chalmers & Luker, 1991; de la Cuesta, 1994) 2. Gaining access/entry work (Luker & Chalmers, 1989) 3. Health promotion work (Chalmers, 1992) 4. Client-centredness; 'fringe work' (de la Cuesta, 1993) 5. Development: changing expectations (Pearson, 1991) 6. Shifting focus in conversation (Cowley, 1991) 7. Unpredicted needs/therapeutic prevention (Cowley, 1995b) 8. Actively promoting resources for health (Cowley, 1995a)	1. Health visitor as facilitator and resource 2. Assessment is integral to practice 3. Flexible view of what constitutes 'need' 4. Encourages client-centred approach to practice 5. Allows professional judgement 6. Fosters acceptance of the client view 7. Proactive search for health needs	1. Client in the lead 2. Promotes 'participatory competence' 3. Non-prescriptive: permitted needs not predetermined 4. Validation of client's perspective/ opinion 5. Inclusive of contextual and socio-cultural issues 6. Non-stigmatizing 7. Assessment as an opportunity to discuss health, not a condition for receiving service

within the interaction, shifting their attention to the direction indicated as acceptable to the client (Cowley, 1991). These approaches are important if health visitors are to follow Kalnin *et al.*'s (1992) suggestion that health promotion must address problems that are defined as important by clients themselves.

Prioritizing the client view highlights the idea of public participation alongside the expert, as suggested by Kalnin *et al.* (1992). In the empowerment approach the consumer is regarded as an active participant in the process; in health visiting the notion of enabling clients actively to develop their own resources for health is stressed (Cowley, 1995a; Cowley & Billings, 1999). Health visitors might regularly expect to meet unforeseen and unpredicted needs when undertaking supposedly 'routine' visits in the course of their work (Cowley, 1995b). The ability of the service to treat the problems of clients as if they are 'normal' rather than 'deviant' in promoting health (Chalmers, 1992) adds to these essential prerequisites in the 'health promotion work' of the health visitor. The term 'therapeutic prevention' describes the combination of support and education used by health visitors to counter the risks and suffering embedded in complex family situations (Cowley, 1995b).

Health visitor–client relationships are not an end in themselves, but they enable health promotion work to be initiated and accomplished (Chalmers & Luker, 1991; de la Cuesta, 1994). Rappaport (1987) suggested that empowerment had much to do with the 'quality of the relationship'. In similar vein, Pearson (1991) showed how development of the professional–client relationship is integrally bound in practice with development of the mother as a person, of the mother as a mother and development of the child (Pearson, 1991).

However, research has shown that health visitors may, despite expressing enthusiasm for participation, practise in a disempowering way (Latter, 1998) Wallerstein & Bernstein (1988) suggest that empowerment is about gaining power to effect change, a point that applies to both practitioners and clients. Working in an empowering way can be very challenging, particularly if set in the context of a hierarchical, paternalistic organization that resists power re-distribution between the different levels of responsibility.

An open assessment tool, used as an adjunct to practice to trigger discussions, can become the catalyst in empowering health visiting practice. One such system is the 'Family Wise' programme (Glover, 2001), which encourages self-identification of needs through the use of cartoons without text. These may be particularly suitable for clients where literacy is a problem or if English is not the first language. Another alternative, suitable for use where cartoons are either not needed or not considered suitable for a particular population, became known as the 'Field of Words (FOW)' in the NHS trust where it was developed. In common with Family Wise cartoons, the aim was to 'trigger' and 'open up' dialogue with clients to enable them to recognize and discuss self-identified needs; this allowed and encouraged an empowerment approach to needs assessment.

Empowerment approach to needs assessment

DEVELOPING THE FIELD OF WORDS ASSESSMENT

The FOW assessment tool (Houston, 1997) was developed with the aim of focusing on an empowerment approach to assessing needs. It is offered here as a work in progress and one way forward in this difficult area of needs assessment in health visiting practice. The development process involved practitioners in a long journey of 'trial and error'. Systems that involved ticking boxes or lists of risk factors were tried and discarded for a number of reasons. Great difficulty was experienced in finding an exemplar, or ideal model, of needs assessment that would fit within the open framework of health visiting practice.

Rappaport (1987), based on the work of Kuhn (1970, 1977), described an exemplar as a defined 'professional community's shared examples of problem solution'. This world-view is then shared by others of like mind, who become a part of this 'disciplinary matrix' of professional knowledge. These matrices then form part of the conceptual world-view held by the professional and learned by the study of exemplars which adds to the body of practical knowledge in the profession. Adding layer of knowledge on layer, the professional, having solved earlier similar problems within their sphere of expertise, is able to apply similar thinking to new problems. This subsequently adds to the knowledge base within the professional community. This 'study of exemplars' led the health visitors, in their development process in the practice setting, towards an understanding of what did not work, in terms of health visiting needs assessment. However, great difficulty was experienced in discovering an assessment process that would fit with the premise of an open, empowered system where relationship-building was part of the process. Various checklist-style assessment forms were tried and with each one there grew a disciplinary matrix towards the formulation of a practical knowledge base suggesting that formal checklist systems were inflexible, uncomfortable to use, created anxiety, caused stigma, caused affront in their bluntness and closed down the normal process of rela-

tionship-building that was so important to the empowered approach.

EXEMPLARS IN HEALTH VISITING PRACTICE

In this case the exemplar for needs assessment was found to be:

- Priority should be given to the client/health visitor relationship when assessing need.

This exemplar was built on a disciplinary matrix of findings of what did *not* work in practice (Fig. 1).

As Barker (1996) suggests, the checklist type of needs assessment seemed to undermine health visitors' professional judgement. As well as creating difficulties in sharing a complicated document with a client, use of this type of assessment implied that a style of closed questioning was preferred when in health visiting the opposite was the case. Avoiding any sense of stigma for families and focusing on the 'normal' rather than on 'deviance' was an important aim. Health visiting should not be regarded as a sort of 'social police', as discussed by Dingwall & Robinson (1993). However, there is a difficulty if the service adheres to a kind of 'archaeological model of health visiting' that requires digging around in the client's past, unbidden, during one-to-one interaction, in the name of a health visiting assessment. This approach may fail to focus on clients' current and future perspectives, which have been shown to have more power to move people on through life's difficulties (O'Hanlon & Weiner Davies, 1988; de Shazer, 1988, 1994; George *et al*., 1990; O'Hanlon & Beadle, 1996; Ratner, 1998).

The foundations of the eventual way forward, of assessing need using this empowerment approach, owes something to the type of current/future focus strategy of 'brief solution focused therapy' (O'Hanlon & Weiner Davies, 1988; de Shazer, 1988, 1994; George *et al*., 1990; O'Hanlon & Beadle, 1996; Ratner, 1998). Focusing on the present and future perspective in this way allows a return to the past, but *only* if the client leads because they control the agenda.

Concerns to validate the client's view, by including them in the process of assessment in a non-stigmatizing way as well as addressing outcome measures were important. The FOW acted as a 'trigger' tool opening up discussion, allowing the client to set the agenda by defining and discussing their perceived needs (see Table 1).

The first priority was to develop a system that would allow an empowerment approach to be maintained in practice. The assessment tool literally used a 'Field of Words' or adjective list. The concept has been used elsewhere, for example, as a method of evaluating a teaching session; participants are asked to circle the words that most relate to their feelings about the session, such as 'enjoyable', 'funny', 'boring', 'too long', or 'too short.' Also, it was one element of a successful study (Gordon & Grant, 1997) addressing the mental health of adolescents in Glasgow.

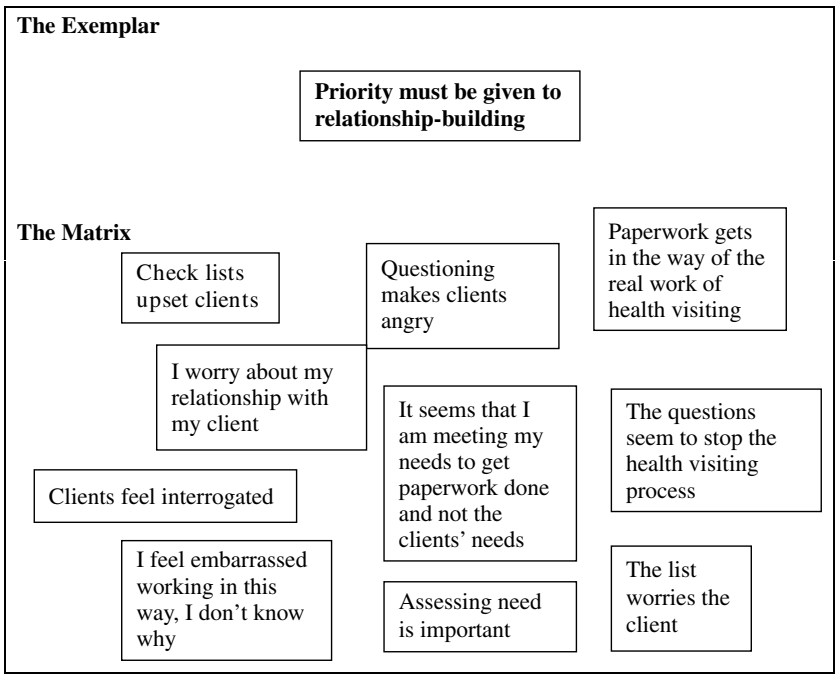

Figure 1 Discovery matrix of problem aspects using 'tick box' tools.

THE HOUSTON 'FIELD OF WORDS' ASSESSMENT TOOL

This trigger tool was developed expressly in response to and in rejection of a 'tick box' assessment process, already in place, that health visitors found difficult to use. This was therefore a service development and was not set within a research frame (see Fig. 2). The search was for a flexible way of assessing need that could meet management demands but did not operate as a barrier in the development of the client–health visitor relationship.

The FOW document began with a statement of intent on the front page to explain what the assessment aimed to do and how it would be used:

> The field of words assessment has been developed by health visitors to help you look at your own health. It will also help the health visitor to get to know more about you and your family so that the health visiting service can assist with any health care needs that you may have.
>
> 'What is health? What are the things that matter to you?'

The main body of the document contained a series of adjective lists, each including positive, negative, neutral and discursive descriptors related to each aspect of the assessment (e.g. like, hate, good, difficulties, enjoy, loved, sad, etc.) (see Fig. 1 for an extract of only four of the aspects).

Ten key areas were identified for the development area (semirural Sussex): (1) home, (2) family life, (3) work life, (4) relationships, (5) my childhood, (6) my health, (7) my family's health, (8) community and environment, (9) emotional health and lifestyle, (10) expectations (of health visiting service).

In other districts, different areas of interest might be central; for example, a specific section for the needs of asylum seekers. The aim was for the process of assessing need to be carried out within a partnership approach between the professional and client, *specifically* reflecting the needs of the area.

THE FIELD OF WORDS IN USE

Control of the interaction would be given to the client by handing them the FOW document to complete in their own way. The timing of the assessment was flexible; health visitors delayed its use when more pressing issues were clearly evident. The client would be asked to circle any words that they felt were relevant to their current life or needs as they interpreted them. They could fill in as little or as much as they wished, adding extra comments to each section. Clients were allowed and even encouraged to focus on one area to the exclusion of other aspects within the tool, if that reflected their preference and awareness of their own needs. They were advised that the process would lead to a plan for future health visiting being drawn up jointly, pooling the professional ability of the health visitor and the client's knowledge of their own situation, to help resolve problems highlighted by the tool.

Professional skills and judgement are a strong element in the use of this tool. One client said:

FAMILY ASSESSMENT

Home own rented like hate concerns about safety temporary
low standard of living high standard of living
.....
.....

Family life good and enjoyable not enough time for myself emotional support
help from family members new family member/step parent difficulties
violence/bullying help from social services problem with my children
.....
.....

Work life unemployed social support job loss/insecurity difficulties
work affects family life do not like my job enjoy work on benefit
stressful
.....
.....

Relationships good with spouse/partner need someone to talk to difficulties
no close friends bad relationships with other family members
problems with spouse/partner close friends
good relationships with other family members
.....
.....

(Houston 1997) p 2.

Figure 2 Extracts from Field of Words assessment.

> I can't possibly fill this in because I would have to write on it that both myself and my husband are on antidepressants.

The health visitor reassured her that she did not need to fill it in but asked if she would like to talk about the antidepressant treatment. The client was relieved to talk about her many problems. A positive action plan resulted with onward referral to the general practitioner, family centre, opportunity nursery group, speech and language therapist and the child psychologist. Although the FOW document was never completed, it had fulfilled its function of opening up meaningful dialogue with a new client in a participatory way that addressed problems defined by the client within a relationship building experience of negotiation and support.

Following discussion, the client and professional agreed the care plan and review date, both signing to this effect on the back page of the assessment document, the rest of the document, in this instance, was never completed.

Compliance was not a requirement in this approach. It was considered entirely valid for a client to highlight a problem but choose not to receive help at that time. A married woman who had discovered that her husband was homosexual, for example, said:

> I know I have relationship problems but I'm not ready to deal with it yet.

HEALTH VISITORS' EXPERIENCE OF USING THE FIELD OF WORDS

Enabling individuals to help themselves can be a slow process that involves accepting their viewpoint and allowing the client to have total control of the assessment process. This means that in practice the client holds the document, reads it and chooses what to write in it. This has an impact on the decision-making process for the practitioner, which may be quite threatening to some professionals. However, positive comments from health visitors who used the assessment were some measure of its usefulness in practice. This style of assessing needs is still regarded as a work in progress with further consumer evaluation planned.

The FOW was used by health visitors as an adjunct to their professional skills to assess need, and not as a replacement of their ability to do the job. The value of this tool was mainly as a '*trigger*' for discussion. For the practitioner, it acts as a method of active reflection of the clients' views and needs. It was not valid as a diagnostic instrument or a screening tool; and was not designed as such. It was expressly developed to allow the client to have control over the interaction, to create focus in the interaction and to act as a trigger to the client's own thoughts to help them set the agenda and have control over the interaction.

This style of assessment may present difficulties for health commissioners and managers who believe that requiring health visitors to operate to a predetermined schedule or protocol of visits is a way of achieving a quality service. The idea of entering into an interaction with a completely open agenda is unusual in healthcare circles; it may even be unique to health visiting. As Dingwall & Robinson (1993) indicate, working in this way may appear unfocused and lacking in purpose, particularly to those who fail to understand the process. This means that health visitors need to take responsibility to explain to managers and commissioners how this style of practice can be rendered manageable and accountable in organizational terms.

PRIORITIES OF CARE

Health visitors involved in developing the FOW devised a method of recording priorities of care (Merrington, 1997) to account for the work that was undertaken through the care planning process using the FOW. This reflected Williams' (1997) finding that health visitors tend to target their work within a framework of a basic minimum service for all and assessment of individuals or families, rather than through community profiles.

In this prioritizing system, families with the highest level of need were designated 'Priority Care 1' (PC1). These included families with whom the health visitor was actively involved on a fairly regular basis, or about whom there was a high level of concern. This group included families that would be expected to move in and out of the category fairly rapidly. When a new baby is born, for example, this generates a need for regular contact with health visiting services for a few weeks; or someone with a high risk of postnatal depression identified through screening (Holden *et al.*, 1989) may also need short-term, intensive support.

The second group, 'Priority Care 2' (PC2), included a large number of clients with particular or specific needs, perhaps following bereavement, diagnosis of a disability or expressions of anxiety. Contact with this group may also be regular, but less frequent than for the PC1 group; alternatively, a client or family may fall into this group, although their needs are complex, but because of their greater independence in coming to groups or clinics they are supported in a different way by the service. In both priority groups, a specific programme of care would be planned and agreed with clients, following completion of

the FOW assessment. Once there was agreement with the family that they had no active need for the health visiting service they would become part of the third group, core programme. This consisted of a minimal programme of child health promotion (Hall, 1996).

All client contacts were recorded on a computer system for workload management purposes in the NHS trust. The Priority of Care system implemented, with the three levels (PC1, PC2 and core programme), replaced the former multitude of descriptors. Using only three classifications allowed health visitors to report changes in client status rapidly and thus a measurable outcome of care following intervention could be seen as clients moved through the system from PC1 to PC2 and ultimately to the core programme. This yielded some measure of work done and positive outcomes achieved.

Conclusion

Normandale (2001) suggests the importance of attending to three key aspects of empowerment and partnership working; to help the client 'feel valued' to be able to 'take part in the decision-making process' and finally allow the client to 'make choices' by right within the process. This is very much a part of the Houston Field of Words type of open assessment. Experience of using the FOW tool showed that offering control and power to the client does nothing to diminish the role of the health visitor in assessing need. Instead, it gives an opportunity for the service to flourish by offering clients what they really need and not a professional ideal of what we think they need.

Anecdotally, the approach of designating priorities according to three different levels (PC1, PC2, core programme) is popular in a number of NHS Trusts, although systems are little reported and no empirical work is known that has evaluated it. It appears 'user friendly' for both practitioners and clients as it avoids the stigmatizing language associated with designating families 'at risk' and so can be explained in a way that enables clients to join in the prioritizing process. Clients often expressed delight that they had moved to the 'core programme', nick-named (after the storage of records) 'in the bottom drawer'. They saw this as a positive step, a marker towards independence and development, and felt empowered to deal with the life issue in question. This avoids the potential, shown by Bowns *et al*. (2000), for 'low-priority' clients to feel dissatisfied with minimal health care provision. Actively involving clients in planning their level of care allows discussion of misconceptions, as well as a reminder of how to contact the health visiting service for future needs.

This service development has shown that systems are needed to demonstrate organizational efficiency and clinical effectiveness without undermining the empowerment aspects of health promotion in health visiting practice. Focusing on only the assessment belies the importance that should be placed on the future plan that is created out of the listening and discussing that is so much a part of health visiting practice and that takes place in conjunction with the client. Any tool or trigger that is used to examine client need must be open and flexible and not get in the way of the seemingly invisible but clearly powerful processes described in health visiting research.

The challenge for the health visiting service is to find ways of addressing the conflicting pressures that others place on it that can lead to dilution of the service and a loss of focus on what health visiting is about or is capable of achieving. Health visitors need systems that allow them to listen to clients, giving time and space to build therapeutic relationships allowing use of their professional judgement to address appropriate action at the appropriate time. However, showing that they are able to achieve some positive change through their work is crucial if health visiting is to adapt to the requirements of the modernized NHS.

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