PERGAMON

International Journal of Nursing Studies 40 (2003) 85–94

INTERNATIONAL JOURNAL OF
NURSING
STUDIES

www.elsevier.com/locate/ijnurstu

Health needs assessment in the health visiting service and the impact on the ethnic community

Anna M. Houston[a,*], Sarah Cowley[b]

[a] R&D The Link Centre, St. Georges Hospital, Hornchurch RM12 6RS, UK
[b] King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, UK

Received 17 December 2001; received in revised form 25 May 2002; accepted 17 June 2002

Abstract

The purpose of this article is to share the experience of using a health needs assessment tool in health visiting practice in Great Britain, with clients who do not speak English. This is an important issue in developing equity of practice across the growing multi-cultural and diverse populations of the United Kingdom. The paper outlines the findings relevant to these issues drawn from a wider study that used qualitative methods to observe and interview both health visitors and clients regarding the use of the tool. It focuses on one vignette to demonstrate the practical and difficult issues when a formal system is used to assess needs in clients who do not speak English as a first language.

---

1. Background

In the year 2001, the United Kingdom has a population of 59 million. In Spring 2000, about one person in 15 in Great Britain was from an ethnic minority group who form, approximately 6.4% of the total population (Office for National Statistics).

Black and ethnic minority groups of people have lived in Britain for more than a century (Bahl, 1993). The contemporary character of the population was developed in the 19th and 20th century as a result of government policy to fill labour shortages with immigration from commonwealth countries; currently less than half of all minority ethnic populations are born in Britain (Smaje, 1995). The ethnic minority population accounts for 25% of Londoners (Alexander, 1999).

Ethnicity is a concept unravelled by Dobson (1991) who quotes Gordon (1964) describing ethnicity as a 'sense of peoplehood' (p. xix), where language, religion and past origins go to make up an individual's identity. She continues by citing Spradley and McCurdy (1977) who define ethnocentrism as a state where one's own culture is regarded as the best or the most appropriate.

It has been demonstrated that the existing health care system does not meet the needs of ethnic populations in this country (DH, 1992, 1997; Atkin and Rollins, 1993; Nazroo, 1997; Baxter, 1997; Acheson, 1998).

> some black, Asian and ethnic minority people experience high levels of disadvantage and deprivation 3.3.1 (Alexander, 1999)

However, Nazroo (1997) adds the cautionary note that much of the variation in health uncovered in the ethnic minority population is related to socio-economic position.

There is a suggestion that this picture has been compounded by the 'poor relation' status of community services (Tomlinson, 1992, p. 14). It remains to be seen whether the new systems of Primary Care Groups and Primary Care NHS Trusts in the UK can exert more power in this regard.

Communicating with clients on an equal footing (Scammell, 1990) and offering non-discriminatory care are just a few of the concerns involved in a good quality NHS service that is, as suggested, modern and dependable (DH, 1997). Care needs to be taken by practitioners

---

*Corresponding author. Tel.: +44-1708-464981.
E-mail addresses: annamhouston@hotmail.com (A.M. Houston), sarah.cowley@kcl.ac.uk (S. Cowley).

0020-7489/02/$ - see front matter © 2002 Elsevier Science Ltd. All rights reserved.
PII: S0020-7489(02)00040-8

to avoid an ethnocentric approach in clinical practice, and effort should be put into promoting primary and preventive services (Smaje, 1995).

In Britain the ethnic minority groups are, disproportionately, a young population (Kurtz, 1998). A large number of the population who were born outside the United Kingdom (particularly the Asian communities) are not fluent in the English language (Donaldson, 1986; Ahmad et al., 1989). In Donaldson's (1986) study many more men were able to communicate than women, a position supported by Alexander (1999) (see Table 1). Illiteracy was high for both men and women in both languages, particularly elderly Asian women.

Ahmad et al. (1989), showed that in order to overcome the lack of fluency, patients attended a GP with linguistic and cultural understanding. Women were again shown at greater disadvantage in fluency, in this study.

However, a survey of 55 Family Health Service Authorities (FHSA) in England (Pharoah, 1995) reported that 76% of GPs were consulted on a regular basis by elderly patients who did not speak any English.

These pronounced difficulties, experienced by minority cultures, were also highlighted in a survey of 3500 adults of black and ethnic minority groups. Sixteen percent of Asian women stated they did not find it easy to communicate with their General Practitioner (GP) (Rudat, 1994). Consequently, this language barrier presents an obstacle for practitioners (Burrows, 1983; Murphy and Macleod Clark, 1993; Johnson, 1999) with people from Bangladesh and Pakistan being at the greatest disadvantage (Modood et al., 1997).

It has also been found that practitioner attitude plays a part in whether the interaction is positive or negative (Bonaparte, 1979). In a recent study Boi (2000) highlighted communication as a difficulty compounded by the problem of accessing interpreters. Interpreting and translating as terms are often used interchangeably in texts however for the purposes of clarity interpreting will be defined here as transfer of the spoken word from one language to another. Translation will be defined as transfer of the written word from one language into another (Sanders, 2000).

Table 1
Communication issues in the ethnic community

Country of origin	Use of interpreter at GP visit (%)	Use of English as the main spoken language (Men) (%)	Use of English as main spoken language (Women) (%)
India	3	32	18
Pakistan	1	24	3
Bangladesh	7	10	1

Adapted from Alexander (1999).

Boi (2000) also found a number of other influential factors that reinforce a barrier to care. These included the inadequacy of understanding, by nurses, of the different cultures in their care, a position supported by other work (Leininger, 1988; Murphy and Macleod Clark, 1993; Dobson, 1991). Practitioners were aware of this inadequacy, and used relatives as interpreters and also as a source of cultural information (Boi, 2000).

Gerrish's work (2000, 2001) addressed these same issues within a community setting. She found that lack of communication and understanding impacted negatively on quality of care with clients who were unable to follow treatment plans appropriately because of inadequate language interpretation (Gerrish, 2001). Interpreting services were found to be inadequate, serving to disadvantage minority ethnic groups. Not speaking English should not be a barrier to appropriate, effective, equitable, care (Gerrish, 2000).

Successive governments have attempted to address the shortfall in quality and equality of care for the ethnic minority populations. Discussing the Patient's Charter (DH, 1991) Johnson (1999) commented on the unique, at that time, experience of seeing provision of the charter, for the public, in nine minority languages offering a standard that was about privacy, dignity and respect for religious and cultural beliefs in health care. This approach has subsequently been continued (DH, 1997a).

The current government has given priority to patient involvement in care as 'active partners' with professionals (Alexander, 1999). They go further, suggesting that

> working practices and cultures must reform to give more power and influence to patients and frontline staff (DH, 2001, p. 7).

In contrast May (1995) cites a body of work demonstrating client resistance to collaboration (Waterworth and Luker, 1990; Hunt and Meerabeau, 1993). It has been suggested too, that the most articulate in the community will drive the process allowing inequality in provision to increase rather than decrease (Jordan et al., 1998). However, much has been made of the ideal of consumer involvement and public participation in health care development (Jordan et al., 1998; McIvor, 1999; McIvor and Brocklehurst, 1999; Hallet and Thompson, 2001).

The study reported in this paper was carried out in North London, in an area where 55% of the community is non-white in ethnic origin. It addressed the use of a health needs assessment tool (HNAT) in health visiting practice and highlighted that much remains to be done in respect of equality and collaboration in health care.

Appropriately assessing need is a communication challenge even when all involved speak the same language. The challenge is even more complex when the client is unable to speak English. Murphy and Macleod Clark (1993) suggested that practitioners were not sufficiently aware of the importance of understanding cultural difference; they also found that in many instances communication was so poor that client needs could not be identified.

2. Approaches to needs assessment

Since the advent of the internal market in the NHS in the early 1990s, health visitors have come under increasing pressure to explain their practice in terms that correlate with the language of service level agreements and financial units. This has given rise to an increased emphasis on the notion of assessing health needs when health visitors first meet families. Increasingly sophisticated and complex descriptors of the interventions are assumed to follow from those assessments. There is little robust empirical work through which to describe or compare the relative advantages of the various forms of assessment in use. Most NHS Trusts have developed some format or guidance through which health visitors are supposed to reach an assessment, but there is no single accepted approach in common use (Appleton, 1997).

Around a third of the Trusts that responded to Appleton's national survey reported that contracts were currently based on specific practice guidelines, and another third expected this to happen in the near future.

Three different priorities are discernible that may influence the implementation of approaches to needs assessment. First, a number of commissioners expect information about the nature and type of families who are selected to receive 'additional' health visiting in an 'episode of care' approach.

The second approach attempts to associate systems used for assessing need at a locality level or ward level, such as deprivation scores, into a mechanism for weighting caseloads and deciding staffing levels. In order to link these weightings directly with the families receiving health visiting services, a public health approach is adopted and practitioners are asked to gather information from individuals by assessing whether particular 'risk factors' are present in order to distribute resources to the most needy or deprived areas and most vulnerable groups.

Both these approaches are regarded, in their different ways, as a means of 'targeting' the health promoting efforts of health visitors where need is considered to be the greatest. This contravenes research that shows assessment to be a continuing process, intertwined with the delivery of health visiting (Cowley et al., 2000).

The third potential approach to needs assessment, anecdotally, is the most commonly used and the least well articulated. Families are engaged through the assessment process, in a health promoting approach; participation and partnership are emphasised. In this approach, assessment is not considered to be separate from the process of the delivery of health promotion or preventive care, but is integral to it.

The assessment process is regarded 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. Despite the wealth of health visiting and health promotion research that might support the potential of this approach, there is no evidence to show whether it happens in reality or if it remains at a level of well intentioned rhetoric.

This paper draws heavily on a single case identified in a wider study that investigated the implementation of an assessment tool that, the health visitors and their managers hoped, would both enable participation and provide structured information for the commissioners of their service. The case demonstrates the difficulties inherent in using an assessment tool that takes no account of the cultural difference between different populations subjected to formal methods to ascertain 'need'. Inequality in health care may be addressed through measurement of access, quality of care and equal treatment (WHO, 1985). The question of whether any of these markers are positively impacted by the use of formal needs assessment tools remains to be seen.

3. The study

The one-year study was completed in 2001. It aimed to explore the extent to which the health visitor assessment process implemented within a North London NHS Trust helped to promote the health of families involved. A HNAT had been developed by staff in the Trust. This was for use with families moving into the area or when a new baby was born. It consisted of a list of structured questions designed to elicit information about the family's medical history and social situation (e.g. Do you or anyone in your family have a serious illness or hereditary condition? Do you or your partner have a dependency for drugs or alcohol?); as well as enquiring about the relationship between the parents and child (Is this a good time for you to have a baby? How loving do you feel towards your baby?).

Families who did not wish to answer the questions were asked to sign the form indicating their refusal. Health visitors were expected to use the tool when they assessed families in all other situations, although several expressed concern about its suitability, particularly for minority ethnic groups. The NHS Trust served a multiethnic population of 500,000 and had a clear policy of providing interpreting services where clients did not speak English. These services were made available to the research team to help elicit views from a range of clients.

The research plan involved the following.

3.1. Informal interviews with management and staff

These were snowballed or self-selecting interviews offered by staff to assist the researcher to gain background knowledge about the Trust and the process involved in development of the HNAT.

3.2. Formal telephone interviews

These were completed with 30 health visitors following face-to-face group meetings used to 'market' the study and discuss the aims and objectives of the research with staff members.

3.3. Case studies

Five health visitors took part in the second stage and were asked to provide the researcher with at least two families who would be willing to have their interaction with the health visitor observed and have a separate follow-up interview. This paper focuses on only one of the 21 clients involved in the study and issues relevant to the use of the HNAT with the minority groups served by the Trust. Full details of the wider study are provided elsewhere, but sufficient background information is included here to demonstrate the context within which the HNAT was used.

4. Factors in the development of the second stage sample

Important factors influencing the choice of health visitor for the second stage were:

- Willingness of the health visitor to be involved in recruiting families for the study.
- Willingness of the health visitor to be involved in observation of the use of the HNAT.
- Willingness of the health visitor to become involved in sample development.
- Ethnicity of the health visitor; those selected were three white, one black and one Asian health visitor (two Asian health visitors withdrew from the second stage).
- Ethnicity of the client group; the study aimed to reflect a range of ethnic groups served by the NHS Trust to enable all consumer viewpoints to be included (families taking part were; 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).
- Health visitor attitude to the HNAT. Of the case study health visitors, two health visitors disliked the HNAT, two liked the HNAT, and one liked the idea of needs assessment but had some difficulty with the model in use.
- Health visitor reflection of their own caseload and area. Each health visitor was asked to select clients that were common to his/her caseload and his/her area. This enabled a wide viewpoint to be contained (within the case study data) that was inclusive of comment across the full range of clients. This included those who spoke to the researcher through the use of an interpreter.

5. Findings

The findings reported in this paper focus on the complexity of taking into account the needs of one consumer group, those who do not speak English, when using a structured assessment tool. The health visitors views of using the HNAT with this group are provided and discussed in general terms. Questionnaires and interviews are capable of telling what people say they do and why they say they do it, but the use of a vignette or case study reveals what actually occurred (Abbott and Sapsford, 1997). Accordingly, one case is described in detail to illustrate more clearly the extent of the difficulties and sensitivities involved.

Data from the telephone interviews demonstrated that consistently all the interviewed health visitors were concerned about the needs of the non-English speaking clients within their caseload in terms of the HNAT. They expressed concern that the questions asked of clients, even through an interpreter, were insensitive or failed to transfer across the cultural divide. Discussing the questions in the HNAT, health visitors said

> Anything that occurred to you, or anything traumatic to you as a child that may affect your parenting, that is an awkward one [question] because it is a mouthful especially if they don't speak English as a first language, it is very, very difficult to get that question across (HV 8)
>
> Generally it was felt that some of the questions were not appropriate and also that it was very difficult to do on non-English speaking clients, of which there are many in the area (HV11)
>
> I am lucky because most of my case load is English speaking so you can really explain [HNAT] and I think there is a slight discomfort that when you go in as a professional and English is not the first language, because I do find it [HNAT] quite intrusive, but I can't really … the nuances, the subtleties of the tool—I feel it is how it is perceived by them and I think possibly, my colleagues who do not have the

> same degree of enthusiasm, [for the HNAT] because a greater proportion of their case load is Bengali or Arabic speaking, so it would probably seem as a question and answer tool, rather than a real working tool that you can really explain. (HV 22)

Questions raised by the health visitors during the fieldwork and interviews included:

- Were the health visitors guilty of collaborating in the development of a two-tier system of care that addressed only the needs of those who were able to vocalise concerns in a format that could be counted by management?
- Were the very vulnerable with the greatest needs being ignored in the development of a system that operated on the basis of categorising high need in a particular way?
- By not persisting in the use of the form with the ethnic community were the health visitors discounting a culture with particular needs and perpetuating an inequitable service?

The HNAT proved so complicated that many health visitors gave up using it with non-English speaking clients because of the difficulties associated with interpreting the complex issues in it. Others, including the health visitor in the following vignette, did persevere with the HNAT, as required by their employing authority.

6. The case study

This case study account of contact with an Asian, Urdu-speaking family was selected to shed light on some of the paradoxes in using a structured instrument designed for the English-speaking population, when caring for clients from another culture.

6.1. First visit

Health visitor and researcher: Mrs. X was a young mother of three small children under six of years of age. She was a pleasant smiling lady who welcomed us into her home. She shared the large residence with her husband's family. We were invited into a well-furnished formal living room decorated with many scriptures from the Koran. At this spontaneous visit (the family had changed GP and so were transferred to the health visitor as a new client), a young relative who lived in the house was happy to interpret for the health visitor the reason for the visit. The health visitor asked to arrange another visit to return with an independent interpreter and speak to Mrs. X about her own health and that of her children and to explain about the health services offered locally. Smiles and ready agreement were given and permission for the researcher to return at the next meeting.

6.2. Second visit

Health visitor, researcher and interpreter: With the help of the interpreting service a long explanation was given regarding the role of the researcher and the aims, anonymity and confidentiality of the research process. Mrs. X and her mother-in-law smiled and agreed to participate in the research.

The health visitor carried out an assessment of need using the HNAT with the assistance of the interpreter. Family health history was discussed, and the health of the children. Some immunisations had been missed due to the change of GP (the family had changed service use because of distance to travel to the previous GP and child health services). Follow up arrangements were agreed to address this need and Mrs. X was asked (in accordance with the assessment protocol) to define the category of service provision she felt she needed: high medium or low. She smiled, thanked the health visitor and said she had her family around her, she said she had no concerns and would contact the service if she needed help. It was jointly decided by the health visitor and the client the category was 'low need', however the health visitor stressed the open door policy and willingness to see Mrs. X in the future. A follow-up visit was arranged for the researcher to return alone with the interpreter, in order to elicit the thoughts and opinions of the client on the HNAT process.

Following the visit the health visitor commented on a non-verbal cue that she had noticed, the distance between Mrs. X and her mother-in-law when they were seated on the couch.

6.3. Third visit

Researcher and interpreter: A smiling welcome greeted us. The formal seating arrangement was again used with the researcher and the interpreter invited to sit at one end of the sitting room while Mrs. X sat on the couch near to the door at the other end of the room. Mrs. X was alone with her children who ran in and out of the room happily during the interview. She said, via the interpreter, she had not minded answering the questions posed by the health visitor previously, although she found some of them strange. Both the client and her mother-in-law had initially responded to the question on domestic violence (in the HNAT) with laughter. She had laughed, she said "because it had seemed a very strange thing to ask". The interview seemed somewhat disappointing from a research viewpoint. The research inquiries were kept very short because of the interpreting needs, but even so the responses, while cheerfully offered, were mainly monosyllabic. Whilst packing up the tape-recording kit the researcher began to talk about the aims of the health visiting service, using only very short bites of information for interpreting purposes and much body language. Mrs. X seemed to warm to the topic and finally became engaged within the conversational triangle. She began to initiate questions that she wanted translated. She became interested and attentive to the words and body language of the researcher. She nodded after each piece of information about the health of children. The researcher then said that the health visiting service also believed that the health of the mother was important. 'What is in the heart and mind of the mother is also important for health'. Mrs. X suddenly stood up and closed the sitting room door. The interpreter looked very worried. "Mrs. X wants to tell us of her life", said the interpreter, "she wants to open up".

Mrs. X moved to sit very close to the researcher and the interpreter in a tight huddle. She was suddenly filled with emotion and very close to tears as a flood of words came forth. She said, through the interpreter, that she was a prisoner in this home of her mother-in-law, she was not allowed contact with her family in Pakistan or in London. Her face was contorted with suppressed grief, "I am not allowed to meet other women or learn English" she said. "My role is to cook and clean for this large household. My wish is to leave this house with my children and have peace in my life. I am fearful of my mother-in-law". Both the interpreter and the researcher were deeply shocked at the transformation that had occurred. The smiling lady who had greeted us was replaced by a deeply troubled soul. We sat together in long silences experiencing her grief and holding hands as she found the courage to tell her story. We talked of the strength that can be gained from sharing and talking and listening. We spent 45 minutes huddled together, often overwhelmed emotionally with the impossibility of her situation and the enormity of her poignant struggle in having kept to herself, for a number of years, her unhappiness, anxiety, frustration and fear. We had moved from a formal physical distance toward intense physical, contact. Mrs. X leaned physically towards the closeness and she said "I now understand about health visiting". She said that she had never been offered the services of an interpreter before.

Prior to leaving the house Mrs. X agreed that the researcher could tell her health visitor about her situation. She said "Please make sure that anything of this nature is never spoken about in this house, it would be very bad for me". A plan was devised that would allow Mrs. X contact with her health visitor on her own to help her to continue to deal with the very painful issues of her life.

The visit ended, after much hand shaking and hugging.

7. Discussion

This case study exemplified issues of race and culture, access and equity that were found in the course of this qualitative study. In many respects, it reflected the kind of debates that are familiar to researchers who discuss the suitability of structured (usually quantitative) and unstructured (qualitative) approaches to eliciting information from research participants. The former are most suitable for finding information within defined parameters, whilst the more open approaches used in the latter are better when unknown or undefined issues are being explored.

This vignette also demonstrated a number of unexpected outcomes. From the research point of view it throws into stark relief the difficulty of field work where roles and boundaries become blurred, ethical issues become complex and caring for individuals caught in the process can often unexpectedly become the main priority. The client was immediately referred back to her health visitor for ongoing support, allowing the researcher to concentrate wholly on the role of ethnographer (Field, 1991).

Many issues arose through this interaction only two will be addressed here:

- The complexity of 'set induction and closure' when using the interpreter service.
- The skills needed by the health visitor or other community practitioner when using an interpreter.

8. The complexity of 'set induction and closure' when using the interpreting service

Beginnings and endings that contain formal structures for interaction are how we impact on each other in our interactive lives (Hargie et al., 1994). It has been estimated that 65–70% of the social meaning of communication is transmitted non-verbally (Birdwhistell, 1970). Set induction is the phrase used to define the sequence of events laid down to establish a communication link between the expectations and realities of a situation. It can involve rapport, motivation, expectations and outcomes and the nature and purpose of the proposed interactive sequence (Hargie et al., 1994). In the vignette a clear contract had been drawn up of what was expected of each encounter and this included prior instructions. The final encounter had been influenced by the previous interactions, disagreement or confusion would have impacted on the outcome of the interaction (Hargie et al., 1994). Involvement of the client in the interaction was crucial as was allowing her to have power within the process to actively lead rather than passively receive each request for information.

8.1. Relationship with the interpreter

Prior to the commencement of the case described, the researcher spent time with the interpreter. This first 'cognitive set induction and closure' (Hargie et al., 1994) between the researcher and the interpreter, involved clarifying the aims of the research interaction, how the information would be delivered and what the expectations were of the interpreter, on the researchers behalf. The interpreter accessed the source language (Urdu) interpreted into the target language (English) returning with verbatim (word for word interpreting used for extreme precision) interpretation for the researcher (Sanders, 2000).

8.2. Interpreting and the communication process

Whyte's (1982) 'directiveness scale' for analysing interviewing technique is adapted and applied here to clarify the complexity of the communication process when using a third party, an interpreter:

- You cannot make 'back channel' noises that coincide appropriately with the spoken word. Back channel signals such as head nods, have a powerful effect on speakers and will increase the rate of speech (Argyle, 1988).
- You cannot immediately reflect on the remarks made by the client and probing the last remark by the client is delayed. Reflecting back what is said has to do with 'accurate empathic understanding' and converts implicit meaning into a communicable form without misrepresentation (Dickson, 1997, p. 166).
- Probing a previous idea is complex, as is introducing a new topic, because of the time delay in the communication triangle.

8.3. Closure

Closure has been defined as drawing attention to the end of an interaction by summarising what has been discussed, addressing future plans and breaking the contact without participants feeling rejected (Hargie et al., 1994). The closure in the case study had incorporated a greater amount of physical contact than would have been expected from such a small amount of previous contact. However, the depth of the interaction and the emotion shared, had moved the relationship to a deeper level.

The end of the interaction with the additional use of non-verbal physical contact demonstrated the feminine solidarity and support that had been a strong element of the contact.

9. The skills needed by the practitioner when using an interpreter

Using an interpreter requires a different type of communication. Analysis of the case study demonstrated different aspects that were helpful to the success of the interaction, these involved:

- Enhanced body language, using the idea of expressive non-verbal communication.
- Non-verbal communication can replace speech, can contradict a verbal message and can initiate and sustain communication (Hargie et al., 1994) even within the interpreting triangle. However, it cannot regulate turn taking of speech as carried out in a same language interaction.
- Language matching, greetings and farewells are easy to understand because they match, however non-verbal cues can highlight a mismatch and create discord.

An easy example such as 'Sabah-il-kheir', 'good morning' in Arabic, demonstrates the straightforward nature of transfer of a word and a concept that match. Used at the outset, clearly a greeting, the body language and the verbal communication can be seen by participants to match the communication. However, if there is a long monologue in either language followed by a short response then one side of this important communication triangle can feel disadvantaged, wonder what has been said and disengage from the process.

Exclusion of one of the parties in the triangle by allowing sidetrack discussions in either language are to be avoided. Trust can never be developed if only some things are translated. Seventy percent of interaction is body language; it is crucial to interpret all sides of the conversation at all times. Without openness and honesty the process becomes corrupted.

Gerrish (2001) reported some of the paradoxes that exist in the use of the interpreting service. Nurses expressed a lack of confidence in the detail and accuracy of the interpretation. This was the explanation for low usage of the interpreting service. However, when the nurses did use the interpreting service they spoke positively of the contribution of the interpreter.

Other useful points in use of an interpreter are

- Managing the exchange of information in very small pieces, smaller than normal conversation.
- Allowing extra time for the slower process of relationship building with the client.
- Preparatory work with the interpreter will enhance the quality of communication.
- Simplifying concepts and questions continually.
- Working closely with the interpreter (try to use the same interpreter for subsequent contacts with

clients). Building a good relationship with the interpreter as well as the client is important.

10. Addendum

The client in the vignette does not read or write in English, however on two separate occasions the outcomes of the research were discussed with her, using the skills of the interpreter to explain, on both occasions she gave her consent and permission for her story to be told.

Following the case study episode a meaningful relationship developed between the health visitor and Mrs. X. Further contacts with the health visitor revealed that the client had spoken to her previous GP about her situation. He reported the consultation and its content to her family. This had greatly compounded her home situation.

Subsequently Mrs. X derived great help from her new health visitor. They met at the GP surgery and using the same interpreter, a positive therapeutic relationship was built. It took a long time to rebuild trust following the betrayal that Mrs. X had experienced with previous health professional contact. With help from the health visiting service and a health visitor who believed in equity Mrs. X is now working towards building a new life for herself and her children.

11. Conclusion

This paper has focused exclusively on a study addressing only one instrument, however parallels may be drawn in how the use of any structured instrument can have a detrimental effect on access to services if English is not the client's first language. One of the aims of this study was to explore the perceived effectiveness and acceptability of this specific HNAT for both health visitors and service users. In the study as a whole, nearly one third of the clients (6 of 21 interviewed) revealed needs to the researcher that had not been uncovered by the use of the HNAT. The case study demonstrated that the HNAT was not useful in uncovering all of this client's needs. It was difficult to gauge the acceptability of the tool because the family members, both mother-in-law and client clearly stated that they did not mind answering the HNAT questions asked by the health visitor. However, as the vignette showed, it became clear that the information elicited using the HNAT addressed superficial issues that were not of immediate significance to the client. Deep-seated emotional and psychological problems were left untouched using the HNAT with its questionnaire, checklist approach. The client had been unable to set the agenda or have control over the process.

The conversational interaction, which occurred as a by-product of the research intervention, demonstrated the possibility of a different outcome when the client was allowed to lead the interaction. Understanding of the health visiting service was clarified slowly. In the case of Mrs. X it was clear that her emotional life and the sharing of it, was dependent on her being allowed time to express her fears without the presence of her mother-in-law. This factor will always remain a challenge to the health visiting service, however it is worthy of note that although Mrs. X had three children less than six years of age, she had never been offered the services of an interpreter before this new contact. Once she understood about the health visiting service and the interpreting service, she was amazed by this deficit.

Many studies discuss the role of family members, interpreting on behalf of relatives (Ahmad et al., 1989; Atkin and Rollins, 1993; Walker and Ahmad, 1994; Askham et al., 1995; Pharoah, 1995; DH, 1999; Tang, 1999; Villarreul et al., 1999; Gerrish, 2001). Pharoah suggests this was particularly common in London Boroughs. Over one third of people who used informal methods of interpreting e.g. family members, reported difficulties including inhibitions, embarrassment and problems with accuracy (Rudat, 1994; Pharoah, 1995).

The family's new health visitor ethically opted not to use a family member to act as an interpreter. If she had done so the visit could have been completed with only one contact, instead the health visitor opted to return to the home with the interpreter at a later date. When questioned about this, the health visitor said, "I am only trying to offer an equal service to all my clients".

Spence (2001) reported a health professional's resentment towards, 'all those refugees' on the one hand, and on the other following the development of a one to one relationship with refugee clients, the same respondent experienced a different emotion, "I'm glad they're here and safe".

There is a strong 'ethical command' within the caring professions to treat all people equally, however a paradox does exist concerning the recognition and relevance of more than one understanding. A precedent has already been set for translation of a tool into an Asian language (Clifford et al., 1997). The needs of Punjabi speaking women were addressed by translating the Edinburgh Postnatal Depression Score (Cox et al., 1987) for use by women in the postnatal period. This proactively addressed both language and health needs of this group. The study found that some expressions written in English were meaningless when translated; content and semantic equivalence became a challenge in the translation process.

At a time when many asylum seekers and refugees are using the services of the health visitor or other community professional, it is important to address how the services of the interpreter are used.

The findings demonstrate that a structured questionnaire used insensitively, far from helping a client, can at best do no good at all and at worst have a detrimental effect. If English is not the first language it can preclude a large part of the population being surveyed in this way and can present a false picture of the real needs of a population such as occurred with this desperate lady from the Indian Subcontinent.

The particular NHS Trust studied, actively encouraged the use of the interpreter service, however the interpreter herself said that her dream was to become a 'law court interpreter'. Perhaps the NHS in the UK needs to raise the status of this important job in meeting the needs of a multi-ethnic society. It seems clear from this case study that engaging the client in the process of assessment yields greater potential for uncovering need and dealing with the often invisible nature of the emotional and psychological life.

A structured questionnaire had been introduced in this NHS Trust, as an aid to the health needs assessment process undertaken by health visitors. The intention had been twofold: first, to provide equity by ensuring that all clients were asked the same questions and, therefore, offered the same opportunity to reveal their needs. However, as shown by this study, the varied understandings and needs of people from different ethnic backgrounds require a deeper sensitivity than is allowed by an inflexible, structured approach that focuses on a list of pre-determined needs. Second, it was hoped that the objectivity implied by the questionnaire would help to demonstrate to health commissioners paying for the service that the health visitors were meeting specific, identified needs. The expectation by commissioners that practitioners should be able to articulate and document their practice can, in some instances, help to focus and clarify health provision. In this instance, it provided an unhelpful pressure that encouraged the blanket application of an instrument for all, instead of a sensitive, individualised approach to practice.

Acknowledgements

Our special thanks go to Jenifer Wilson-Barnett, who stressed to us that we must speak for those who cannot speak for themselves. For her encouragement and help in unravelling this issue, that ultimately led to this paper, many grateful thanks. This study used special research Funds from the Florence Nightingale School of Nursing and Midwifery King's College London for which the authors are grateful. The conclusions are the authors own.

References

Abbott, P., Sapsford, R., 1997. Research into Practice A Reader for Nurses and the Caring Professions, 2nd Edition. Open University Press, Buckingham.

Acheson, D. (Chair), 1998. Inquiry into Inequalities in Health. TSO, London.

Ahmad, W.I.U., Baker, M., Kernohan, E., 1989. Patient's choice of General Practitioner: influence of patients fluency in English and the ethnicity and sex of the doctor. Journal of the Royal College of General Practitioners 39, 153–155.

Alexander, Z., 1999. Department of Health (DH) Study of Black, Asian and Ethnic Minority Issues. Department of Health, London DH.

Appleton, J., 1997. Establishing the validity and reliability of clinical practice guidelines used to identify families requiring increased health visitor support. Public Health 111, 107–113.

Argyle, M., 1988. Bodily Communication, 2nd Edition. Routledge, London.

Askham, J., Henshaw, L., Tarpey, M., 1995. Social and Health Authority Services for Elderly People from Black and Minority Ethnic Communities. HMSO, London.

Atkin, K., Rollins, J., 1993. Community Care in a Multi-racial Britain: A Critical Review of the Literature. HMSO, London.

Bahl, V., 1993. Development of a black and ethnic minority health policy at the Department of Health. In: Hopkins, A., Bahl, V. (Eds.), Access to Health Care for People from Black and Ethnic Minorities. Royal College of Physicians of London, London (Chapter 1).

Baxter, C., 1997. Race Equality in Health Care and Education. Bailliere Tindall, London.

Birdwhistell, R., 1970. Kinesis and context. University of Pennsylvania Press, Philadelphia. In: Niven, N., Robinson, J. (Eds.), The Psychology of Nursing Care. BPS Books, 1994. Macmillan, London.

Boi, S., 2000. Nurses experiences in caring for patients from different cultural backgrounds. NT Research 5 (5), 382–389.

Bonaparte, B., 1979. Ego defensiveness, openmindedness, and nurses' attitudes towards culturally different patients. Nursing Research 28 (3), 166–172.

Burrows, A., 1983. Patient-centred care in a multi-racial society. The relevance of ethnographic perspectives in nursing journals. Journal of Advanced Nursing 8 (6), 477–485.

Clifford, C., Day, A., Cox, J., 1997. Developing the use of the EPDS in a Punjabi-speaking community British. Journal of Midwifery 5 (10), 616–619.

Cowley, S., Bergen, A., Young, K., Kavanagh, A., 2000. A taxonomy of needs assessment, elicited from multiple case study of community nursing education and practice. Journal of Advanced Nursing 31 (1), 126–134.

Cox, J.L., Holden, J.M., Sagovsky, R., 1987. Detection of postnatal depression: development of the ten-item Edinburgh postnatal depression scale. British Journal of Psychiatry 150, 782–786.

DH (Department of Health), 1991. The Patient's Charter: Raising the Standard. HMSO, London.

DH (Department of Health), 1992. Health of black and ethnic minorities on the state of the public health for the year 1991: The annual report of the Chief Medical Officer of the Department of Health, HMSO, London, p. 54.

DH (Department of Health), 1997. The New NHS: Modern, Dependable. TSO (Cmd 3809), London.

DH (Department of Health), 1997a. On the state of the public health for the year 1996: the Annual report of the Chief Medical Officer of the Department of Health, HMSO London, p. 82.

DH (Department of Health), 1999. Patient and Public Involvement in the New NHS. Department of Health, London.

DH (Department of Health), 2001. Shifting the Balance of Power: Securing Delivery, Department of Health, London.

Dickson, D.A., 1997. Reflecting. In: Hargie, O.D. (Ed.), The Handbook of Communication Skills, 2nd Edition. Routledge, London (Chapter 6).

Dobson, S.M., 1991. Transcultural Nursing. Scutari Press, Royal College of Nursing.

Donaldson, L.J., 1986. Health and Social status of elderly Asians: a community survey. BMJ 293, 1079–1082.

Field, P.A., 1991. Doing fieldwork in your own culture. In: Morse, J.M. (Ed.), Qualitative Nursing Research: A Contemporary Dialogue. Sage Publications, London (Chapter 6).

Gerrish, K., 2000. Individualized care: its conceptualisation and practice within a multiethnic society. Journal of Advanced Nursing 32 (1), 91–99.

Gerrish, K., 2001. The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their careers. Journal of Advanced Nursing 33 (5), 566–574.

Gordon, M.M., 1964. Assimilation in American life. Oxford University Press, New York. In: Dobson, S.M. (Ed.), (1991). Transcultural Nursing. Scutari Press, Royal College of Nursing.

Hallet, L., Thompson, M., 2001. Clinical Governance a Practical Guide for Managers Book and CD Rom Emap. Public Sector Management, London.

Hargie, O., Saunders, C., Dickson, D., 1994. Social Skills in Interpersonal Communication, 3rd Edition. Routledge, London.

Hunt, M., Meerabeau, L., 1993. Purging the emotions the lack emotional expression in subfertitility and in the care of the dying. International Journal of Nursing Studies 30, 115–124.

Johnson, M., 1999. Communication in health care. NT Research 4 (1), 18–30.

Jordan, J., Dowswell, T., Harrison, S., Lilford, R.J., Mort, M., 1998. Whose priorities? Listening to users and the public. BMJ 316, 1668–1670.

Kieffer, C., 1984. Citizen empowerment: a developmental perspective. Prevention in Human Services 3, 9–36.

Kurtz, Z., 1998. Women and children. In: Rawaf, S., Bahl, V. (Eds.), Assessing Health Needs of People from Minority Ethnic Groups. Royal College of Physicians pub Royal College Physicians, London, pp. 213 (Chapter 14).

Leininger, M., 1988. Leinenger's theory of nursing: cultural care diversity and universality. Nursing Science Quarterly 1 (4), 152–160.

May, C., 1995. Patient autonomy and the politics of professional relationships. Journal of Advanced Nursing 21 (1), 83–87.

McIvor, S., 1999. Public involvement in primary care: implications for primary care groups. NT Research 4 (4), 245–256.

McIvor, S., Brocklehurst, N., 1999. Public involvement: working for better health. Nursing Standard 14 (1), 46–52.

Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S., Beishon, S., 1997. Ethnic minorities in Britain: diversity and disadvantage. Policy Studies Institute, London.

Murphy, K., Macleod Clark, J., 1993. Nurses experiences of caring for ethnic minority patients. Journal of Advanced Nursing 18 (3), 442–450.

Nazroo, J., 1997. Health of Britain's Ethnic Minorities; Findings from a national survey. Policy Studies Institute, London.

Office for National Statistics www.statistics.gov.uklast updated 11.05.01 accessed 6th August data set CM01J.

Pharoah, C., 1995. Primary Health Care for Elderly People from Black and Minority Ethnic Communities. HMSO, London.

Rudat, K., 1994. Health Education Authority Black and Ethnic Minority Groups in England: health and lifestyles. HEA, London.

Sanders, M., 2000. As Good as Your Word: A Guide to Community Interpreting and Translation in Public Services. The Maternity Alliance, London.

Scammell, B., 1990. Communication Skills: Essentials of Nursing Management Series. Macmillan, London.

Smaje, C., 1995. Health Race and Ethnicity: Making Sense of Evidence. Kings Fund Institute, Kings Fund, London.

Spence, 2001. Prejudice paradox and possibility. Journal of Transcultural Nursing 12(2), 100–106.

Spradley, J.P., McCurdy, D.W. (Eds.), 1977. Conformity and Conflict Readings in Cultural Anthropology, 3rd Edition. Little Brown, Boston, MA. In: Dobson, S.M. (Ed.), 1991. Transcultural Nursing. Scutari Press, Royal College of Nursing (use of terms xix).

Tang, S., 1999. Interpreter services in health care. Journal of Nursing Administration 29 (6), 23–28.

Tomlinson, B., 1992. Report of the Inquiry into London's Health Service Medical Education and Research. HMSO, London.

Villarreul, A.M., Portillo, C.J., Kane, P., 1999. Communicating with limited English proficiency persons: implications for nursing practice. Nursing Outlook 47 (6), 262–270.

Walker, R., Ahmad, W.I.U., 1994. Asian and black elders and community care: a survey of care providers. New Community 20 (4), 635–646.

Waterworth, S., Luker, K., 1990. Reluctant collaborators: do patients want to be involved in decisions concerning care? Journal of Advanced Nursing 15, 971–976.

Whyte, W.F., 1982. Interviewing in field research. In: Burgess, R.G. (Ed.), Field Research a Source Book and Field Manual. George Allen and Unwin, London, pp. 111–22.

World Health Organisation, 1985. Social justice and equity in health. A report from the programme of social equity, WHO Meeting, Leeds, July 22–26, 1985.