Available online at www.sciencedirect.com
SCIENCE DIRECT®
PERGAMON
International Journal of Nursing Studies 40 (2003) 413–426
INTERNATIONAL JOURNAL OF NURSING STUDIES
www.elsevier.com/locate/ijnurstu

Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool

Jan Mitcheson[a,*], Sarah Cowley[b]

[a] *Suffolk College, Rope Walk, Ipswich, UK*
[b] *Community Practice Development, King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, UK*

Received 25 August 2002; received in revised form 27 November 2002; accepted 29 November 2002

Abstract

The demand for explicitness in the way health visitors target their services has given rise to a plethora of different health needs assessment tools (HNATs). This paper describes an in-depth conversational analysis of the use in practice of these structured health needs assessment tools (HNATs) in two different NHS Community Trusts in England. These HNATs aimed to enable clients to participate in the assessment of their own health needs, as well as fulfilling the political requirements of justifying the expenditure of health visitor time where needs are identified.

However, conversational analysis of 10 interactions showed that use of the instruments was associated with a failure to either identify needs that are relevant to the client or to enable clients to participate in the process. Use of the structured instrument simultaneously emphasises the significance of a professional lead, instead of client participation, and minimises the importance of inter-personal relationships and communication. In one site, a directly controlling style was apparent in the practice of health visitors who were, themselves, explicitly controlled by their managers. In the other site, professional expertise was emphasised, and a covert assessment style acted to disempower clients.

The controlling nature of the interactions, the number of missed cues and the possibility of distress caused by the insensitivity of questioning style are all potentially harmful side effects of using structured instruments to assess needs. The problems seem to stem from the use of a pre-determined list of questions that form the basis for assuming that any family's health promotion needs can be categorised and predicted in advance. In conclusion, therefore, it is recommended that health visitors should use the open, conversational style of needs assessment that has been shown to be effective and acceptable, rather than an approach based on a structured instrument.

Keywords: Needs assessment; Conversational analysis; Health visiting; Health promotion; Empowerment; Participation; Control

1. Introduction

In the last decade British health visitors, in common with other health and social care practitioners, have come under increasing pressure not only to be more explicit in articulating the function and purpose of their work but also to target that work to those most in need. In response, a plethora of clinical practice guidelines and assessment tools have emerged to assist the health visitor in the identification of vulnerable families, with the intention of identifying need so that health visiting interventions may be targeted accordingly.

At the same time there is a clear acknowledgement within a number of policy directives (DH, 1989, 1997, 2000) of the importance of client participation in the process of identifying needs at both an individual and community level. Participation is viewed as essential in establishing empowerment and autonomy, which in turn

*Corresponding author. Tel.: +44-1473-702507.
E-mail address: jan.mitcheson@suffolk.ac.uk (J. Mitcheson).

0020-7489/03/$ - see front matter
doi:10.1016/S0020-7489(02)00107-4

are considered essential for health and health promotion (Tones, 1998).

This paper describes an in-depth conversational analysis of the use in practice of structured health needs assessment tools (HNATs) in two different NHS Community Trusts in England. The stated purpose of the needs assessment tools is to enable clients to participate in the assessment of their own health needs, as well as fulfilling the political requirements of justifying the expenditure of health visitor time where needs are identified. The tools are implemented as an adjunct to, or replacement for, unstructured conversational assessments that culminate in a professional judgement of what needs are to be met by the health visiting service. The study examined the extent to which the client is enabled to participate in the needs assessment process when structured tools are used.

2. Background

Health promotion is central to the purpose of health visiting, which is primarily concerned with improving health and social well being, by enabling people to improve their own health (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2002). The associated concepts of empowerment and enablement are central to the philosophy and practice of health promotion, based upon the World Health Organisation's definition of health promotion as 'the process of enabling people to increase control over and to improve their health' (World Health Organisation, 1986). Empowerment is a political concept that emerged from the feminist and radical socialist ideology of the 1970s encompassing notions of collective consciousness and shared responsibility. Health and social care services have embodied the concept of empowerment, at least in principle, and there have been a number of attempts to clarify meaning (Rappaport, 1984; Gibson, 1991; Rodwell, 1996; Ryles, 1999). There remains a great deal of ambiguity with regard to the precise nature of empowerment (Rissell, 1994) although it seems to be viewed as a positive ideal that entails a process of helping people to master their environment and achieve self-determination.

Participation in decisions about matters that affect health is an essential prerequisite to empowerment (Kendall, 1993, 1998). At the micro and macro level of health promotion, the practitioner–client interaction is of paramount importance in enabling participation. Key features that are considered essential in empowering practice are the practitioner-client relationship and the personal skills and attributes of the practitioner (Tones, 1998).

2.1. Practitioner–client relationships

Studies exploring the practitioner–client relationship have emphasised collaborative interactions, concluding that health visitors and clients mutually interact in order to achieve outcomes of the exchange, which are valued by each person (Robinson, 1982; Kristjanson and Chalmers, 1991; Chalmers and Luker, 1991; de la Cuesta, 1994). A wealth of studies record client satisfaction with the health visiting service based upon a positive client–health visitor relationship in which a non-authoritarian style of communication which enables client participation is adopted (de la Cuesta, 1994; Machen, 1996; Normandale, 2001). Sadly, many other studies suggest that health visitors do not all adopt an empowering stance (Sefi, 1985; McIntosh, 1986; Abbott and Sapsford, 1990; Foster and Mayall, 1990). On the whole, these studies describe an authoritarian top down approach in which health visitors offer unsolicited advice, thus undermining the self-confidence of the mother and causing dissatisfaction with the service.

This diversity in the literature may be attributed to organisational and managerial demands that dictate health visitors' working practice in terms of the timing of and reasons for contact (Audit Commission, 1994). Alternatively, the current education and training of health visitors may be inadequate to prepare practitioners to develop the necessary skills (Oldman, 1999). Finally, practitioners' ability to promote the health of the client may correlate with the extent to which the practitioners experience empowerment themselves (Read and Wallcraft, 1992; Latter, 1994). A recent survey (CPHVA, 1998) concluded that a substantial number of health visitors wished to leave the profession because they felt stressed, undervalued and overstretched. In view of this, Normandale (2001) suggests that health visitors may be so disempowered through stress and feelings of being undervalued themselves, that they may well find it difficult to empower clients.

2.2. Personal skills and attributes

Respect, empathy and genuineness appear to be central to any activity that endeavours to empower clients. When clients were asked to identify the attributes of an effective practitioner the most frequently cited are being easy to talk to, having a friendly manner and being a good listener (Twinn, 1989). Cowley (2000) suggests of the search for health needs, that the key lies 'not in the proactive nature of the enquiry but in the ability of the health visitor to convey a caring interested stance rather than a judgmental and inquisitorial attitude (Cowley, 2000, p. 17).

Importantly, there are a number of studies that suggest that the clients' perception of need often differs from that of the professional (Blackburn, 1991; Pearson,

1991). Labonte (1994) draws attention to the professional need to respect how people identify their own health concerns and issues, asserting that if health workers fail to start where people are, they risk being irrelevant to the lives and conditions of those people. Moreover, the very act of enabling clients to name their experiences is essential to self-efficacy and empowerment. This seems particularly relevant in health visiting practice where clients find the service most acceptable when health visitors are responsive to client need and engage in discussion determined by the clients' own agenda (Machen, 1996; Normandale, 2001) and where negative perceptions of the profession are likely to stem from an apparent failure to meet the perceived needs of the client (Collinson and Cowley, 1998).

2.3. Health needs assessment

Tones (1998) maintains that the use of demystified counselling skills provides the best opportunity for practitioners to gather the information required to make an accurate assessment. Needs assessment is, therefore, revealed in the literature as a complex and skilful activity. The ability to assess the needs of individuals, families and communities is central to the practice of health visiting and has for some time been recognised, within the profession, as a key skill (Clark, 1985; Orr, 1992). Indeed the search for health needs is a principle objective of health visiting practice (CETHV, 1977; Twinn and Cowley, 1992). It is evident that the process of assessing health needs is complex, skilful and part of an on-going process (Cowley, 1995; Cowley et al., 2000a, b; Bryans and McIntosh, 2000) that is intimately bound up with professional judgement and ability to prioritise families with the greatest needs (Appleton, 2002, 1993; Williams, 1997). This literature suggests that client participation requires a practitioner with the skill to adopt an empowering approach, which in turn requires the development of practice strategies that enable the client to control the process. Clearly, if that is the case then questions are raised about the use of a predetermined agenda in the guise of an assessment tool or schedule. However, there is a requirement upon health visitors to be able to articulate their practice to those who commission (and thus pay for) the service.

Indeed, the requirement that health visitors target their practice according to identified need increased throughout the 1990s (Audit Commission, 1994; NHS Executive, 1996; Roberts, 1996). Targeting involves determining, usually at a first contact and sometimes within one visit, that a need exists; only then may a prescribed treatment or programme of care be initiated. In response, around two thirds of the NHS Community Trusts that employ health visitors have developed assessment tools or guidelines to assist health visitors in this endeavour (Appleton, 1997).

Although their popularity with managers and service commissioners appears to be spreading, the validity of many of the identified tools is seriously questioned by Appleton and others. First, there is little evidence to suggest that the use of a checklist of risk factors can accurately predict outcomes; indeed the use of such indicators can lead to families being wrongly identified and vice versa (Barker, 1990, 1996; Browne, 1995; Goddard et al., 1999). Furthermore, the prolific development of assessment tools has, according to Twinn (2000), 'led to practitioners negating the art of practice and adopting routinised and mechanistic approaches to practice. This approach to practice fails to allow practitioners to identify needs from the clients' perspective since it fails to acknowledge the significance of practice criteria in informing professional judgements' (p. 67). Twinn argues persuasively that Schon's (1983) concept of professional artistry is an essential component of health needs assessment if that process is to identify and meet the health needs of clients.

Given these different requirements, there has arisen a division of opinions about how health needs assessments are best carried out by health visitors. Two key alternatives can be discerned from the professional literature. One emphasises the development of professional judgement and communication skills, stressing the importance of developing a trusting interpersonal relationship between client and practitioner. It suggests that active listening and an open agenda is the most effective way to ensure that health needs are identified (Davis and Spurr, 1998; Bidmead et al., 2002). The second approach, likewise, assumes that interpersonal skills are important, but sheds doubt on the effectiveness of practitioners working with an open agenda, promoting use of a structured format to guide communication and needs assessment instead.

This apparent contradiction in the literature may be a result of different skills and approaches used by individual health visitors. What is not clear is the extent to which these are affected by the organisational structures imposed upon health visitors, nor is it clear whether or not structured needs assessment protocols and tools support empowering practice or create additional barriers to participation. In summary, the extent to which structured health needs assessment tools help or hinder the communication process or enable clients to participate remains largely unknown.

3. Method

The aim of this research was to examine what happens between the health visitor and the client during an assessment process using a structured needs assessment tool. The responsibility of the health visitor to assess the needs of the family is necessarily discharged through

verbal, face-to-face interaction with clients. Given that the features believed to characterise an empowering approach to needs assessment are rooted at the level of communication between individuals, a research approach was sought that would facilitate a detailed examination of naturally occurring conversations between the health visitor and the client during the assessment process.

The study therefore broadly draws upon the approach of ethnomethodology (Garfinkel, 1967) and in particular upon conversation analysis (CA) developed by Sacks et al. (1974) defined as 'the study of talk-in-interaction'. Indeed, it is the specific interactional situation, its local interactional requirements and importantly the ways in which the interactants show their orientations to these situations and requirements, that are of particular interest. The assumption is that it is fundamentally through interaction that institutional imperatives originating from outside the interaction are evidenced and made real and enforceable for the participants. Heritage (1997), building upon earlier work by Drew and Heritage (1992), suggests three main features of institutional talk:

1. Institutional interaction normally involves the participants in specific goal orientations, which are tied to their institution relevant identities, doctor patient, teacher pupil and so on.
2. Institutional interaction involves special constraints on what will be treated as allowable contributions to the business at hand.
3. Institutional talk may be associated with inferential frameworks and procedures that are particular to specific institutional contexts (Drew and Heritage, 1992, pp. 163–4).

These features 'create a unique fingerprint for each kind of institutional interaction' (Heritage and Greatbatch, 1991, p. 95) consisting of the specific tasks, identities, constraints on conduct and procedures that the participants deploy. Heritage (1997) suggests that there are six basic places to probe the institutional nature of the interaction when looking for these and other related features of institutional interaction. These are detailed in Table 1.

3.1. Participants

Data were gathered from two NHS Community Trusts, in which health visitors were requested to volunteer to become part of the study. The sites were selected because each used a different, structured approach to needs assessment. In Site A, the Trust covered a multi-cultural population of about 300,000 within a large metropolitan area, stretching from inner city to the suburban fringe. Issues concerning the effectiveness of the instrument and matters arising directly for the assessment of clients who do not speak English are detailed elsewhere (Houston and Cowley, in press). Site B served a similar sized county area, encompassing rural and urban populations. Both Trusts served a range of client need, from advantaged to deprived. Both had adopted the needs assessment protocols in response to mounting and unmanageable workload pressure and a wish to ensure the health visiting service was targeted, in some way, upon those who needed it most. Site B were particularly concerned to ensure that child protection issues were addressed, whilst Site A was most interested in ensuring equity of workload. Systematic comparative data were not collected about other issues, as the focus of this study was specifically upon the health visitor/client interaction within a structured assessment process.

A maximum variation sample (Sandelowski, 1995) of health visitors and clients was sought, to provide as wide a range of interactions as possible. The health visitor

Table 1
Analysis points (after Heritage, 1997)

Turn-taking organisation	Seeks to determine the existence of a specific turn-taking system
Overall structural organisation	A map of the interaction in terms of its phases is developed
Sequence organisation	Lies at the heart of CA and considers how opportunities for action are opened up and activated or withheld and occluded
Turn design	Refers to two distinct selections that a persons speech embodies: (a) The action that the talk is designed to perform (b) The means that are selected to perform that action
Lexical choice	It is a component of turn design and is significant in highlighting the *choice of words* used, the use of organisational *we* and *institutional euphemisms* representing ways of talking that seem to minimise the pain or discomfort of the situation under discussion.
Interactional asymmetries	Manifest in a number of ways most notably in asymmetry of participation, knowledge and know how

was asked to select a client with whom she/he planned to carry out a home visit for the purpose of needs assessment. Ten health visitor client interactions, five from each site, comprising a total sample of twenty participants was deemed to be an adequate sample size. Assurances of confidentiality were given to both health visitors and clients and their consent to participate obtained.

The health visitors in Site A are required to use a highly structured assessment questionnaire and complete it within 16 weeks of the initial visit although in reality, given the nature of health visitor caseloads, this was usually accomplished in one or two visits. The assessment results in families being scored by the health visitor as having high, medium or low needs and the result is entered on to a database. The plan was, therefore, for the level of need to determine the level of health visiting service offered The process is formally audited and failure to comply by the health visitor results in possible disciplinary action by the organisation, although clients are allowed to opt out if they so wish.

In Site B health visitors are required to use a framework, The early intervention strategy (EIS) developed by Crompton et al. (1998) and adopted by the trust, to guide the assessment. The EIS was originally developed over a period of five years and has its initial roots in child protection (Naughton and Heath, 2001). In practice the health visitors are required to carry out a first level screen on all families within the antenatal period and if concerns arise a second in depth assessment follows. The intention of the assessment was to identify risk factors relating to child protection and to target the health visiting service accordingly. Within this trust the requirement to use the EIS guideline was written in to the health visiting standards for practice but there seemed to be limited auditing of the standard and at the time of the study there appeared no real compulsion to comply.

3.2. Data collection

The data for this study were collected by means of audio-taping. The strength of this method lies in its ability to diminish the basic problems associated with other forms of qualitative data collection, most notably the gap between beliefs and actions and between what people say they do and what they actually do. This was particularly pertinent in this study as much of the work of the health visitor is conducted in the private sphere of the clients' home and is therefore largely hidden from external observation.

3.3. Data analysis

Conversation Analysis uses the processes of analytic induction to search for patterns of interaction and an explication of the emic logic that provides for their significance. In order to apply the principles of conversation analysis utilised in this study, the audio recordings of the health visitor client interaction were first subjected to methodical listening as recommended by Psathas and Anderson (1990). Hearing the interaction as it occurs gives the analyst an intimate familiarity with the *lived reality* of the interaction. It facilitates the transcription process, which utilised the Jeffersonian Transcription System and was adapted to the purpose of the study and its potential audience (Psathas and Anderson, 1990; Have ten, 1999).

4. Findings

On the whole, the interactions between the health visitor and the client during the assessment process do not appear to enable client participation or open assessment of needs. Indeed the assessment process is structured so that the health visitor controls the interactions and there is limited opportunity for the clients to participate in identifying and determining their needs.

The findings revealed various stages, including the overall structure of the assessment, the process of the assessment which involved both information gathering and information giving and the outcome of the assessment related to determining the level of need and planning future interventions. This paper will focus on the processes involved in the assessment itself, including information gathering and information giving; details of the other aspects are reported elsewhere (Mitcheson, 2001).

A key purpose of health needs assessment is, supposedly, to identify health needs accurately so that the health visitor can offer information and advice that is relevant and wanted by the clients. An empowering approach would enable clients to contribute fully to this process, so that the assessment of health needs reflects their views and contributes to the acceptability of both the health visiting service and the health promoting information and support offered. Analysis of the taped conversations revealed a very different process from this ideal way of working.

4.1. Information gathering

The needs assessment process is accomplished within the interactions primarily by information gathering when the health visitor and client were, without exception, aligned as questioner and answerer. Within the data it was possible to identify long sequences of interaction where the health visitors act exclusively as questioners and the client correspondingly as answerers

Table 2
Asymmetry of participation

	HV questions	Client questions
Site A		
HV/Client 1A	43	3
HV/Client 2A	32	1
HV/Client 3A	31	0
HV/Client 4A	134	8
HV/Client 5A	46	1
Site B		
HV/Client 1B	73	6
HV/Client 2B	35	0
HV/Client 3B	36	5
HV/Client 4B	88	15
HV/Client 5B	72	12

(Table 2). In this sense, question and answers are 'adjacency pairs' in which the first creates a strong moral expectation that the second will appear (Perakyla and Silverman, 1991) and when it does, it gives control back to the questioner.

A noticeable feature of the sequences in Site A is that the questions are unequivocal and short, designed specifically to gather information. The following example illustrates this point well:

Extract 1 HV/C3A

Line 15 HV	You or your partner have experienced mental health problems?
Line 16 Client	No
Line 17 HV	You or your partner have a dependency for drugs or alcohol?
Line 18	Do you smoke?
Line 19 Client	I smoke, yes.
Line 20 HV	What about ((partners name))?
Line 21 Client	He did (.) but not any more.
Line 22 HV	What about drinking?
Line 23 Client	We don't drink no more
Line 24 HV	Neither of you?
Line 25 Client	I don't drink no more and he don't

This extract is of particular interest for two further reasons: firstly it is evident that the health visitor shapes the topic in that she specifically asks the client about smoking and alcohol but not about other types of drugs and secondly it is the health visitor who decides when the topic is satisfactorily concluded and a new topic commences. Whilst this may be a relatively simple example, it serves to demonstrate the significant asymmetries of participation within the interaction. On the rare occasions a client was able to raise concerns, it was invariably blocked, dismissed or minimised, even when these referred to quite worrying issues as in the following extract:

Extract 2 HV/C1A

Line 65 HV	Have you got serious financial worries?
Line 66 Client	Yes I do.
Line 67 HV	erm (…) How loving do you feel towards the baby?
Line 68 Client	I do, I do feel (…)
Line 69	there are days when I wish she would just go away sometimes when she's Line
70	just constantly screaming all the time=
Line 71	but there are other days where I just wanna squeeze he (…)
Line 72	if I've been up all night with her (…)
Line 73 HV	Do you feel fairly happy with her?
Line 74 Client	(…) Yeah (…) I'm happy with her

The client was undoubtedly expressing serious concerns to the health visitor yet these were not acted upon and the assessment continues with the client acquiescing to the health visitor's demand for an answer. The health visitor did not return to these issues at any time in this visit. On some occasions, health visitors indicated that they would return to an issue, but did not do so. It appeared that the health visitor would not or could not be distracted from a line of questioning determined by the assessment format, continuing the line of questioning until the client gives an answer that fitted the categories available on the form. This was a recurring theme throughout the information-gathering phase of the interaction and particularly evident in Site A where, without exception, the interaction seemed orientated around the questions contained in the schedule. In this extract the client indicates by a deep sigh that she feels a pressure to answer affirmatively.

Extract 3 HV/C1A

Line 36 HV	Is this a good time for you to be a parent?
Line 37 Client	When isn't, when is? ((*laughter*))
Line 38 HV	yeah::
Line 39	So are you saying yes, or no?
Line Client	((*sighs*)) ye::ah

Similarly lengthy sequences could be identified in site B in all the interactions, although many of the question–answer–question sequences were of a more exploratory nature, enabling clients to express their own perspective more readily. They did not require a yes/no response in the same way as in the previous example. The following extract contrasts with extract 3, where the rationale for

the line of questioning is, similarly, to assess the client's feelings about being a parent:

Extract 4 Extract HV/C2B

Line 251 HV	so ermm you know in terms of being a parent has it you know have you
Line 252	found it difficult or (.) have you (.) you know kind of fallen in to it
Line 253 Client	I have fallen in to it but I was
Line 254 HV	ye::ah
Line 255 Client	when I was carrying her and I said to my boyfriend you know I'll be
Line 256	alright I reckon I'll find it easy I reckon now I'll be ok and that
Line 257	But when I had (child's name) that was difficult that was harder when she
Line 258	was smaller you know when she was tiny that was more on demand but as
Line 259	she's older like she is now I've sort of I have fallen in to it now I can cope
Line 260	you know I I don't panic as much now you know with her age and that
Line 261	now
Line 262	she's she's you know a real ple-pleasure to look after now
Line 263 HV	Good

The health visitor then goes on to use similar open questions to explore how the client was raised as a child and her own experiences of parenting. The style is much less interrogative and the questions do not appear to bombard the client in the same way, or require a yes/no response as in the previous example. As indicated in Table 2, the clients in Site B asked more questions themselves, but health visitors also asked more. In both sites, a common pattern in the interactions involved the health visitor informing the client of the reason for a question after the client had given her answer.

Extract 5 HV/C5A

Line 90 HV	Have you or ((husbands name)) experienced any mental health problems,
Line 91	psychological problems, depression?
Line 92 Client	No.
Line 93 HV	The reason around that especially for you is to do with postnatal
Line 94	depression because in a way it can start from the time of birth up to
Line 95	eighteen months of age -
Line 96 Client	No
Line 97 HV	So because there is health… say you suffered from depression before, or
Line 98	there is a history of depression in your family, then of course you know it
Line 99	is something to look at and be aware of because there is a (unclear) so we
Line 100	can get everything in place, if and when you needed it and also if your
Line 101	husband suffered from depression, you know, so he can get the appropriate
Line 102	help he needed, how that would impact on family life having a new baby
Line 103	and that sort of thing. That is the reason why I am asking all that.
Line 104 Client	okay

It would appear that the health visitor was making some kind of moral justification for requiring the information. However, the health visitor leaves the client in little doubt that she requires the information and therefore the client has an obligation to provide it. The option to withhold information is effectively closed down. Simultaneously, the right is asserted of the professional to determine which needs are to be discussed. Also, from the outset in Site B the health visitors positioned themselves as experts, offering detailed accounts of their role as advisor, as in the following extract:

Extract 6: HV/Client 2B

Line 1 HV	OK the purpose of this visit is just to tell you a little bit about the health
Line 2	visiting service. We're all trained nurses so when you see us you're
Line 3	consulting a nurse basically whose got extra training
Line 4 Client	oh I didn't know that ((laughter))
Line 5 HV	yeah it's really important because a lot of people confuse our role with that
Line 6	of social workers
Line 7 Client	yeah yeah
Line 8 HV	like being inspected you know
Line 9	no no nothing to do with that at all
Line 10	its all about health and if you think about it we're attached to the GP's
Line 11	surgery//
Line 12 Client	//yeah
Line 13 HV	so we do the weighing, we give you the advice, we do the developmental assessments

Another significant difference between the sites was that all the health visitors in Site A informed their clients that they were completing a proforma needs assessment at the start of the questioning process, whereas only one of the health visitors in site B openly introduced the EIS in this way. In another interaction the health visitor briefly alluded to it in name but without explanation, and in the following extract the health visitor informed the client of the reason for her questioning some 40 min

after she began it:

Extract 7 HV/Client 5B

Line 452 HV	But no really we just we just come along and sort of ask a few
Line 453	questions because obviously we need to know if everything's going
Line 454	to be alright// when baby arrives
Line 455 Client	//yeah

It is of obvious concern that some health visitors are assessing the needs of their clients in such a covert manner. In institutional interactions where the objectives of the encounter are unclear, opaque or even suspicious to one or both of the participants then confusion and conflict of interests is more likely to occur.

4.2. Information giving

Information giving emerged as an integral component of the process of identifying needs, highlighting again the asymmetries of participation within the interaction. The recordings contained many examples of long information giving sequences that the health visitors made which were, on the whole, unsolicited and not in response to an issue the client had raised or requested information about. Within these *question answer information/advice (QAI)* sequences the health visitor chooses to respond to the clients' response by delivering information about an aspect or topic. A notable feature of the QAI sequence is the length of the HV responses.

In extract 8, the health visitor uses a form of questioning that has the potential to explore the client's feelings and her resources for coping, demonstrating elements of a more empowering approach to practice. Unfortunately, when the client response in line 331 and 334 indicates that it is not a problem to her, the HV still proceeds to deliver a lengthy information turn (line 336 to line 351) that reinforces the role of the health visitor as the expert, whilst at the same time minimising the client's contribution. It is noticeable that the client does not produce any continuers such as 'ummm' within the information giving turn, indicating that she is a passive recipient of the information.

Extract 8 HV/C 4A

Line 330 HV	How does it make you feel when she cries?
Line 331 Client	Well I (.) I get her and make her stop crying (.).
Line 332 HV	But if she is crying what newborn babies cry a lot and its difficult to stop
Line 333	them
Line 334 Client	She does not cry that much,
Line 335 HV	that's really nice but
Line 336 Client	just sometimes it is when she is really hungry
Line 337	and when I change her nappy, but I just get her and say ah its okay and stuff.
Line 338	
Line 336 HV	Sometimes new born babies erm (.) they go through a stage where they do
Line 337	seem to cry quite a bit especially in the evening. =
Line 338	some babies don't, their characters are quite sort of obvious from quite
Line 339	early on because some babies have much more sort of (.) easy going
Line 340	digestive systems than others so =
Line 341	but some babies do seem to sleep the first week or two to wake up from Line
342	their journey to to recover from their journey to the world
Line 343	and then they start waking up and not really able to make much sense of
Line 344	it =
Line 345	And babies can't talk, (.) so they cannot move you know if I 'm sitting
Line 346	for a long time in this position and all of a sudden my backside will feel a
Line 347	bit sore, so I can just shift and move to the other side to move, but she
Line 348	can't do that (.) so she might just be saying =
Line 349	I'm bo;;red I'm too hot too cold, please move me or she might be saying Line
350	there's something wrong, but my brain is so sm::all it hasn't worked before Line
351	I can't make sense of what's going on =
Line 352 Client	she really does not cry a lot
Line 353 HV	that's lovely

This extract typifies many of the long information giving sequences that the health visitors made, which were unsolicited and not in response to an issue the client had raised or requested information about. The mismatch between the client's clear expression that she has no concerns about the child's crying, and the health visitor's apparent determination to deliver information anyway, draws attention to earlier work by Heritage and Sefi (1992). They concluded that health visitors initiate information/advice regardless of the response. Table 3 represents the number of occasions in which a health

Table 3
Episodes of advice-giving

	Solicited advice	Unsolicited advice
Site A		
HV/C 1A	0	1
HV/C 2A	0	4
HV/C 3A	2	5
HV/C 4A	0	35
HV/C 5A	0	5
Site B		
HV/C1B	1	5
HV/C2B	2	4
HV/C3B	2	7
HV/C 4B	2	5
HV/C 5B	1	14

Box 1
Key features of health visitor–client interaction during assessment process

- Overtly or covertly controlling
- Asymmetry of participation and know-how
- Health visitor dominated agenda
- Information/advice giving is predominantly unsolicited
- Client cues are missed
- Client questions invited only when *business* is concluded

visitor gave solicited and unsolicited information/advice during the interactions, with the most extreme involving 35 unsolicited information-giving sequences during one interaction.

In most instances, the health visitor gave the client no opportunity to ask questions until the end of the encounter when it was evident that the business of the visit, determined by the professional completing the assessment agenda, was concluded.

Extract 9 HV/C3B

Line 355 HV	Now is there anything you can think you can think of that you'd
Line 356	like to ask me?
Line 357 Client	No not really
Line 358 HV	because what// we-
Line 359 Client	// I probably will when you go as always
Line 360	No I can't think of anything at the moment
Line 361 HV	No

In conclusion, analysis of the interactions of the structured needs assessments revealed a number of features that act as barriers to empowerment or directly contravene the principles of client participation. Some, summarised in Box 1, not only reduce the likelihood of needs being identified, they have the potential to cause actual harm by the extent of their insensitivity and the failure to respond where real risks and dangers are apparent.

5. Discussion

Overall, it seems that these particular structured tools render the needs assessment process ineffective, since use of the instruments is associated with a failure to either identify needs that are relevant to the client or to enable clients to participate in the process. Indeed, the number of missed cues, the insensitivity of questioning style and the controlling nature of the interactions seem potentially quite harmful to vulnerable clients. Furthermore, the extent of unsolicited and inappropriate advice-giving implies that the tools are as irrelevant to the health visitors using them as to their clients, since the former apparently dispense information regardless of responses to their questions.

However, the gap between health visitors' positive intentions and the negative reality of practice has been reported before (Sefi, 1985; McIntosh, 1986; Abbott and Sapsford, 1990; Foster and Mayall, 1990; Kendall, 1991), in interactions that did not use structured instruments but were equally controlling. In contrast, positive consumer views associated with improved communication style have been reported in a number of more recent studies that involved no structured needs assessment instruments (Machen, 1996; Collinson and Cowley, 1998; Almond, 2001; Normandale, 2001), although these studies did not use conversational analysis, so are not direct comparators. So, the question inevitably arises as to whether the controlling nature of the communications is attributable to the structured assessment tools, to the health visitors using them or some wider influence.

Neither the method used in this study nor the sample of five health visitor/client interactions in each site are designed to demonstrate causation or generalisable results; instead understanding about how power and influence is reflected in the interactions is sought. Accordingly, the findings show that the way the interactions are structured reflect some similarities as well as the different organisational expectations in each site. These differences provide an opportunity to reflect upon three possible explanations for the negative features revealed in the interactions. These concern matters of relationship and trust as essential precursors to effective communication; the need for practitioners to be empowered themselves so they may work in an empowering way and, finally, the different forms of

education that are needed if professionals are to be able to assess health needs effectively.

5.1. Practitioner–client relationships

Labonte (1997) argues that services can only be empowering if the practitioner constantly strives to understand the person in the context of his or her life, rather than as merely a set of symptoms or problems. Numerous studies (Chalmers and Luker, 1991; Chalmers 1993, 1994; de la Cuesta, 1994) have highlighted the importance of the health visitor–client relationship in achieving this, reporting the strategies health visitors employ to ensure the development of a facilitative relationship. Importantly, de la Cuesta (1994) concluded from her study that an effective interpersonal relationship is the resource that will enable clients to volunteer information and share matters of private concern, thus enabling the health visitor to 'know the client and the family' (de la Cuesta, 1994, p. 453) and move forward with relevant health promoting information. Mc Naughton (2000) in a qualitative review of public health nurse–client relationships, which relied heavily on the British health visiting literature, concluded that the goals of relationship building are related to empowering clients, supporting their independence and decision-making and that to some extent this can and is being achieved.

In the two sites studied here, there were clear barriers to relationship building. In Site A, the workload was such that the needs assessment process usually had to be completed within one or two visits around the time of the birth of a new baby. A very instrumental approach was evident in this site, with a heavy emphasis on simply getting answers to the prescribed questions. In contrast, in Site B, there appeared to be less pressure in terms of workload and the transcripts highlighted far more examples of the health visitors demonstrating warmth and caring in an apparent bid to develop relationships for the future. However, the covert nature of the assessment, which was carried out by four of the five health visitors without the clients being informed that it was happening, must raise doubts about how much authenticity and trust could be invested in the relationships.

5.2. Disempowered or expert workers?

Labonte (1994) has commented that 'many front line health workers are relatively powerless in their organisation and need to claim a legitimacy for themselves in order for them to be effective in their work with less powerful individuals and group' (Labonte, 1994, p. 256). Certainly, in her study of nursing in an acute setting, Latter (1998) showed a convincing relationship between nurses' own sense of self-empowerment and their ability to foster it in patients as part of their health promotion role. Conversational analysis reveals no information about interactants' own self-concept, but data about the different study sites matched the conversational styles adopted by the health visitors.

In Site A, the management view was that health visitors could complete the assessment tool over a 16 week period during contacts with families on their caseloads, yet the testimony of the health visitors was that they saw clients only once or twice, because their workload prevented more frequent contact. Any further professional decisions about how, when or whether to use the HNAT were constrained by the requirement to make monthly returns to managers to prove that the assessments had been completed. The tape-recorded interactions, in this site, showed a central emphasis on completing the questionnaires, almost regardless of the content of the answers. It seems unlikely to be mere coincidence that the highly controlled health visitors in Site A appeared to use the most explicitly controlling communication style with their clients.

In Site B, no mention was made of such constraints and the health visitors seemed able to choose the manner in which they introduced or used the Early Intervention Strategy. However, the idea of the health visitor as the 'parenting expert' pervades the operational framework of the EIS (Crompton et al., 1998) and was very apparent in the interactions recorded in Site B. Socialisation of the 'practitioner as expert' does not accord with practice that values partnership and participation. Instead, an expert discourse results in the client's perspective not being given priority and the practitioner seeking agreement to propositions rather than encouraging input (Opie, 1998). The covert nature of the assessment in Site B clearly limited the ability of clients to contribute to their assessments. Furthermore, the technicality of language (lexical choice) as an integral part of the expert discourse also contributes to the disempowerment of clients (Heritage, 1997). It was noticeable in the data how often the words 'assessment' 'needs assessment' and 'assessment tool' were used assuming that the client understood the terms. Many studies (Drew and Heritage, 1992) have shown how the speaker selects descriptive terms, which are fitted to the institutional setting or their role within it.

It is a matter of conjecture, but it may well be that individual health visitors enjoy the professional kudos that the expert role entails. However, the belief that professionals must wield their expertise or lose their own personal power has significant consequences for their clients. Labonte (1997) comments that 'many of us have to confront the vestiges of historic power-over: the way in which our construction of the client functions unintentionally to disempower, rather than to empower. This tendency slots people into the target problems defined by the health professionals, in which we get the answers we want and create the reality we expect by

virtue of the questions we ask and the problems we look for' (Labonte, 1997, p. 65). This seems to typify the control that exists within the health visitor–client interaction when the assessment tool was used. In the 'expert' model the professional is the ultimate decision maker or does not offer the resources that the individual needs to be an active participant in decision-making (Paterson, 2001). In this study it was evident that the health visitors remained in control when deciding the needs of the client, denoted by the way in which they controlled the agenda and did not enable the client to participate on their own terms until the 'business' of the visit was concluded.

5.3. Education for health needs assessment

It is possible that the apparent shortcomings in individual health visitors' communication skills may be attributable to their education and training. The basic curriculum was changed in 1995 (UKCC, 1994), raising serious concern within the profession that critical aspects of health visiting practice are not currently included in the health visitor training programme (Kelsey and Hollindale, 1996; Oldman, 1999; Cowley et al., 2000a, b), and a new programme is to be introduced in 2003.

No data were collected about when health visitors in this study qualified, so any links to education would be speculative. However, there seems little doubt that health visitors who are given the opportunity to develop a more open style of working can enable partnership working, client participation and the identification of needs (Davis et al., 1997; Bidmead et al., 2002). Studies have shown that use of an open agenda, conversational style of communication and respectful listening are effective in enabling the identification of health needs (Davis and Spurr, 1998). However, an investigation into the learning needs of district nurses and health visitors for needs assessment concluded that this activity requires a breadth of learning that includes, but is not confined to, the development of sophisticated communication skills (Cowley et al., 2000a, b).

This earlier research highlights two issues of relevance to this study, that move beyond the simple (if potentially devastating) failure to use a facilitative communication style. First, the capacity to work with an open agenda requires an ability to genuinely accept and value the clients' position and opinions, even if they differ from those of the health visitor or her employer. As highlighted in the last section, this is very difficult for anyone socialised into believing that professional expertise is superior or more correct than the different form of knowledge held by clients about their own situation. Also, having an open-ended agenda can expose the worker to a range of questions on almost any topic, requiring a breadth of knowledge of a far greater order than that required for a pre-determined, prescribed list of needs.

The second point highlighted by Cowley et al. (2000a, b) related to the ability of practitioners to understand and critically analyse wider issues concerned with needs assessment practice. The clear objective in both sites was to gather and deliver information about a predetermined range of issues. It would seem that the relatively uniform pattern of the interactions in both sites resulted from the participants' orientation to their tasks and the different activities arising from them, rather than from a knowledgeable orientation to health promotion or empowerment practice. Education for successful needs assessment, however, would ideally include some attention to consciousness raising and enhancing awareness of these wider matters.

6. Conclusion

The demand for explicitness in the way health visitors target their services has given rise to a plethora of different needs assessment tools, of which only two featured in this study. However, many of the problems identified in this analysis seem to stem from the fact that they are structured, with a pre-determined list of questions that form the basis for assuming that any family's health promotion needs can be categorised and predicted in advance. The results suggest that it is the pre-determined structure that simultaneously emphasises the significance of a professional lead, instead of client participation, and minimises the importance of inter-personal relationships and communication. In the site that emphasised professional expertise, a covert assessment style acted to disempower clients, whereas a more directly controlling style was apparent where the health visitors were, themselves, most explicitly controlled. There seems no reason to believe that a HNAT with a different list of questions or different training in its application would be any more successful.

Use of the instruments was associated with a failure to either identify needs that were relevant to the client or to enable clients to participate in the process. Furthermore, the controlling nature of the interactions, the number of missed cues and the possibility of distress caused by the insensitivity of questioning style are all potentially harmful side effects of using structured instruments to assess needs. In contrast, there is clear research evidence from other studies that a trusting practitioner/client relationship combined with a skilled, open communication style can provide a very successful basis from which to elicit health needs. This study, therefore, adds to growing body of literature that is critical of the use of structured guidelines and needs assessment tools. Accordingly, it is recommended that health visitors should use the open style of needs assessment that has

been shown to be effective and acceptable, rather than an approach based on a structured instrument.

References

Abbott, P., Sapsford, R., 1990. Health visiting: policing the family. In: Abbott, P., Wallace, C. (Eds.), The Sociology of the Caring Professions. Farmer Press, Basingstoke.

Almond, P., 2001. The search for health outcomes: a qualitative study exploring clients and health visitors conceptualisations of health outcomes. Unpublished M.Sc. Thesis, Kings College London, University of London.

Appleton, J.V., 1993. An Exploratory Study of the Health Visitors Role in Identifying and Working with Vulnerable Families in Relation to Child Protection. Unpublished M.Sc. Thesis, Kings College London, University of London.

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

Appleton, J.V., 2002. An examination of health visitors' professional judgements and use of formal guidelines to identify health needs and prioritise families requiring extra health visiting support. Unpublished Ph.D. thesis, King's College London.

Audit Commission, 1994. Seen but Not Heard. Co-ordinating Community Child Health and Social Services for Children in Need. HMSO, London.

Barker, W., 1990. Practical and ethical doubts about screening for child abuse. Health Visitor 1, 14–17.

Barker, W., 1996. Form filling: a demotion of professional skills. Community Practitioner 69 (10), 407–408.

Bidmead, C., Day, C., Davis, H., 2002. Partnership working: what does it really mean? Community Practitioner 75 (7), 256–259.

Blackburn, C., 1991. Poverty and Health: Working with Families. Open University Press, Milton Keynes.

Browne, K., 1995. Preventing child maltreatment through community nursing. Journal of Advanced Nursing 23 (3), 499–507.

Bryans, A., McIntosh, J., 2000. The use of simulation and post-simulation interview to examine the knowledge involved in community nursing assessment practice. Journal of Advanced Nursing 31 (5), 1244–1251.

Chalmers, K.I., 1993. Searching for health needs: the work of health visiting. Journal of Advanced Nursing 18, 900–911.

Chalmers, K.I., 1994. Difficult work: health visitors work with clients in the community. International Journal of Nursing Studies 31 (2), 168–182.

Chalmers, K.I., Luker, K.A., 1991. The development of the health visitor–client relationship. Scandinavian Journal of Caring Sciences 5 (1), 33–41.

Clark, J., 1985. The Process of Health Visiting. Unpublished Ph.D. thesis, Polytechnic of the South Bank, London.

Collinson, S., Cowley, S., 1998. An exploratory study of demand for the health visiting service within a marketing framework. Journal of Advanced Nursing 28 (3), 499–507.

Community Practitioners and Health Visitors Association, 1998. Staffing crisis: a third of health visitors say they want to leave. Community Practitioner 71(11), 350.

Council for the Education and Training of Health Visitors (CETHV), 1977. An Investigation into the Principles of Health Visiting. CETHV, London (reprinted 1993, English National Board for Nursing, Midwifery and Health Visiting, London).

Cowley, S., 1995. In health visiting a routine visit is one that has passed. Journal of Advanced Nursing 22, 276–284.

Cowley, S., 2000. Situation and process in health visiting. In: Appleton, J.V., Cowley, S. (Eds.), The Search for Health Needs: Research for Health Visiting Practice. Macmillan, Basingstoke.

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

Cowley, S., Buttigieg, M., Houston, A., 2000b. A first steps project to scope the current and future regulatory issues for health visiting. Florence Nightingale School of Nursing and Midwifery King's College, London (Report to United Kingdom Central Council for Nursing, Midwifery and Health Visiting).

Crompton, K., Davies, M., Humphries, A., 1998. Child protection: developing an early intervention strategy. Community Practitioner 71 (2), 56–58.

de la Cuesta, C., 1994. Relationships in health visiting: enabling and mediating. International Journal of Nursing Studies. 31 (5), 451–459.

Davis, H., Spurr, P., 1998. Parent counselling: an evaluation of a community child mental health. Journal of Child Psychology and Psychiatry 39 (3), 365–376.

Davis, H., Spurr, P., Cox, A., Lynch, M., Von Roennne, H.K., 1997. A description and evaluation of a community child mental health service. Clinical Child Psychology and Psychiatry 2 (2), 221–238.

Department of Health, 1989. Working for Patients. Cmnd 555. HMSO, London.

Department of Health, 1997. The New NHS: Modern, Dependable. Cmnd 3809. Stationery Office, London.

Department of Health, 2000. The NHS Plan: A plan for investment A plan for reform. The Stationery Office, London.

Drew, P., Heritage, J., 1992. Analysing talk at work an introduction. In: Drew, P., Heritage, J. (Eds.), Talk at Work: Interaction in Institutional Settings. Studies in Interactional Sociolingiustics 8. Cambridge University Press, Cambridge, pp. 3–65.

Foster, M.C., Mayall, B., 1990. Health visitors as educators. Journal of Advanced Nursing 15, 286–292.

Garfinkel, H., 1967. Studies in Ethnomethodology. Prentice Hall, Englewood Cliffs, NJ.

Gibson, C.H., 1991. The concept of empowerment. Journal of Advanced Nursing 16, 354–361.

Goddard, C.R., Saunders, B.J., Stanley, J.R., 1999. Structured risk assessment procedures: instruments of abuse? Child Abuse Review. 8, 251–263.

Have ten, P., 1999. Doing Conversation Analysis: A Practical Guide. Sage Publications, London.

Heritage, J., 1997. Conversational analysis and institutional talk. In: Silverman, D. (Ed.), Qualitative Research; Theory, Method and Practice. Sage Publications, London, pp. 161–182.

Heritage, J., Greatbatch, D., 1991. On the institutional character of institutional talk: the case of news interviews. In: Boden, D., Zimmermann, D.H. (Eds.), Talk and Social Structure: Studies in Ethnomethodology and Conversation Analysis. Polity Press, Cambridge, pp. 93–137.

Heritage, J., Sefi, S., 1992. Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Drew, P., Heritage, J. (Eds.), Talk at Work: Interaction in Institutional Settings. Studies in Interactional Sociolingiustics 8. Cambridge University Press, Cambridge, pp. 359–417.

Houston, A., Cowley, S., 2002. Health needs assessment in the health visiting service and the impact on the ethnic community International Journal of Nursing Studies, accepted for publication.

Kelsey, A., Hollindale, P., 1996. Equal but different: health visiting and the new curriculum. Health Visitor 69 (11), 457–458.

Kendall, S., 1991. Client Participation in Health Visiting; an Analysis of the Health Visitor Client Interaction. Unpublished Ph.D. Thesis, Kings College University of London, London.

Kendall, S., 1993. Do health visitors promote client participation? An analysis of the health visitor-client interaction. Journal of Clinical Nursing 2, 103–109.

Kendall, S., 1998. Health and Empowerment: Research and Practice. Arnold, London.

Kristjanson, M.N., Chalmers, K.I., 1991. Preventive work with families: issues facing public health nurses. Journal of Advanced Nursing 16, 147–153.

Labonte, R., 1994. Health promotion and empowerment: reflections on professional practice. Health Education Quarterly 21 (2), 253–268.

Labonte, R., 1997. Community and public health: an international perspective. Health Visitor 70 (2), 64–67.

Latter, S., 1994. Health education and health promotion: perceptions and practices of nurses in acute care settings. Unpublished Ph.D. Thesis, Kings College University of London, London.

Latter, S., 1998. Health promotion in the acute setting: the case for empowering nurses. In: Kendall, S. (Ed.), Health and Empowerment: Research and Practice. Arnold, London, pp. 11–37.

Machen, I., 1996. The relevance of health visiting policy to contemporary mothers. Journal of Advanced Nursing 24, 350–356.

McIntosh, J., 1986. A Consumer Perspective on Health Visiting. Report to Scottish Home and Health Department Glasgow, University of Glasgow.

Mc Naughton, D.B., 2000. A synthesis of qualitative home visiting research. Public Health Nursing 17 (6), 405–414.

Mitcheson, J., 2001. Empowerment or control: an analysis of the health visitor client interaction during the assessment process and the extent to which it enables client participation. Unpublished M.Sc. Thesis, Kings College London, University of London.

Naughton, A., Heath, A., 2001. Developing an early intervention programme to prevent child maltreatment. Child Abuse Review 10, 85–96.

NHS Executive, 1996. Child Health in the Community: A guide to good practice. Department of Health, London.

Normandale, S., 2001. A study of mothers perceptions of the health visiting role. Community Practitioner 74 (4), 146–150.

Oldman, C., 1999. An evaluation of health visitor education in England. Community Practitioner 72 (12), 392–395.

Opie, A., 1998. 'Nobody's asked me for my view': users empowerment by multidisciplinary health teams. Qualitative Health Research 8, 188–206.

Orr, J., 1992. Assessing individual and family health needs. In: Luker, K., Orr, J. (Eds.), Health Visiting: Towards Community Health Nursing. Blackwell Science, Oxford.

Paterson, B., 2001. Myth of empowerment in chronic illness. Journal of Advanced Nursing 34 (5), 574–581.

Pearson, P., 1991. Clients perceptions: the use of case studies in developing theory. Journal of Advanced Nursing 16, 521–528.

Perakyla, A., Silverman, D., 1991. Reinterpreting speech-exchange systems: communication formats in aids counselling. Sociology 25 (4), 627–651.

Psathas, G., Anderson, T., 1990. The 'practice' of transcription in conversation analysis. Semiotica 78, 75–99.

Rappaport, J., 1984. Studies in empowerment: introduction to the issue. Prevention in Human Services 3, 1–7.

Read, J., Wallcraft, J., 1992. Guidelines for Empowering Users of Mental Health Services. Mind/COHSE, London.

Rissell, C., 1994. Empowerment: the holy grail of health promotion? Health Promotion International 9, 39–47.

Roberts, C., 1996. The proof of the pudding. Health Service Journal 106 (5494), 27.

Robinson, J., 1982. An Evaluation of Health Visiting. ENB/CETHV, London.

Rodwell, C., 1996. An analysis of the concept of empowerment. Journal of Advanced Nursing 23, 305–313.

Ryles, S.M., 1999. A concept analysis of empowerment: its relationship to mental health nursing. Journal of Advanced Nursing 29 (3), 600–607.

Sacks, H., Schegloff, E.A., Jefferson, G., 1974. A simplest systematics for the organization of turn taking for conversation. Language 50, 696–735.

Sandelowski, M.Q., 1995. Sample size in qualitative research. Research in Nursing and Health. 18, 179–183.

Schon, D.A., 1983. The Reflective practitioner. How Professionals Think in Action. Ashgate Publications, Aldershot.

Sefi, S., 1985. The First Visit-a study of Health Visitor-Mother Verbal Interaction. Unpublished MA Dissertation Coventry, University of Warwick.

Tones, K., 1998. Health education and the promotion of health: seeking wisely to empower. In: Kendall, S. (Ed.), Health and Empowerment: Research and Practice. Arnold, London.

Twinn, S., 1989. Change and conflict in health visiting practice. Dilemmas in assessing the professional competence of student health visitors. Unpublished Ph.D. thesis, Institute of Education University of London.

Twinn, S., 2000. Professional artistry: the contribution to the search for health needs. In: Appleton, J.V., Cowley, S.

(Eds.), The Search for Health Needs: Research for health Visiting practice. Macmillan Press, Basingstoke.

Twinn, S., Cowley, S. (Eds.), 1992. The Principles of Health Visiting: A Re-examination. HVA/UKSC, London.

United Kingdom Central Council for Nursing, Midwifery and Health visiting, 2002. Developing Standards and Competencies for Health Visiting. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health visiting, 1994. The future of Professional Practice—the Councils Standards for Education and Practice Following Registration. UKCC, London.

Williams, D., 1997. Vulnerable families: a study of health visitors prioritization of their work. Journal of Nursing Management 5, 19–24.

World Health Organisation, 1986. Ottawa Charter for Health Promotion: Conference on Health Promotion, 17–21 November 1986 Copenhagen WHO Regional Office for Europe.