Measuring the parent/health visitor relationship: Piloting the questionnaires

› Abstract

This final paper of five presents the steps taken to construct and pilot questionnaires to measure the parent/health visitor (HV) relationship. Construction of the questionnaires built on evidence from qualitative research undertaken with parents and HVs, and was presented in the previous papers. The questionnaires were piloted in the community, with involvement from parents and HVs to adjust the wording of statements for ease of understanding and clarity, and to ensure construct validity and reliability. The questionnaires proved acceptable and understandable to parents and HVs who quickly completed them. Statistical analysis confirmed that the questionnaires were sensitive to different relationships and that, overall, HVs had positive relationships with parents. The clinical significance of the evidence was also analysed.

Key words

› Qualities › Relational skills › Qualitative research › Measurement indicators › Health visitor relationships

This is the final paper in a series of five presenting the development and validation of questionnaires to measure the parent/health visitor (HV) relationship. This relationship is obscure, varied and personal to each situation, while measurement requires observable behaviours or activities. These behaviours and activities are 'indicators' of something much deeper and felt at a personal level by the participants. The measure is not of the 'relationship' itself, therefore, but is an indicator of it. The importance of measuring the relationship should not be underestimated as it is essential to research and practice to provide evidence for what HVs have long asserted—that a positive parent/HV relationship is central to the health visiting process (Bidmead and Davis, 2008; Condon, 2011; Pound, 2013a; Pound, 2013b).

The interpretive enquiry described in the last three papers (Bidmead et al, 2016a; Bidmead et al, 2016b; Bidmead et al, 2016c) concentrated on identifying parents' and HVs' subjective experiences of their relationships, clarifying the details and processes present. An analysis of these factors enabled a synthesis, to distil common indicators needed to measure the relationship and formulate a set of questionnaires, explained below. These instruments were then piloted through observation to verify and confirm the findings.

Distilling the content of questionnaires

Questionnaires are described as having 'content validity' when they are based on professional knowledge, including evidence and clinical experience. To achieve this, the content of the questionnaires was distilled from the preliminary work reported in the earlier papers. This complex process involved integrating the analysis of parent (Bidmead et al, 2016b) and HV (Bidmead et al, 2016a) interview data and a facet analysis of other measures of client and therapist helping relationships reviewed at the start of the study (Bidmead et al, 2015). In the parent interview data, the emphasis was on the HV's experience and knowledge. HVs were a useful source of advice and were valued by parents because of this. However, the HV also had to be non-judgemental, caring, friendly and able to put parents at their ease. None of these qualities or skills featured in existing measures where clients were asked to rate their therapist or social workers, or patients to rate their doctors or nurses. The relationship measures used in other professions were, therefore, inappropriate for use in parent/HV relationships.

The parent interview data also identified various organisational factors that affected the

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Table 1. Factors that define the relationship of parent/health visitors not found in other helping relationship measures

Health visitor factors	Parent factors	Organisational factors
Health visitor knowledge and expertise Non-judgemental attitude Caring Friendly The ability to put parents at their ease The ability to relate to babies and children The skill of relating to other adults who may be present	Openness and honesty Friendliness Interest Trust Respect for health visitor	Continuity of care Home visiting

Table 2. Constructs used in parent questionnaires

First visit	Established relationship	Organisational
Health visitor (HV) introductions HV openness HV empathy HV respect HV information/knowledge HV listening HV body language HV relationship to baby	HV empathy HV encouragement HV remembering HV reliability/trust in HV HV information giving HV respect/punctuality HV body language HV ability to give time Continuity of contact	Continuity of HV contact Ability to identify HV from other professionals at clinic Social contact at clinic with other parents Welcoming approach of HV Ability of HV to give parent time HV record keeping in *Red Book*

ability of HVs and parents to build and maintain their relationships with each other (Bidmead et al, 2016c). Continuity of care and home visiting were found to be important. However, these factors were absent in other measures as clients may always see the same therapist and home visiting may not be their usual method of service delivery (*Table 1*).

Also, it was particularly noted that HVs' knowledge and experience in relation to child health and development were important to the relationship. Moreover, although their prime relationship was with the mother, HVs also needed to relate to babies and children, as well as fathers or other family members who may be present. The relationship measures from other helping professions do not take this fact into account. Furthermore, none of the existing measures mentioned the client contribution to the relationship. However, this was considered important by HVs and, therefore, necessary for inclusion in the new measure.

Construct validity is present if the coding definitions can demonstrate real and clinically significant changes. The interview data revealed the importance of organisational factors, along with the qualities and skills of both parents and HVs, and showed how these all combined to achieve change through the health visiting relational process (Bidmead et al, 2016c).

The new objective measure of parent/HV relationships needed to reflect these details. To encompass them all, three sets of two questionnaires were devised. Each set included one for completion by the parent and one for the HV about their relationship. One set was designed to be suitable for the first meeting (usually the new birth visit) and one for further along in the relationship when the infant might be 3–4 months old. Also at this stage in the relationship, parents and HVs were each asked to complete an organisational questionnaire.

Questionnaire design

For accuracy of measurement, the questionnaires needed to be as objective as possible. A simple statement followed by a 'Yes, I agree' or 'No, I disagree' was used. Subjective statements were avoided to enhance the objectivity of the respondent and to make it possible for a 'Yes' or 'No' answer. 'Feeling' statements, which were common in some relationship measures reviewed, were omitted and replaced with observable characteristics; for example, not 'I felt the parent

Table 3. Constructs used in health visitor questionnaires

First visit	Established relationship	Organisational
Parent interest	HV remembering	Workload and its effect on provision of services
Parent welcome and friendliness	Parental autonomy	Team leadership
Parental acceptance of service	Parental acceptance of service	Size of HV team
Parent body language	Parental information seeking	Record-keeping
Willingness to work in partnership	Parental openness	Meeting attendance
Parent communication skills	Parental use of services	Clinical supervision
Health visitor (HV) trust of parent	Parental self-confidence	Skill mix
Parent openness	HV trust of parent	Ability to give follow-up care in clinic/home
		Professional autonomy

was unhappy to see me' but 'The parent's facial expression indicated that she was unhappy to see me'. *Tables 2* and *3* summarise the constructs used in the design.

Approximately half the statements on each questionnaire were worded negatively so that a 'No' response would be positive for the relationship; for example, 'The role of the health visitor is unclear to me'. This meant that the respondent needed to read the statements carefully and give a considered response, thus avoiding response bias.

Statements on the parent versions of the questionnaires gave the parents' perceptions of the HV's contribution to the relationship. Likewise, statements on the HV versions gave the HV's perceptions of the parent contribution to the relationship. The differing perspectives have been addressed in previous papers (Bidmead et al, 2016a; Bidmead et al, 2016b).

It was anticipated that the questionnaires would be completed at the end of a parent/HV meeting in which young children and/or babies may be present, so the questionnaires were kept as brief as possible to maximise ease of completion (10–12 questions in each).

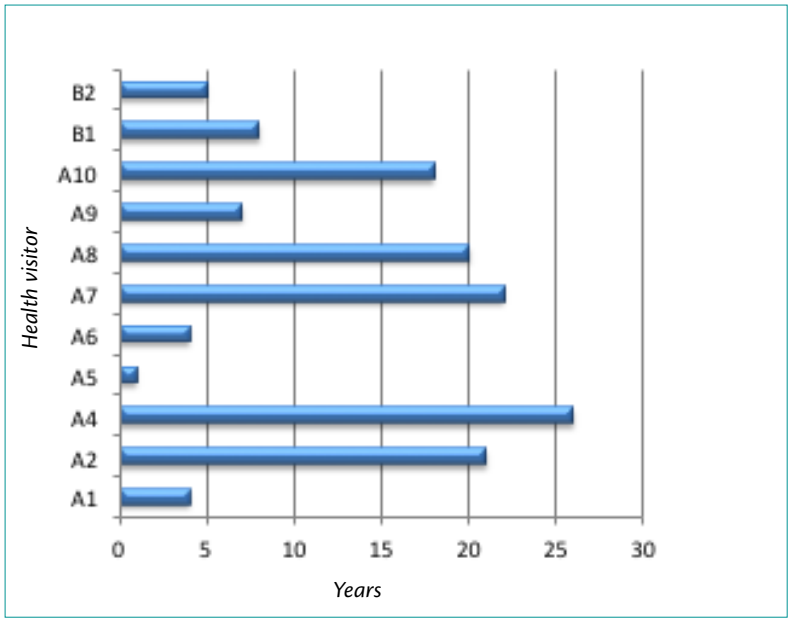

Figure 1. Health visitors' years of experience

Pilot phase 1

Aims and objectives

Following NHS ethical approval the first pilot phase was initiated with the aims:

- To test the construct and content validity of the questionnaires
- To test the methods of analysis.

Methods

Sample

Two inner city Trusts were chosen as they had a history of training HVs in the Family Partnership Model (Davis and Day, 2010). This meant they would be familiar with the concept of needing to establish and maintain relationships with parents. Eleven HVs volunteered after presentations of the study aims and objectives at HV meetings. All the HVs worked in skill mix teams covering health visiting services for the under-5s in various wards of the borough. The HVs' experience varied from 1–26 years (*Figure 1*).

The HVs were asked to take the researcher to visit as many different kinds of families as possible, having previously sought their permission. Heterogeneity of the sample was important so that the instruments developed might be applicable to the many different types of families that comprise a health visiting caseload. The views of these families were needed to establish the validity of the constructs across

diverse communities. HVs recruited families where English was spoken but not necessarily as a first language. Included in the sample were families from France, Spain, Russia, Lithuania, Cameroon, Sierra Leone, the West Indies, New Zealand and Ireland as well as British parents. They were asked to record the number of children they had along with their age. No parents under the age of 20 years took part.

The piloting process

The researcher accompanied 11 HVs on visits to 36 parents and observed the visit, recording field notes on the interaction and the context in which it took place. After each visit, the parent was asked to complete the questionnaire and was interviewed to ascertain its relevance using a semi-structured interview technique. Parents' comments were recorded in field notes. The HV was also asked to complete two questionnaires: one about her relationship with the parent and the other about her employing organisation. She was also interviewed in the same way as the parent and her comments noted.

A database of participants was constructed in Excel. All participants were logged and coded so that parent–HV dyads could be identified for future analysis. Field notes were also recorded about the HV's team and working environment. The notes included observations of the parent/HV interaction, relationship and any particular problems experienced by the family.

The six pilot versions of the questionnaire proved acceptable to parents and HVs. They were easy to complete in a short space of time. HVs and parents agreed that the statements reflected items that were important to them as indicators of their relationships with each other. However, there were instances where the wording of the items needed changing and some overlapping of items required amalgamation or removal from the questionnaire to reduce item non-response and response bias. For example, in the parent version of the first visit questionnaire, a statement read 'The health visitor ignored my baby'. This statement was later removed as it overlapped with 'The health visitor played with/examined my baby' and 'The health visitor complimented me on my baby'.

Following an analysis of the response profile it was noted that 'The health visitor ignored my baby' was never given a positive response, meaning that HVs evidently responded to every baby. However, four out of the 13 parents completing the questionnaire indicated that the HV did not play with or examine the baby. Only one HV failed to compliment the parent on her baby. Although there was overlap in the statements, it appeared that HVs do not ignore the baby completely, so removal of this item was justified. Consequently, the statements 'The health visitor played with/examined my baby' and 'The health visitor complimented me on my baby' were retained as it is part of the HV role to at least see, if not examine, the baby at a first visit.

Statistical analysis

The treatment evaluation by the Le Roux method (TELER) approach was chosen as its philosophy respects the individual and acknowledges the imperfect nature of measurement, which can only be as precise as the understanding of the phenomenon under scrutiny, i.e. the parent/HV relationship. The foundations of the measurement tool are clinical knowledge and expertise, which is brought to bear on that understanding as developed between practitioners and parents during the interpretive enquiry.

TELER is a structured system for making and presenting clinical notes for an individual receiving treatment or care (Le Roux, 2003). These clinical indicators are used as a measure of the effectiveness of the treatment or care received. The method had already been piloted in the field of health visiting, to investigate decisions and judgements during a new birth visit (Newland, 2004). As it was deemed suitable in health visiting it was, therefore, decided to explore its use further as a measuring tool for the parent/HV relationship. The questionnaires were time independent, so could be used when a client was seen only once (Le Roux, 2003) and were, therefore, particularly pertinent to the way in which HVs often work.

The questionnaire has the potential for a high level of objectivity (Le Roux, 2003). The level to which this potential is realised is determined by clinical knowledge and the questionnaire design. The knowledge can be from experts in the field, from literature and from specific research. The review of measures (Bidmead et al, 2015) allowed an in-depth exploration of items researchers considered important to measure when assessing helping relationships. The last three papers in this series revealed what parents and HVs believed to be of importance in their relationships. This was compared with existing knowledge present in the measures allowing a synthesis of knowledge to ensure the content validity of the questionnaires.

The questionnaires produced data on the number of barriers experienced by each health visitor and parent during an interaction. These were counted and numeric codes applied to the

Table 4. Allocation of TELER codes

Number of health visitor or parental barriers to the relationship	TELER code	Impact on the parent/health visitor relationship
10 or 11	1	Severe
8 or 9	2	Moderate
4 to 7	3	Indeterminate
2 or 3	4	Slight
0 or 1	5	None

data (*Table 4*) so ordinal data were produced making it suitable to the application of non-parametric statistical tests. Using the TELER method meant that not only would group level data be generated but also, of more practical concern, data at an individual level would not be lost. This meant that individual problems could be identified and potentially addressed. The researcher remained in contact with the data at all times so that interpretations could be made of the clinical significance of the findings at both the group and individual level. The same statistical processes were used on the HV and the parent data.

Results

The statistical tests (chi-squared test of association and a T-test) revealed that there were no relationship problems between HVs and parents in this pilot sample. The result was statistically significant (p=0.05). Having established the content and construct validity of the questionnaires through the first pilot the new adapted questionnaires were ready for further testing in the community with more parents and HVs.

Pilot phase 2

The three sets of questionnaires were piloted with 15 HVs and 53 parents aiming to test the newly designed questionnaires to gain support for their construct validity. The methods and procedures used for pilot phase 1 were repeated for phase 2.

Results

The questionnaires proved acceptable to the parents and health visitors. There were fewer comments relevant to the wording of the statements, and parents and HVs found them simple to complete. The construct validity of the questionnaires was established, as demonstrated by their sensitivity to the differences in the parent/HV relationships.

The statistical analysis of the data from the first visit questionnaire showed that parents and HVs can establish positive relationships at a first meeting. However, for both data sets there was one barrier that was statistically significant. For HVs it was the parents' lack of interest in the information they gave (T=5.15; degrees of freedom [df]=24; p=≤0.05) and for parents it was the HV's failure to examine or play with the baby (T=5.15; df=24; p=≤0.05).

An explanation of the fact that parents may not have been interested in the information given by HVs may have been because they were given unsolicited advice (Mitcheson and Cowley, 2003). It may also have been that the parent was not having her first baby so had already received the information.

The HVs failure to examine or 'play' with the baby was surprising in that the *Healthy Child Programme* (Department of Health, 2009) refers to this as the 'new baby review'. However, it also suggests that the baby is monitored for growth and development at this stage only if there is professional concern or if the parents wish it. It would seem important, however, that the HV establishes a baseline of information from which to assess future growth and development, as failure to do this may lead to delay in identifying difficulties. Also, as far as the relationship is concerned, it could lead to a misunderstanding of the role of the health visitor. For example, when HV (A4) failed to examine the baby the parent remarked that she felt that it was not the role of the HV to examine the baby. This could have repercussions later in the relationship when developmental reviews were due.

The analysis of the established relationship questionnaire revealed that parents in this study had positive relationships with HVs. However, five parents experienced HV barriers to their relationships, so although the group data could obscure this fact, at an individual level it could not be ignored. There were three barriers that

Table 5. Health visitor established relationship data

	TELER code	Parental impact on the relationship	Number of health visitors
10 or 11	1**	Severe	
8 or 9	2*	Moderate	
4 to 7	3	Indeterminate	7
2 or 3	4*	Slight	7
0 or 1	5**	None	14
Total			28

** $p \leq 0.0059$
* $0.0059 < p \leq 0.1134$

achieved a statistically significant result (T=5.45; df=27; p≤0.05). The three barriers identified meant that parents may have felt undermined by HVs not supporting their decisions, did not feel listened to and that they were unable to meet their HV in clinic.

The HV data revealed that HVs experienced parent barriers to their relationship but statistically these had little or no impact on the relationship. However, this is not the same as having no effect. For seven HVs who statistically had an 'indeterminate' (code 3) response (*Table 5*), there were observed relationship problems. The parents were often a 'cause for concern' to the HV because of child protection or child in need issues. Seven HVs (coded 4–7 'slightly affected') (*Table 5*) reported other parent problems such as postnatal depression or child health problems, which may also have influenced their relationships. The analysis showed that, although HVs may be struggling to maintain their relationships with parents, especially where there were child protection issues, parents did not perceive any relationship problems or difficulties.

This result reflects the findings of psychotherapy literature showing that clients rate their relationships with therapists more positively than therapists do (Huber et al, 2005) and lends further evidence to the construct validity of these instruments.

Analysis of the organisational questionnaire showed that for HVs there were seven statistically significant possible barriers to their relationships with parents (T=4.18; df=14; p≤0.05) out of a possible 11. The problem areas were around workload, record-keeping, clinical supervision, skill mix, attendance at meetings and two concerns about continuity of contact. Statistically, these did not create a problem for the relationship, which seemed unlikely as 12 of the 15 HVs were experiencing organisational 'indeterminate', or 'moderate' problems affecting their relationships with parents. For parents, on the other hand, statistical analysis of the data revealed that the organisational barriers they encountered did affect their relationships with HVs but only slightly. Five of the 10 barriers were statistically significant (T=5.35; df=28; p≤0.05). The problems were to do with two concerns about continuity of care, HV approachability, the business of clinics and peer support.

Clinical significance

It was clear from observation that, in practice, there were some clinically significant difficulties in relationships for both HVs and parents that were obscured by the statistical analysis. All of the questionnaires were, therefore, re-examined and recoded for clinical significance.

For example, the statistical analysis of the data of the HV established relationship questionnaires revealed that 14 of the 28 HVs found that potential parental barriers influenced these specific relationships either 'slightly' or 'indeterminately' (*Table 5*). However, there were some clinically significant difficulties in the relationships for these 14 HVs as each statement on the questionnaire is an important indicator of the relationship, so even one barrier may have clinical significance.

Clinical significance was determined by consulting the database of participants in the study with the notes made about each family and their interaction with the HV. It was readily apparent that where there were a number of concerns for the parent or the HV, action would need to be taken by the HV to remedy the relationship. This may mean, for example, that the HV would need to discuss her concerns in supervision to gain understanding of what was happening in her relationship with the parent. Similarly, if the parent questionnaire showed

Box 1. Case study

Health visitor (HV) (A12), with over 20 years' experience in the profession, visited a father (P2.2) with eight children. Neither he nor his partner, who had learning disabilities, were literate. The children's ages ranged between 13 years and 2 years. The door was opened by a child and there were clothes and dirty nappies strewn in the hallway. Mum and Dad were in bed watching a video. The house was poorly furnished with no carpets or floor coverings. Eventually, the mother appeared shouting and swearing at the children who responded in like manner. The mother had limited conversational abilities and understanding but eventually the father appeared partially dressed. He was more articulate than his partner and the HV discussed an upcoming 'team around the child' meeting at the school concerned with the elder son's stealing, and not attending the appointments at the child and adolescent mental health unit. An audiology appointment had also been missed. Letters were often ignored due to literacy problems. During conversation with the father, the HV was respectful at all times. However, the HV said to the researcher that she despaired of there ever being any change with this family, with whom she had been involved for the last 18 months. She had many concerns for the wellbeing of the children. She found it hard to deal with the father, whom she neither liked nor trusted. He was the parent with whom the HV had most interaction, as he seemed to take charge of the household. HV (A12) marked seven barriers to her relationship with this father. He needed constant advice from her and did not make his own choices. He disregarded information given to him and failed to ask questions in the interests of his children. The HV's records showed that the parent had not acted positively in the children's best interests and he failed to contact the HV when there was a problem and he never attended clinic. Unsurprisingly, the HV felt unable to comment on the parent's growing confidence in the management of the family. The parent, on the other hand, only marked the HV as presenting two barriers to the relationship. He agreed that he never saw the HV at clinic and he indicated that when he was speaking with the HV she failed to make eye contact. It is possible that he misunderstood this statement on the questionnaire as from observation the HV made good eye contact with the father. The researcher read the statements to the parent to ensure understanding of the written word. As shown in the statistical analysis, although the HV struggled with the relationship the father was happy with his relationship with the HV. The seven barriers encountered by the HV, however, are considered statistically 'indeterminate'.

difficulties in the relationship, this would signal the need for an open discussion with the parent about the problems the parent was facing. The willingness of the HV to address the situation may enhance the relationship without necessitating further steps.

The data were re-coded to allow for clinical significance and re-analysed (*Table 6*). The example given in *Table 6* is data from the HV established relationship questionnaire. The level of coding 2–5 may indicate the HV's lack of trust in the parent and parent's lack of trust in the HV. This could be indicative of child protection issues being present (*Box 1*). In the example shown, there were concerns for the welfare of the children in the family and the statistical analysis revealed that although the HV struggled with the relationship, the father was happy with his HV relationship. The seven barriers encountered by the HV, however, were considered statistically 'indeterminate'. When re-analysed for clinical significance then seven points are revealed that may act as barriers, potentially severely inhibiting the relationship. This may require some action by the HV. In this sample, all those with a TELER code one to three either were a cause for concern to the HV or were on the child protection register. However, on the HV questionnaires seven of the 14 families with a code zero to one had either a child in need, cause for concern or child protection issues so clearly HVs and parents were able, in some circumstances, to maintain good relationships where these issues were present.

Discussion

Traditional approaches to instrument development depend heavily on expert knowledge and the use of psychometric tests to validate instruments. However, the expertise about parent/HV relationships lay in not only the literature and experts in the field, but also with the parents and HVs. It is they who observe and experience these relationships and their knowledge was therefore the basis of the formation of the questionnaires through the qualitative study. Knowledge from health visiting literature was also used, as was the knowledge of theories of relationship. This knowledge ensured minimal bias in the development of the measuring tools. As it was the parents and HVs who would be completing the questionnaires, their views were kept to the forefront during instrument development.

Further steps were taken throughout the study to ensure that the instruments produced would be valid and reliable. The content validity of the instruments was established by making certain that the questionnaires provided an adequate description of the parent/HV relationship. The meaning and relevance of the items on the measures was self-evident to the users, as was confirmed by the post questionnaire interview data, and so face validity was also established (Le Roux, 2003). The hypothesis that the barriers, as measured by the items on the questionnaire, would constitute an indication of a positive or negative relationship was tested with HVs and parents in the communities from which the tools had been developed. Construct validity of the instrument was established using hypothesis

Table 6. Clinical significance of parental barriers to health visitor established relationships

Parental barriers	TELER code	Parental impact on the relationship	Clinical significance	Number of health visitors
9, 10, 11**	1	Severe	Barriers obstruct relationships	0
6 or 7 or 8*	2	Moderate	Barriers severely inhibit relationships	4
4 or 5	3	Indeterminate	Barriers inhibit relationships	3
2 or 3++	4	Slight	Barriers mildly inhibit relationships	7
0 or 1+	5	None	Barriers do not obstruct relationships	14
Total				28

testing. It was hypothesised that barriers experienced by the HV or parent as measured by the items on the questionnaire would or would not constitute a relationship problem. The pilot studies showed that it was possible to use the instruments to measure the parent/HV relationship and the results demonstrated that the instruments were sensitive to differences in those relationships. The items on the relationship questionnaires also demonstrated differences between parents and between HVs. The organisational questionnaires showed an impact of organisations on HV relationships but not on parents' relationships.

The questionnaire was sensitive to differences between HVs perceptions of organisational support for the building of relationships with parents. Group data showed that parents and HVs establish positive relationships at a first meeting and that their ongoing relationships are unaffected by barriers. An underlying realistic assumption is that, if observable barriers are absent, a positive relationship will be established. However, at an individual level the data revealed important differences in the relationships formed and demonstrated the questionnaires' sensitivity towards these differences. The clinical significance of these findings was established.

Limitations

The validation of any new instrument is an ongoing process that is increased by use in research (Stewart and Archbold, 1997). The instruments devised in this study thus require further testing in the field with parents and HVs across different communities and organisations (*Box 2*).

Conclusion

The instruments developed have content, face and thus construct validity. The central part played by parents and health visitors both during this phase and during the pilot phases cannot be underestimated. As described above, their contributions have been invaluable to the validation of the instruments. This study has demonstrated that indicators of the parent/HV relationship can be measured. In the process of achieving this, there have been five contributions to HV knowledge and theory development:

- Identification of the HV micro-skills and qualities involved in forming working relationships with parents (Bidmead et al, 2016a)
- Identification of the parental contribution to the HV working relationship in terms of their qualities and skills (Bidmead et al, 2016b)
- Identification of the health visiting process (Bidmead et al, 2016b)
- The creation of a valid instrument to measure the impact of organisations on HV and parent working relationships (Bidmead et al, 2016c)
- The creation of valid instruments to measure parent/HV relationships in this paper.

Box 2. Recommendations for use of questionnaires

1. To measure the relationships of one health visitor (HV) with all parents visited at the new birth or removal in using both HV and parent questionnaires
2. To measure all HVs' relationships with parents in one area
3. To measure new birth and ongoing relationships between HVs and parents
4. To measure the organisational impact on parent/HV relationships
5. To compare organisations' impacts on parent/HV relationships over different areas
6. As an aid to learning about effective relationships in health visiting for students or those newly qualified in the profession
7. For use in research where parent/HV relationships are considered relevant

Key points

- Instruments developed for other professions omit key issues of the parent/HV relationship
- Piloting this set of instruments demonstrated that it is possible to measure observable behaviours and indicators of the parent/HV relationship
- The instruments are for the relationship at first meeting between parents and HV, for established relationships and to show the impact of the employing organisation
- The instruments are based on an underlying realistic assumption that, if observable barriers are absent, a positive relationship will be established
- The paper explains the TELER method used to develop and validate the instruments, which are suitable for groups (e.g. in research or across an organisation) or individuals (e.g. for one HV to use in supervision)

It is to be hoped that further validation of the questionnaires will take place in other communities and that they will contribute to demonstrating the worth of the health visiting profession. JHV

This article has been subject to peer review.

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For queries regarding use of the questionnaires and licensing, please contact: Roger Young, Managing Director, Longhand Data, 11 Welburn Business Park, Greets House Road, Welburn, York YO60 7EP roger.young@longhanddata.com

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